

Advancing the Agenda for Home Healthcare Quality

**Effective Pain Management: Lessons from a Nursing Home Research Project
Executive Summary**

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Prepared for the Advancing the Agenda for Home Healthcare Quality Meeting
Center for Home Care Policy and Research
The Visiting Nurse Service of New York
March 31 – April 1, 2005

THE ISSUE

Pain is a complex problem to manage in all health care settings. Multiple barriers exist to the optimal management of pain, and these can be categorized by provider group (physicians, nurses, aides, others), by patient and family caregivers, and by the organization and environment. Thus, addressing the problem of effective pain management in all settings requires multifaceted interventions based on the best scientific evidence and the specific array of barriers and challenges facing the clinicians as they strive to improve clinical performance. In the home care setting, these particular circumstances include:

- Limited knowledge and many misperceptions relative to pain and its management
- Personal beliefs that may lead to under-treatment of recognized pain by clinicians, and under-reporting of pain by patients
- Reimbursement systems that limit the options for effective treatment
- Agency staffing levels and turnover rates that preclude comprehensive pain assessments and care planning and continuity of care

PAPER OBJECTIVES

The paper describes an intervention study that was conducted in the nursing home setting with the goal of improving staff pain knowledge and attitudes and nursing home pain practices. This was a translation research project, using existing clinical practice guidelines relevant to the elderly and to the nursing home setting and developing a multifaceted intervention to implement specific guideline recommendations and achieve clinical process improvement. The study was based on Roger's theory of innovation diffusion, and utilized educational, behavioral, social influence, and organizational theories in the development of specific translation strategies. The study was conducted in 12 urban and rural Colorado nursing homes using a controlled comparison approach. The educational component of the intervention

consisted of 4 short training sessions, pain resource binder, consultations, pain factoids, resident educational pamphlets and video, and a continuing medical education (CME) session. The behavioral component of the intervention consisted of an internal pain team of change agents, role modeling during pain rounds, and feedback reports of performance on staff surveys and resident pain assessments.

FINDINGS

The pain intervention had minimal effect on nursing home and physician pain practices. The primary difficulty was in the implementation of the intervention in the treatment homes. Attendance at training sessions was spotty, especially if administration did not actively support the project. Physicians were resistant to altering prescribing practices when contacted by nursing home staff about residents in moderate or severe pain. It was also difficult to convince physicians to attend a short continuing education seminar about current pain practices, in spite of multiple incentives. Residents themselves were hesitant to report their pain, and staff infrequently inquired about pain during their medication rounds. Even when strong medication was ordered, nurses did not administer it. Organizational and environmental factors also presented challenges to improving pain management. These included low staffing levels and frequent use of agency nurses, poor communication patterns, discontinuity in assignments, exclusion of Certified Nursing Assistants (CNAs) from rounds and reports, and high turnover rates among staff and administration.

Many similarities exist between nursing homes and home health agencies, which leads one to conclude that many of our findings are relevant to improving home health pain practices. The number of patients who are elderly with chronic conditions is growing, increasing the likelihood that pain will be a clinical issue. Low knowledge levels and negative belief systems about pain and its management have been reported for home health staff. Much of the care is delivered by aides, who require educational materials at lower reading levels and in non-English languages.

Physicians are remote and communication with them is challenging. There is a need to rely on consulting pharmacists as well. The regulatory system (Medicare and Medicaid rules and requirements) dictate much of what the agencies can and must do. On the other hand, home health care has characteristics that allow some different translation strategies. These include a stronger RN presence, patient and family self-care management, lower turnover rates and less use of agency nurses, and greater use of technology. The availability of information and clinical decision support systems is therefore higher in home care, and the variety of educational programs that can be developed and implemented is greater. Stability of leadership and staff facilitates the sustainability of interventions that are implemented for clinical improvements. However, effort would still need to be placed on educating patients and families about the importance of controlling pain, as well as a focus on improving communication about pain between nurses and aides, and nurses and physicians.

IMPLICATIONS FOR HOME CARE

Achieving improved pain practices in all settings is a complex problem and requires a thoughtful, comprehensive approach that addresses the many existing barriers. A clinical improvement intervention is likely to be successful when 1) the home health leadership is committed and involved with the project; 2) the administrative team is stable and has been in place for a while; 3) the educational programs are required and inclusive of all relevant staff members; 4) communication channels between levels of staff, and between nurses and physicians, are open, timely, and accurate; and 5) the materials developed for the training program are culturally and linguistically appropriate. Furthermore, a special emphasis needs to be placed on educating the patient and the caregivers regarding the likely outcomes of untreated pain – insomnia, loss of appetite, withdrawal from social and physical activities, delayed rehabilitation and wound healing, and lower quality of life.