

Pain Identification and Screening Training for Front Line Staff Members

Quality Palliative Care in Long Term Care Alliance (QPC-LTC)



Winter of 2014



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Acknowledgements

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For more information regarding the project please visit www.palliativealliance.ca or email our team at palliativealliance@lakeheadu.ca

Introduction

The information in this toolkit is based on a pilot educational event that was conducted in both Bethammi Nursing Home and Hogarth Riverview Manor. The purpose of the training was to support all members of the interdisciplinary team in identifying, screening, and communicating pain. **Please note that this innovation is not meant to be used as a pain assessment tool.**

Objectives of Training

After this educational session, staff will be able to:

- Identify residents who are experiencing pain
- Complete a pain screening using provided tool
- Communicate presence of pain to registered staff

Content of Training

- Pain Management Decision Tree
- Pain Identification and Screening protocol
- Revised PSW flow sheet.
- Link sections of LTC Act and education in service



Planning the Training Event

Prior to planning the training event please consider the following:

Get buy-in from the management team. It is important for the management team to understand the objectives of this training prior to planning this event. It is also important that they understand that this training can include all staff members and does not need to be limited to registered nursing staff. Please note that this training does not support staff in conducting formal pain assessments, it is solely for identifying, screening, and communicating pain.

Tip: Management within the long term care home may consider assigning staff members to attend this training as well as making this event mandatory to ensure all staff are able to attend.

Advertising the event. Ensure that the training event is advertised in locations that are accessible for front-line staff well in advance.

Staff Compensation. It is important that you have a clear message on whether the staff will be compensated for this training / education. Can they complete it during work time?

Participation. It is advised that 5-15 staff participate in the training during a session. This will allow for full engagement of participants. Determine a target— example: 70-80% will receive target during one month blitz.

Location. It is recommended that the training room be able to accommodate a lecture type format to present. Location should be appropriate for learning and should be comfortable for staff members.

Tip: Consider tagging this education session on to other sessions to maximize time and efficiency. A palliative care in-service may make a good fit.

Facilitation of the Training. It is suggested that the trainer be someone accustomed in an educator role with an understanding of long term care, an understanding of pain and pain management and familiar role of each member within the long term care team. The facilitator may be internal or external to your facility.

Discussion. In most training experiences participants are eager to ask questions. In this training participants frequently ask questions and want to share related personal experiences. It should be noted that relevant discussion enhances the training and incorporation of the material.

Facilitator's Guide

This portion of this module is intended to support educators carry out this pain identification and screening event. This may be customized to fit the needs of your long term care home.

Step #1: Welcome all participants to the event.

- Greet all participants
- Presenter (s) introduce themselves
- State the next 20 minutes of training will consist of:
 - introducing staff to the pain program
 - introducing staff to the decision tree and CARE acronym
 - introducing staff to the pocket card and becoming familiar with it
- Take down attendance (if required by your organization)
- Provide handouts for participants
 - pain management decision tree (Appendix A)
 - CARE educational card (Appendix B), and
 - case scenarios (Appendix C)

Step#2: Linking the training to your home's pain program.

Example: Our home provides resident centered care in order to provide the best quality of life for residents that live within the home. The purpose of the Pain Management Program in Long- Term care is to provide an interprofessional approach to pain management.

Step #3: Linking the program to the Long Term Care Home Act.

Example (based on Ontario's LTCH Act): The Long Term Care Health Act (2007) mandates that every licensee of a long-term care home shall have a pain management program to identify pain in residents and manage pain. This poster addressed the following requirements:

- Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.
- Monitoring of residents' responses to, and effectiveness of, the pain management strategies
- Ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.
- Comfort care measures

Retrieved from: Long Term Care Homes Act and Regulations, 2007

Step #4: Review Pain Decision Tree (See Appendix A)

- The purpose of the pain decision tree is to help all staff understand their role and the roles of their team members in the decision making process.
- The tree follows Health Quality Ontario symbols:
 - Decision point– diamond
 - Start or stop point– oval
 - Document—document shape
 - Process– rectangle
- Outline all steps of the decision making tree
- Indicate that all staff can contribute to initial steps within the decision tree until it is required that the staff member reports to the RPN or RN
- Highlight that it is the responsibility of the RPN or RN to communicate with the reporting staff member throughout the later stages of the decision tree

Step #5: Review and Refer to CARE Pocket Card (Appendix B)

- Explain pain subjectivity—each resident experiences pain in a way that is unique to him/ herself. (If possible use an example to demonstrate)
- Review the CARE acronym
 - Consider
 - Assess/Screen
 - Reassess
 - Evaluate
- Self-Report should be the best and most accurate source of assessing resident's pain. If the resident has the ability to communicate ask him/her to rate pain from 0–10.
- Explain the faces scale for residents who are unable to communicate a score from 0-10. Highlight that residents should pick which face best represents them rather than the staff member choosing the face.
- Review expressions of pain vocabulary and highlight how these terms can be used in written and verbal communication.

Step #6: Utilize a case scenario to affirm training (Appendix C)

- Read chosen scenario
- Discuss scenario with staff utilizing Pain Decision Tree and CARE pocket care

Step #7: Thank participants for attending and ask if there is any final questions



Following the Training

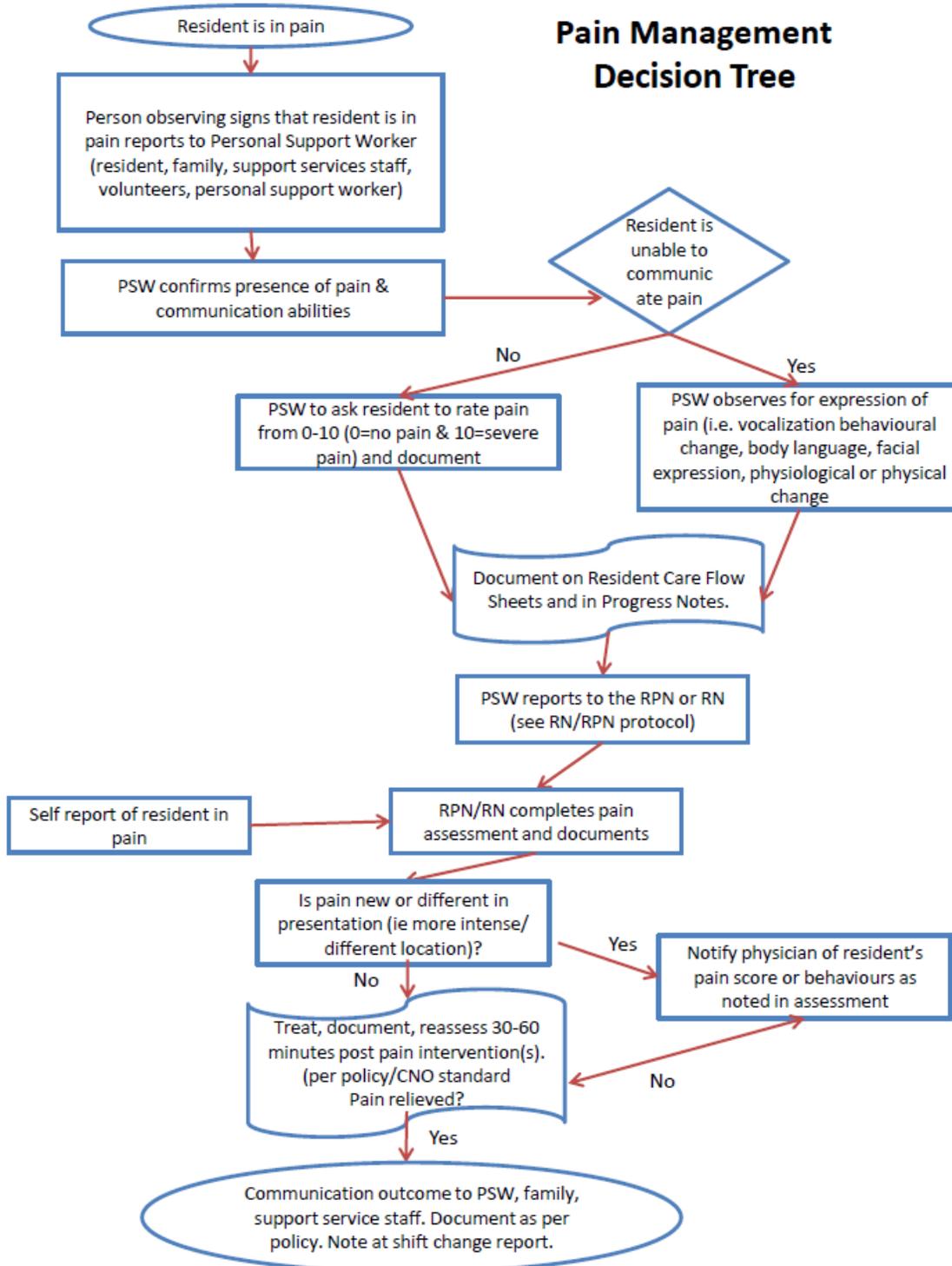
Evaluation. In order to track your process and success of your training it is important to include an evaluation component to your training. Consider completing Plan Do Study Act (PDSA) cycles and/or evaluation surveys. Example questions for an evaluation survey can be found in Appendix D.

On-going Training and Mentorship. When a front line staff member has completed his or her training will there be support for him or her if questions arise? Consider having a few “go to” people that may support staff with ongoing questions. There should be coverage of a “go to” person for each shift and home area. Reference posters can also be posted in documentation areas to remind staff of their training. For a sample reference poster see Appendix E.

Next Steps. Identification and screening is just the first step within pain management. Consider having a series of education using this module as the foundation. You may choose to include formalized pain assessments, and documentation of pain in your series.



Appendix A: Pain Decision Tree



Appendix B: CARE Pocket card

Pain is Subjective – Each resident experiences pain in a way unique to him /herself.

Self Report should be the best and most accurate source of assessing resident's pain. If the resident has the ability communicate ask him/her to rate pain from 0 -10.

Numerical Score	Type of Pain Experienced
0	No pain
1-3	Mild pain
4-6	Moderate pain
7-9	Intense pain
10	Worst possible pain



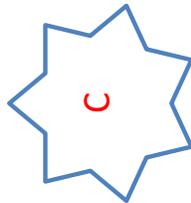
Faces Scale¹

0 2 4 6 8 10
¹Hicks, C., vonBaeyer, C., Spafford, P., van Kortrijk, & Goodenough, B. (2001)

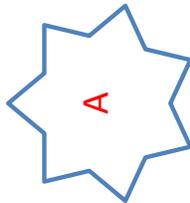
Expressions of Pain – If unable to self report look for these signs

Vocalization	Moaning, groaning, crying out, calling out
Body language	Tense, fidgeting, rigid, knees up, fists clenched
Behavioural change	Pacing, striking out, or quieter
Facial expression	Sad, frowning, grimacing
Physiological or Physical Changes	Overall status worse, vitals changing.

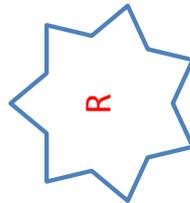
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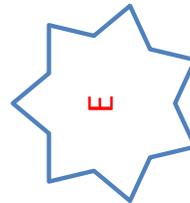
- **Consider** presence of pain.
- Confirm resident is able to communicate
- Can be observed and reported by the resident, interprofessional staff, volunteers and family.



- **Assess/Screen** with pain tools considering cognitive/communication abilities
- Observe /record signs of pain-groaning, grimacing, behavioural/physiological changes
- Use pain scale (e.g. numerical, faces)
- Provide intervention(s) both pharmacological and non pharmacological



- **Reassess** for effect of intervention(s) and level of pain. Approximately 30 to 60 minutes after intervention(s) and as necessary. Record/report response to intervention (s) as required by policy/CNO standards



- **Evaluate** CARE- for status and effect(s):
 - Status- is there a change in health or pain? Is this end stage disease or end of life process?
 - Effect(s)- results of assessment / scores and effect(s) of the intervention(s).
- **Document** (RAI, Flow Sheets, MAR, progress note) screening/assessment / scores, intervention(s) and effect(s)
- **Communicate** to- Resident, interprofessional team, family, and Physician)
- **Communicate** status/effect(s) at shift reports, care conferences, individually (Physician, RN, RPN, etc.)

Appendix C: Pain Scenario

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Scenario #1

Mr. Ray is a 94 year old man who has lived at Sheridan Home for 3 years. He has dementia, and he suffered a stroke prior to long term care admission. This stroke caused right sided paralysis and subsequently his right hand has contractures.

Typically Mr. Ray is described as being receptive to staff and often smiles in the company of others. He eats well at meals and interacts with others during activities. Mr. Ray requires assistance with his basic care needs. In the morning when staff are getting Mr. Ray up his facial expressions and colour often change. When staff attempt to move Mr. Ray or touch him to change his position he will cry out or grimace. Mr. Ray will curl into a fetal position when staff attempt to remove his clothing to change his continent product and dress him in his daytime clothes. If staff continue to move, reposition or dress Mr. Ray may strike out, kick or bite. Mr. Ray's face becomes very red, his hands clench and he begins to shake. At times, Mr. Ray will grab onto the wrist of staff or grab onto the side rail of his bed with his left hand. When attempting to provide oral care to Mr. Ray staff have noticed that his gums are red and swollen. Mr. Ray has eight lower teeth and one tooth is broken. Once Mr. Ray's morning care is complete he is transferred to his wheelchair at which time any signs of discomfort cease.

Scenario #2

Mrs. Smith is a 78 year old woman with dementia and arthritis. Mrs. Smith walks about the floor for several hours a day. Mrs. Smith wears an alarm device to notify staff when she attempts to leave the floor. The alarm sensor is often activated on the floor as Mrs. Smith ambulates about the floor for long periods of time. When Mrs. Smith has been walking for any length of time her face is sweaty clammy to the touch. Mrs. Smith's ankles and feet become swollen when she walks for long periods, and she declines to sit down when staff offer her a chair. At meal time it is difficult for Mrs. Smith to stay seated long enough to complete her meal and her memory loss makes it difficult for her to recognize how to use her cutlery.

Mrs. Smith receives pain medications for her arthritis and medication for dementia. When it is time for Mrs. Smith to receive her medication she will clench her mouth closed and refuse to take the medication turning and walking away. If staff attempt to stop Mrs. Smith this action increases her agitation. Mrs. Smith prefers to have care provided by female staff and if male staff attempt to provide her care she will slap the staff member in his face.

Appendix D: Sample Evaluation Survey Questions

1. How well are you able to recognize pain in residents?
2. How often do you recognize pain?
3. How often do you report pain?
4. When you report pain, how often is it followed up with?
5. Based on this education do you think you will use the pain identification and screening tool?
6. Do you think this education on identification and screening will make a difference in the identification reporting and documenting of pain?

Appendix E: Pain Identification Reference Poster

Long-term Care Home Pain Identification and Screening Reference Poster

Bethammi Long-term Care Home provides resident centered care in order to provide the best quality of life for residents that live within the home. The purpose of the Pain Management Program in Long- Term care is to provide an interprofessional approach to pain management.

- The Long Term Care Homes Act (2007) mandates that every licensee of a long-term care home shall have a pain management program to identify pain in residents and manage pain.

Pain is Subjective – Each resident experiences pain in a way unique to him /herself.

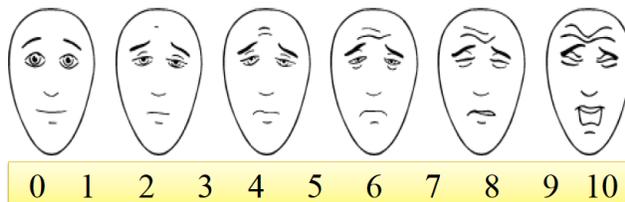
Self Report- should be the best and most accurate source of assessing resident’s pain. If the resident has the ability communicate ask him/her to rate pain from 0 -10.

Expressions of Pain¹: If unable to self report look for these signs

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0	No Pain
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7-9	Intense Pain
10	Worst Possible Pain

Vocalization	Moaning, groaning, crying out, calling out
Body language	Tense, fidgeting, rigid, knees up, fists clenched
Behavioural change	Pacing, striking out, or quieter
Facial expression	Sad, frowning, grimacing
Physiological or Physical Changes	Overall status worse, vitals changing.

Faces Scale²



¹ Warden, V., Hurley, A.C. & Volicer, L. (2003).

² Hicks CL, von Baeyer CL, Spafford P, van Korlaar I, & Goodenough, B. (2001)

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