PAIN COLLABORATIVE

The Control of Pain in the Elderly (COPE) Collaborative involved 28 homes in IL working together with the Illinois Foundation for Quality Health Care to help lessen both chronic and acute pain in the elderly. The year long collaborative process in 2004 called for 3 learning sessions and a celebratory outcomes congress where facilities shared lessons learned and best practices for addressing pain in the long term care resident. This document addresses the outcomes of the collaborative and illustrates how working as a collective group produces creative ideas and interventions which decrease incidents of pain in the elderly. The nursing homes involved in this collaborative effort found that their chronic pain quality measures declined by an average of 5% and their post acute measures declined by an average of 1%.

Collaborative Barriers	Collaborative Successes
Team Issues: No time to meet as a team	Set same time to meet weekly or every other week Meeting should be short but sweet; 15-20 minutes every other week works well Create an agenda for each meeting Involved all disciplines on pain management committee – the more ideas and insight the better It needs to be a team approach so do what ever you can to make this happen
Staff buy in	Have peers educate each other on pain Send info to staff in their pay check Use pain scales Pain test - award for turning the test in (bag of candy, and then all who turned it in are entered in to main drawing for monetary prize. Hang up “Did You Know” information near time clock Involved the direct care staff in problem solving; ask what do you think? What would you do? This empowers staff
Staff, resident and family buy in that pain is manageable	Pain Awareness Month Involve Resident Council Good feeling affair – booths were set-up that had different pain focus (i.e. aroma therapy, paraffin therapy, old time remedies, bread machine, lotion and massage booth) Received media coverage (2 newspapers and radio station) & increased staff, residents, family’s awareness to pain. Pain newsletter Care Watch system put in place, Resident Q&A program, Monthly case study with pharmacy Pain Booklets provided to residents and families upon admission and care plan meetings
Attitude that pain is a symptom of old age or being in a Nursing Home	Alternative approaches to pain do work Provided pain meds prior to therapies or soon after to help with progress and pain relief Set-up schedule for re-screening residents for pain Look at admission data so that pain is screened properly upon admission Consider pain the 5th vital sign Screen for pain on all 3 shifts after admission
Leadership issues: Don’t become too dependent on any one staff member or you will fail Loss of key members of the team may have negative affect on moving forward.	Assign each staff member different task/assignments so that everything is not the responsibility of one person Leader needs to be a facilitator and involve whole group in the process If you ask yourself the question, “Would the success that we have experienced continue if one member of the team was

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	gone?" and the answer is "No," then you need to look at your process and systems.
Residents who have dx which may be conducive to pain don't always have proper tx Lack of pain meds ordered Lack of alternative interventions being used	Screen for pain on admission Residents with a diagnosis of arthritis are enrolled in the P.A.C.E. program, (Patients with Arthritis Can Exercise). Certified Nurse's Aides attend a special training program to provide this therapy. Majority of residents in program have no or minimal pain. Utilize anodyne treatment for residents besides those with a diagnosis of Diabetic Peripheral Neuropathy, such as bursitis, muscle aches, etc. It is also successful when administered to an uncooperative resident while that person is asleep – results have been positive on residents with shingles.
We already have a lot of paper work to complete	When you implement a new form take away an old form. Screen for pain on Medication Administration Records
Communication issues: Team gets it – but rest of facility doesn't - particularly Administrator and corporate people Ownership needs to support facility effort, from the top down.	Every meeting invite someone outside the team to the meeting including facility ownership Keep simple minutes and share with those who need to be kept in the "loop" If using the 1-10 scale for pain or the 1-5 scale, always refer to this number when discussing resident pain with staff and encourage staff to use as standard also Always discuss residents pain level at Care Plan meeting – review with other basic info that is reviewed when discussing resident's care
It was hard to get into the collaborative to begin with and then it was over too quickly	Helpful for QIO's to take reports orally Nice to have relationship with QIO and QIC Great resource information Homes that share ideas are active in achieving collaborative success.
Financial constraints Not enough funding to cover cost of in servicing, changing forms, etc Non – pharmacological approaches to problem solving Quality of care and Quality of life issues may increase cost of interventions (i.e. additional staff)	Use outside resources Colleges in your area can provide interns for such things as Music Therapy, massage therapy, etc Pharmacy and hospice can provide free in servicing Use volunteers and family members as resources
Not enough time to track information	Use pharmacy to track PRN use for you Use midnight CNAs and Nursing who may have some time on their hands to do some of the paper work – get them on the team! Using the Quality Measures to track success is useful because CMS does the calculating for you
Potential for a lot of changes to occur, so how do you know what will truly work?	When changing forms, don't change the whole house. Test on one unit, adapt as needed then implement form slowly
Residents don't want to admit they are in pain	Choose alternative words such as discomfort; uncomfortable, achy, etc.
Pain is a Nursing issue only	Use non-pharmacological approaches to pain; music therapy, pet therapy, paraffin treatments, lotion and massage, aroma therapy, relaxation therapy, Spa Therapy that combines listening to classical music and aromatherapy Make teams interdisciplinary Convey message everyone is an expert in pain because we have all experienced it and we have all provided interventions.
Confused residents and pain	Look at the possibility that a behavior may really be an expression of pain Look at alternative methods to evaluate pain o FLACC

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	o Wong-Baker Faces Dementia residents on pain management have displayed decreased behavioral symptoms as a result of regularly scheduled medication and assessments. Antipsychotic use has decreased and all residents are participating in scheduled activities.
Others may not feel the passion that the team feels	Acknowledge that it's ok not to feel as passionate but make sure everyone understands that no one has the right to be in pain
MDS Coding- discovered they were coding pain on the MDS because a resident was on a pain med.	Learned to code correctly based on look back period and residents signs and symptoms or complaints of pain
Non-licensed staff did not attend in-services.	Learned to begin including non-licensed staff after reviewing attendance.
Pain assessment form not providing valuable information	Revised the form to include questions about recent pain and additional graphics On assessment, ask residents what typically works for them when they are in pain Revised form to include a pain assessment and space for summarizing interventions
Survey window interrupts activities.	Learned to continue with pain management activities while preparing for survey Make interventions that you are doing part of the daily life of the facility
Medicare Unit Issues: Lack of follow-up with 24 hr pain assessment on Medicare A residents. High volume of admissions to Medicare unit	Learned that nurses are more aware of residents' signs and symptoms of pain and look for alternatives ways to control pain such as music therapy. Learned to consistently audit charts and keep pain assessments on the MAR for all 3 shifts Learned to focus on a smaller number of residents in their population
Inconsistent documentation	Learned to check on a daily basis and educated staff about screening for pain. Resulted in improvement in nursing documentation

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