

PHARMACY NEWS CAPSULE

Wisconsin Department of Health and Family Services

Division of Quality Assurance

July-September 2007

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Assessing Pain in Older Adults with Dementia

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WHY?:

There is no evidence that older adults with dementia physiologically experience less pain than do other older adults (American Geriatrics Society (AGS), 2002). Rather than being less sensitive to pain, cognitively-impaired elders may fail to interpret sensations as painful, are often less able to recall their pain, and may not be able to verbally communicate it to care providers (AGS, 2002). As such, cognitively impaired older adults are often under-treated for pain. As with all older adults, those with dementia are at risk for multiple sources and types of pain, including chronic pain from conditions such as osteoarthritis and acute pain. Untreated pain in cognitively impaired older adults can delay healing, disturb sleep and activity patterns, reduce function, reduce quality of life, and prolong hospitalization.

BEST TOOLS:

Several tools are available to measure pain in older adults with dementia. Few of these have been comprehensively evaluated, and each has strengths and limitations (Herr, Decker, & Bjoro, 2006). The American Medical Directors Association has endorsed the Pain Assessment in Advanced Dementia Scale (PAINAD) (Warden, et al, 2003).

We recommend the following:

- Ask older adults with dementia about their pain. Even older adults with mild to moderate dementia can respond to simple questions about their pain (American Geriatrics Society, 2002).
- Use a standardized tool to assess pain intensity, such as the numerical rating scale (NRS) (0-10), or a verbal descriptor scale (VDS) (Herr, 2002; See also Try This: Pain Assessment). The VDS asks participants to select a word that best describes their present pain, e.g., no pain to worst pain imaginable, and may be more reliable than the NRS in older adults with dementia.
- Use an observational tool, e.g., PAINAD, to measure the presence of pain in older adults with dementia.
- Ask family or usual caregivers as to whether the patient's current behavior, e.g., crying out, restlessness, is different from their customary behavior. This change in behavior may signal pain.

- If pain is suspected, consider a time-limited trial of an appropriate type and dose of an analgesic agent. Thoroughly investigate behavior changes to rule out other causes. Use the PAINAD to evaluate the pain before and after administering the analgesic.

TARGET POPULATION:

Older adults with cognitive impairment who cannot be assessed for pain using standardized pain assessment instruments. Pain assessment in older adults with cognitive impairment is essential for both planned or emergent hospitalization.

VALIDITY AND RELIABILITY:

The PAINAD has an internal consistency reliability ranging from .50 (for behavior assessed at rest) to .67 (for behaviors assessed during unpleasant care-giving activities). Interrater reliability is high (r = .82 - .97). No test-retest reliability is available.

STRENGTHS AND LIMITATIONS:

Pain is a subjective experience and there are no definitive, universal tests for pain. For patients with dementia it is particularly important to know the patient and to consult with family and usual caregivers.

BARRIERS to PAIN MANAGEMENT in OLDER ADULTS with DEMENTIA:

There are many barriers to effective pain management in this population. Some common myths are that pain is a normal part of aging; if a person doesn't verbalize that they have pain, they must not be experiencing it; and that strong analgesics, e.g., opioids, must be avoided.

An effective approach to pain management in older adults with dementia is to assume that they do have pain if they have conditions and/or medical procedures that are typically associated with pain. Take a proactive approach in pain assessment and management.

MORE ON THE TOPIC:

- Best practice information on care of older adults: www.GeroNurseOnline.org (exit DHFS).
- American Geriatrics Society Panel on Persistent Pain in Older Persons. (2002). Clinical practice guidelines: The management of persistent pain in older persons. *JAGS*, 50, S205-S224. Available at http://www.americangeriatrics.org/products/positionpapers/persistent_pain_guide.shtml, from the American Geriatrics Society Web site, www.americangeriatrics.org (exit DHFS).
- Herr, K. (2002). Pain assessment in cognitively impaired older adults. *AJN*, 102(12), 65-68.
- Herr, K., Bjoro, K., & Decker, S. (2006). Tools for assessment of pain in nonverbal older adults with dementia: A state-of-the-science review. *Journal of Pain and Symptom Management*, 31(2), 170-192.
- Warden, V., Hurley, A.C., & Volicer, L. (2003). Development and psychometric evaluation of the pain assessment in advanced dementia (PAINAD) Scale. *Journal of the American Medical Directors Association*, 4(1), 9-15.



New Drugs

Brand Name	Generic Name	Use
Letairis	Ambrisentan	For pulmonary arterial hypertension.
Neupro	Rotigotine	Patch for Parkinson's Disease.
Torisel	Temsirolimus	For advanced renal cell carcinoma.

Drug of the Month By Doug Englebert, R.Ph.

Zostavax® Zoster Vaccine Live

Zostavax is a live, attenuated virus vaccine indicated for use for the prevention of herpes zoster (Shingles) in individuals 60 years of age and older. Zostavax is not recommended for the treatment of zoster or postherpetic neuralgia.

Zostavax is administered as a subcutaneous, single-dose injection of 0.65 ml. The most common adverse effects of the vaccine include head ache and injection site reactions. Zostavax must be stored in the freezer and kept frozen. It should be reconstituted immediately upon removal from the freezer. The diluent should be stored separately at room temperature or in the refrigerator. Separate sterile needles should be used for reconstitution and administration of Zostavax.

The manufacturer advises that: "THE VACCINE SHOULD BE ADMINISTERED IMMEDIATELY AFTER RECONSTITUTION, TO MINIMIZE LOSS OF POTENCY. DISCARD RECONSTITUTED VACCINE, IF IT IS NOT USED, WITHIN 30 MINUTES. DO NOT FREEZE RECONSTITUTED VACCINE."

Shingles is a disease that can cause significant pain and have a long-term impact on individuals. Based on an average three-year follow-up, Zostavax has been shown to be effective for shingles in about 64% of individuals between the ages of 60 and 69. Zostavax is not a magic bullet, but it is an option that is available to prevent shingles and post herpetic neuralgia.

Nursing Home Guidance Update By Doug Englebert, R.Ph.

What questions are being posed from around the country by surveyors and providers?

F 329 - Unnecessary Medication

(F329 is the federal nursing home survey tag for the unnecessary drug regulation in nursing homes)

The interpretive guidance, F 329, addresses gradual dose reductions for antipsychotics, as well as tapering for sedative hypnotics. The guidance provides information on gradual dose reduction by attempting a dose reduction in two separate quarters, with at least one month between the attempts, unless clinically contraindicated for those residents with ordered antipsychotics. After the first year, the gradual dose reduction must be attempted annually, unless clinically contraindicated. Specifics as to psychopharmacological medication (other than antipsychotics and sedative hypnotics) are the same.

In the case of sedative/hypnotics that are used routinely and beyond the manufacturer's recommendations for duration of use, the facility should attempt to taper the medication quarterly unless clinically contraindicated. The question many people have is: What if a resident is already on a psychopharmacological medication (of any of the above categories); and is now to the point of the annual review, and the dose is increased, does the clock "restart" for gradual dose reduction or tapering during at least two separate quarters due to the increase in dose, OR does the facility continue with annual attempts in that the medication itself remained the same?

RESPONSE: This is a complex question. First, keep in mind that the medication regimen review should be conducted by the consultant pharmacist on a monthly basis, enabling all medications to be closely monitored for ongoing efficacy. Per the Interpretive Guidance, there is no directive to "restart" the clock when a dose is increased for a psychopharmacological medication previously ordered for the resident. However, the questions that need to be asked when this occurs include the following:

- a. Why was the medication increased?
- b. Is the increase working?
- c. What is the goal or objective for the medication increase? and
- d. Have adverse events occurred with the dose increase?

Although the guidance does not address "restarting the clock" specifically, the guidance does say that psychopharmacologic medications need to be adequately monitored. In order to have adequate monitoring, the questions posed above need to be addressed and answered. In some cases, in order to answer and address those questions, gradual dose reduction and tapering may need to be done. The main point is that focusing solely on the gradual dose reduction will not assure that a resident is free from unnecessary drugs.

Consultant Corner By Doug Englebert, R.Ph.

Available Tools

Various regulations that apply to facilities the Division of Quality Assurance regulates identify specific intervention for certain medications. It may be difficult for surveyors to look at a list of medications and easily determine which ones require specific interventions.

For example, some regulations require proof-of-use sheets for schedule II medications; while others require specific monitoring for psychotropic medications. A couple of tools have been developed to help assist in identifying these types of medications. The tools are available as an attachment to this newsletter. Also attached to the newsletter is a "list" of medications. This list identifies those medications that are considered high risk for medication errors and adverse events. Systematically creating awareness of the potential risks with these medications can significantly reduce negative outcomes associated with these medications. Medications on this list warrant attention during survey investigations.

Attachments

- [Controlled Substances-Quick Reference for Schedule \(PDF, 31 KB\).](#)
- [High Alert Medications \(PDF, 27 KB\).](#)
- [Psychotropic Medications \(PDF, 16 KB\).](#)