

A multidisciplinary team pain management model for residential aged care

A roadmap to fostering
a pain vigilant culture

Pain is often seen as inevitable in older age and perhaps this perception contributes to the under-recognition and under-treatment of pain for residents in residential aged care.

The situation is compounded for residents living with dementia who may not be able to express pain using language. So too for the person of non-English speaking background who culturally, may express pain differently.

We have the tools and the knowledge to treat pain effectively however, we know they don't get used routinely in RAC. This model describes how to foster culture change within RAC to promote a 'pain vigilant culture'.

The model takes the responsibility of pain assessment, intervention and monitoring away from a few individuals to develop confidence in all staff, particularly at the frontline of care to make pain everybody's business.

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GLOSSARY OF TERMS

CALD:	Culturally and Linguistically Diverse
Care staff:	Refers to personal care assistants, assistants-in-nursing and other non-professional staff involved in care of residents
COM-B:	'capability', 'opportunity', 'motivation' and 'behaviour'
E-B:	Evidence based
EN:	Enrolled Nurse
L&L:	Lifestyle and Leisure staff
MDT:	Multidisciplinary Team
OT:	Occupational Therapist
PAR:	Participatory Action Research
PAS:	Psychogeriatric Assessment Scale
PCA:	Personal Care Assistant
POAKS:	Pain in Older Adults Knowledge Survey
PT:	Physiotherapist
RAC:	Residential Aged Care
RACF:	Residential Aged Care Facility
RN:	Registered Nurse
SEM:	Standard Error Mean
SD:	Standard Deviation
TL:	Team Leader

1. BACKGROUND

THE CHALLENGE OF PAIN MANAGEMENT

In Australia, the prevalence of dementia has increased by 40% between 2006 and 2016. A total of 580,000 people are predicted to be living with dementia by 2028 (AIHW, 2016). With a growing preference towards ageing at home in Australia, entry into **residential aged care (RAC)** is occurring later in life when individuals often have comorbidities and a higher associated level of care.

One key area of care is effective management of pain. The Australian Pain Society (2018) reports that up to 93% of residents in RAC experience pain.

The situation is even more concerning for people living with dementia, and especially those who can no longer articulate their pain. Unidentified or undertreated pain can not only reduce the quality of life in an individual, but also increase their risk of falls, depression, aggression, agitation and anxiety. Together, these can lead to more medical interventions, hospitalisations and a corresponding larger economic impact.

Therefore, the delivery of appropriate responses to pain experienced by people living with dementia is a care imperative in RAC.

However, often pain is not recognised as a factor affecting an older person's quality of life, and can be dismissed as a normal part of ageing. To date, studies show that key challenges to best-practice management of pain in older people living with dementia in RACs include limited use of validated pain assessment tools, and lack of capability and confidence amongst aged care staff to interpret pain cues and then initiate treatment. Earlier studies have shown trends that people with dementia were less likely to be given analgesia.

Care staff make up the largest proportion of the aged care workforce (The Aged Care Workforce, 2016). A recent HammondCare project (Cunningham, 2016) investigating prevalence and treatment of pain in RAC suggests a high level of care staff involvement in pain identification, but variable use of formal pain assessment scales and other aspects of the pain management process.

Staff involved in this project from eight Australian RACs reported ways of working characterised by fragmented, episodic and hierarchical engagement across differing staff groups (e.g. RNs, ENs, and PCA/AINs), echoing other reports (Nembhard et al. 2009). These factors, along with inconsistent knowledge of how to use formal pain assessment scales and the lack of a clear pain management protocol were reported to contribute to the gap observed between evidence-based pain management and current practice.

INTERVENE PHASE 2 PROJECT

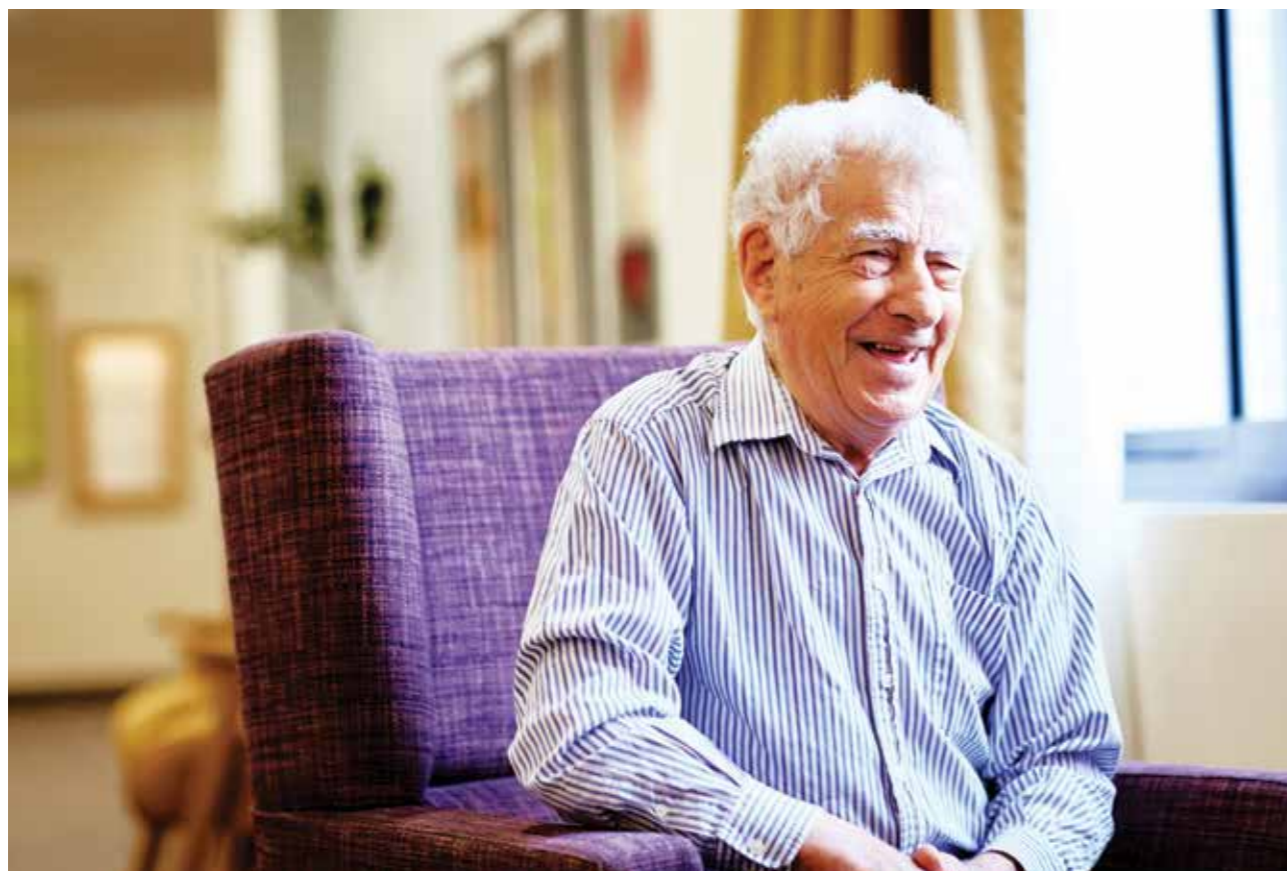
Intervene Phase 2 was an implementation project designed to minimise this evidence-practice gap by addressing barriers to the development of best-practice pain management and support the development of a pain vigilant culture.

The approach was to work with local **multidisciplinary teams (MDTs)** of staff at each of the four aged care services using a behaviour change framework within the context of a Participatory Action Research (PAR) approach (Kock & Kralick 2006). This approach was used for its explicit focus on collaboration between local stakeholders, in this case the staff at the project sites; in partnership with researchers, to critique the conditions and taken-for-granted assumptions that shape their day-to-day practice; then to develop and embed best-practice, evidence-based approaches to pain management for people living with dementia.

This approach encourages empowerment and democratic engagement of multidisciplinary teams (MDTs) of staff and therefore takes account of local stakeholders' expertise and knowledge relevant to the problem being addressed (Reason & Bradbury 2001).

A Participatory Action Research (PAR) approach is underpinned by collaboration and inclusion; and recognises that frontline staff spend most of their time with the people from the local setting. Therefore, it is predicated on the acknowledgment that they are the experts in their local setting and their involvement is integral to the success of any planned strategies or interventions.

The Intervene Phase 2 project report and related outputs can be accessed online at: <https://www.dementiacentre.com/intervene>.



2. ABOUT THIS RESOURCE

The pain management model has been developed as an outcome of the Intervene Phase 2 project. It provides a suggested framework for residential aged care organisations to establish MDTs of staff to drive and adapt the pain management model to change practice in pain management.

This model is not meant to serve as a prescriptive tool, but rather a reference point for similar initiatives of improving pain management in residential aged care. It offers 'necessary elements' as well as 'adaptable facets' for consideration when looking to establish a pain vigilant culture.

The four different residential aged care facilities that took part in the Intervene Phase 2 study reported varied approaches to implementation of interventions, with adjustments made to account for their local requirements.

The pain management model has been developed to be a transferable tool centered on a MDT. It outlines a 'roadmap' to improve pain management practices for people with dementia living in residential aged care.

As shown in figure 1, the model contains:

- Guiding principles for the development of action-oriented MDTs;
- A defined network and pathway that supports integration of the MDT to facilitate best practice identification, assessment and treatment of pain;
- A compilation of staff behaviour change strategies and evaluation processes that MDTs can utilise to support the development of a proactive evidence based pain management culture; and
- Useful resources related to pain management from the Intervene Phase 2 project.

Figure 1: A pictorial of the Pain Management Model



3. CONSIDERATIONS FOR IMPLEMENTING THIS MODEL

Prior to establishing a MDT to drive the process of changing practice, there are some key considerations in determining readiness for change and successful implementation of the pain management model:

- Culture of the organisation and how it influences organisational motivation and willingness to support evidence-based pain management for people living with dementia, and supports an understanding that 'pain is everyone's business.'
- Process – there should be clear organisational processes and procedures to support the implementation of the pain management model.
- Support – operational and financial support from site management. This includes allowing time for MDTs to meet, and time for staff to train in pain management during paid hours.
- Team – central to the implementation of this pain management model is a group of staff at the RAC who are committed to drive and support change.

ORGANISATIONAL CULTURE AND MOTIVATION

Firstly, the organisation must have an environment conducive to change. One expression of organisational culture is teamwork.

The culture of the organisation is expressed in teamwork; including the relationships of hierarchies, roles and responsibilities of staff. It was our experience that for a MDT to function well, there needs to be an understanding of how much responsibility care staff have in day-to-day practice relative to the other RAC staff and the organisational tolerance for having care staff involved in assessment, intervention and monitoring aspects of pain management.

Intervene Phase 2 identified that existing systemic structures influenced how the model would be implemented.

Effective team communication is also an expression of the organisation's culture. We also found that clear written plans of communication concerning the intention of implementing the model as well as managing continuity of processes in the event of a change in staff were essential to successful implementation.

PROCESSES

Organisational processes, including the manner of generating and communicating policies and associated processes need to be flexible enough to adapt to changes in pain management. With our project, some RACs had control over their policy and processes, while others had to negotiate with parent organisations concerning change.

SUPPORT

The priority that the organisation places on improving pain management practice relative to other areas of service delivery will determine how much support the program will have.

Again, our experience was that diverse forms of management support were essential both for implementation of the model and sustaining change. The ability to provide three key forms of support need to be examined prior to commencing this type of program:

- First, support from management for suitable staff members to participate in a MDT is essential. This includes paid time to attend MDT meetings, the provision of a suitable venue and where necessary, support of internal or external change management or pain management expertise to support the MDT. Two types of support are specifically referred to; support for the change practice processes and support for education and building capacity.
- Secondly, staff reported that having consistent management (either consistent personnel or consistency of support and management knowledge of the process) for the duration of the program was critical. Management support served as a foundation for introducing pain management interventions.
- We also found that changing managers over the project was often accompanied with a review of RAC priorities which did not necessarily support the objectives of the Intervene project.
- Thirdly, management is necessary to approve and make available budget and resources to facilitate training internally, or to pay for an external resource to provide appropriate training for staff including the use of pain assessment tools.

TEAM

In drawing together a MDT, it is important to bring together a wide representation of staff from the RAC. Consideration should be made to include staff from all shifts, sessional allied health staff and general practitioners. The sole focus of this MDT is to improve pain management practices for residents within the RAC home by assessing their current practice as well as planning, driving and communicating change.

This MDT could vary depending on the staffing composition at the RAC. In the Intervene Phase 2 Project, each of the four sites had unique team make ups.

To promote a sense of ownership, the MDT can also be encouraged to rename themselves. For example, two MDTs in the Intervene project opted to rename themselves 'Comfort Carers' and 'Pain Champions' to better highlight their focus.

Table 1: Examples of staff membership for pain champion teams

Site	Dementia-specific beds	MDT Membership	Features of Staffing at RAC Service
1	80	N=9 2xEN, 1xOT, 4xPCA, 2xRN	<ul style="list-style-type: none"> • Service has 5 days per week coverage shared between Occupational Therapist (OT) and Physiotherapist (PT). • GPs from four practices visit residents at the service.
2	24	N=11 4xRN, 3xPCA, 1xL&L, 1xPT, 1xOT	<ul style="list-style-type: none"> • Service has approx. 5 days coverage per week between OT and PT who visit the service.
3	84	N=8 7xPCAs, (including team leader), 1xRN – workplace trainer	<ul style="list-style-type: none"> • This service has a contracted physiotherapist, no regular visiting OT. • This site is predominantly staffed by personal carers. • Two RNs were onsite during the day – Manager and Assistant Manager. • This service does not have specific lifestyle and leisure staff.
4	100	N=11 2xRN, 7xPCA, 1xL&L	<ul style="list-style-type: none"> • This service has a contracted physiotherapist service. • Does not have a regular visiting OT or other allied health involved in pain management.

Key – EN: Enrolled Nurse; L&L: Lifestyle and leisure; OT: occupational therapist; PCA: Personal Care Assistant; PT: Physiotherapist; RN: Registered Nurse

4. IMPLEMENTING THE MODEL

IMPLEMENTATION OVERVIEW

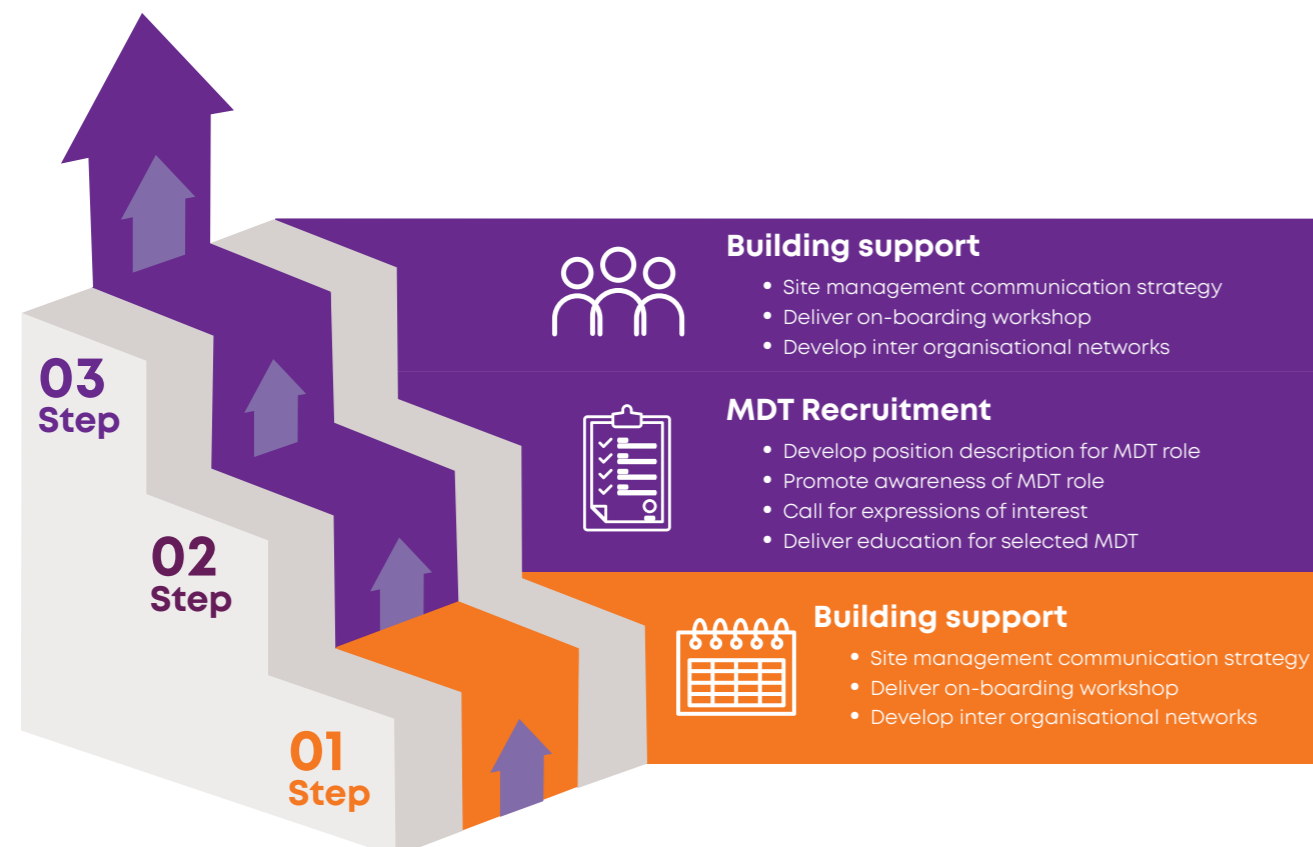
While a developmental change management approach is used to support the implementation of this model, the RAC needs to have assembled evidence-based pain management information, resources and to provide ease of staff access to these before commencing. Information and resources include:

- Pain management guidelines
- Validated formal pain assessment tool/s
- Training material and appropriately skilled and experienced trainers to upskill staff in the use of tools and other relevant information.

Where there is a gap in available resources, the RAC may decide to develop some. For example, in response to staff feedback, a Pain Management Protocol was created in the Intervene Phase 2 Project to provide staff with a decision making pathway that could articulate a stepwise approach to pain management. This was designed in consultation with staff and advocates of people living with dementia.

This section details three key steps for implementing the pain management model - setting up, recruitment of the MDT and building ongoing support for implementing the pain management model (figure 2).

Figure 2: Implementing pain management model



STEP 1: PROJECT PREPARATION

A guiding framework for the process of change is essential. There are a number of different approaches to change. In Intervene Phase 2, we chose to use a behaviour change framework within the context of Participatory Action Research (PAR) approach (Kock & Kralick 2006). This approach was used for its explicit focus on collaboration between local stakeholders, in this case the staff at each RAC to critique the conditions and taken-for-granted assumptions that shape practice around the way pain in people with dementia is detected, treated and monitored. This approach encourages empowerment and democratic engagement of each multidisciplinary team (MDT) and leverages from their expertise and knowledge at their own RAC.

The MDT promoted a “bottom-up” approach to translating knowledge into practice. The people, in this case the staff who would need to make changes in pain management, were the creators and communicators of the process.

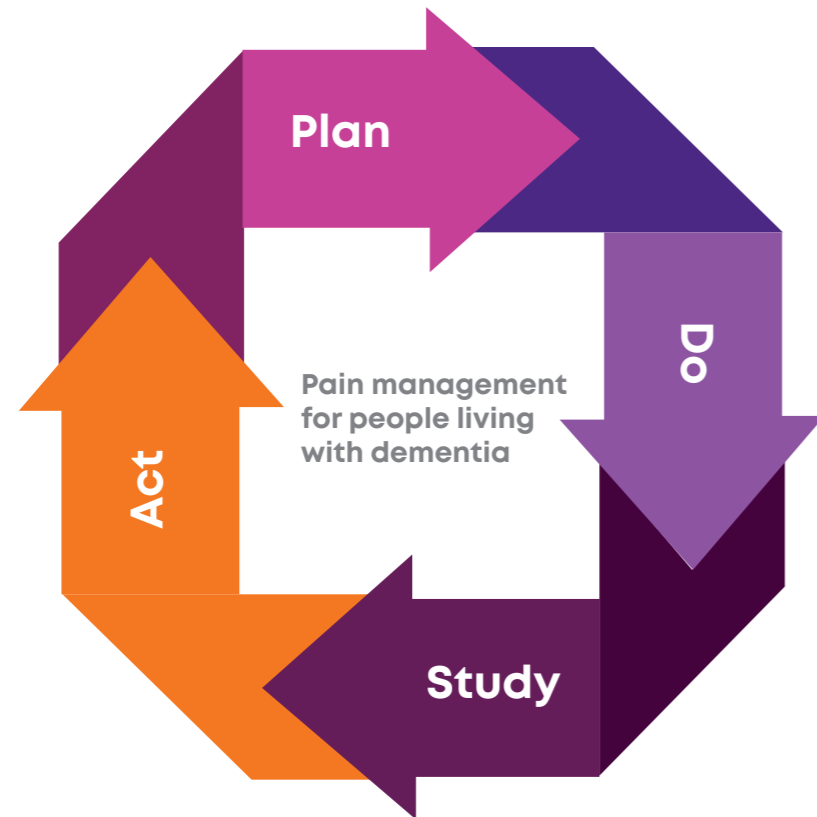
This approach embraces the understanding that people have a right to be involved in decision making and the development of knowledge that is about them and affects them (Reason & Bradbury 2001, p.10).

The project used Participatory Action Research (PAR). PAR consists of a number of ‘action cycles’ and as illustrated in figure 3, in each cycle the MDT would:

- 1. Plan.** The MDT would analyse the issues, problems and successes of delivering evidence-based pain management for people living with dementia and decide how they could go about improving processes, clearly setting out the steps to be tested in the next stage. Analysis could be informed by data.
- 2. Do.** This involves putting the plan devised in step 1 into practice, often initially using a small scale trial;
- 3. Study.** This is a reflective or evaluative process of the success of the plan in action which may throw up new issues such as how best to train and deploy on a larger scale. This will highlight ongoing and new issues; and
- 4. Act.** Involves refining the change based on learnings of the small scale trial and implementation of the updated solution. This could be characterised by activities such as formal and informal communication of the changes, development and deployment of new resources and additional staff training.

The Intervene Phase 2 project used 3 action cycles (i.e. 3 iterations of plan, do, study and act), one for each stage of the project.

Figure 3: Plan, Do, Study, Act stages of action cycle



ADDITIONAL IMPLEMENTATION SUPPORT

This document gives information and resources that will enable any RAC to establish their own MDT. However, it may be helpful to consider collaborations with knowledge translation agencies (such as a university department) or experts in dementia, and pain in people living with dementia to support initiatives to improve pain management practice. In particular, external experts could assist with any of the areas outlined above or provide preparatory training to the MDT, independent commentary on audit data, assist with staff training or provide expertise in implementation.

EVALUATION OF CURRENT PAIN MANAGEMENT PRACTICES AT THE RESIDENTIAL AGED CARE SERVICE

Before the MDT can begin to develop interventions to improve pain management practices, a review of existing practices at the RAC is required in order to understand the current landscape of pain management practice. This can include:

- Auditing existing pain management procedures e.g. existence and use of recognised guidelines and a pain protocol
- Collecting staff perceptions and knowledge by surveys and/or interviews
- Conducting a clinical audit of resident notes. Identify people living with dementia in the service, to have their documentation (nursing and medical notes, assessments, care plans, medication charts) clinically audited.

STEP 2: RECRUITING CANDIDATES FOR A MDT

Recruitment of staff for the MDT can be undertaken in consultation with the residential aged care site staff and management.

Rather than nominating staff for membership for the MDT, our experience during Intervene Phase 2 was that allowing the staff to volunteer ensures that the members have a desire to be involved and are most likely committed to the process.

MDT members selected should include a diverse team with representation from as many of the aged care disciplines at the RAC as possible. This brings a range of perspectives, knowledge and skills to work on improving pain management.

The following recruitment activities could be considered for encouraging ideal candidates:

- Raise awareness about the project and the MDT role
- Provide staff with a position description about the MDT role (a sample role description is provided in figure 4)
- Call for expressions of interest for staff who have a desire to be a MDT member and meet the inclusion criteria
- Undertake a formal selection process when volunteers have indicated interest in the MDT role and
- Liaise with site management to make final membership selections.

Figure 4: Sample role description for a MDT member

Role title: Multidisciplinary Team Member

Hours: 2 hours/ fortnight

Purpose of the position

To drive the improvement of internal pain management practices in collaboration with other staff.

Responsibilities

Responsibility 1 – Attend regular MDT meetings

Responsibility 2 – Undergo training sessions on dementia, pain management and action research

Responsibility 3 – Mentor other staff members in pain management practices.

Essential criteria

To be considered for the MDT position:

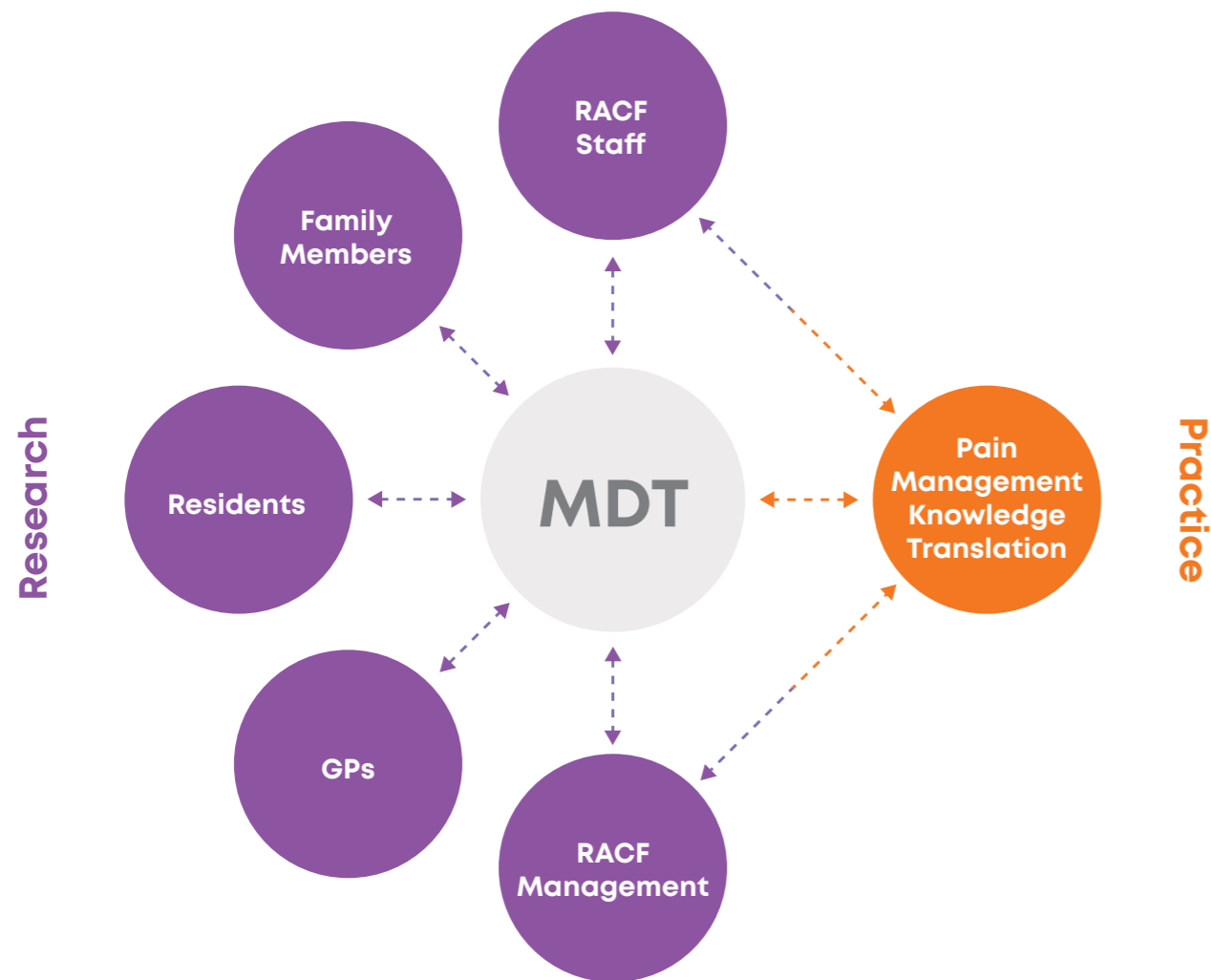
- The staff member needs to have keen interest in pain management
- The staff member needs to have a minimum of 3 months working at the Residential Aged Care (RAC) service and have responsibility for providing direct care to people living with dementia (physical, emotional or psychosocial care).
- PCAs, nursing staff, lifestyle and leisure staff and other assistant staff will have been employed either part-time or full time for a minimum of six shifts per fortnight.
- Allied health staff, such as physiotherapists and occupational therapists or other visiting allied staff will need to work at the facility for a minimum of 3 days per fortnight.
- General Practitioners or other medical specialists will need to demonstrate regular attendance at the facility, at least one visit per week.



THE MDT MEMBER ROLE IN SUMMARY

The Intervene project was carried out in partnership with MDT members and the success of the project was reliant on involvement of MDT members at all stages. The guiding principle is that the research team was working with rather than “on” the MDT; and recognition that MDT members are the “experts” in their local setting. Figure 5 shows a representation of this role, with the MDT serving as a conduit between the different stakeholders of the organization as well as the vehicles of knowledge translation into practice.

Figure 5: Representation of the MDT role



PREPARATION OF THE MDT MEMBERS

The MDT may require preparation or additional training before they undertake their roles. This preparation may include understanding how to present change in practice and/or build the capacity of staff at the RAC to implement MDT plans. As previously described, MDT members need to understand and feel comfortable with the ‘Plan, Do, Study, Act’ action cycles, in particular to see failure of any plans in a positive light.

Below are some key considerations for preparing MDT members for their role.

The MDT should be familiarised with the evidence supporting the need to change pain management for people with dementia in RAC. The evidence provided to the group could include:

- A clear summary of a clinical audit of pain management at the RAC,
- Barriers to translation of knowledge into practice,
- Strategies to address these barriers.

POSSIBLE BARRIERS TO IMPLEMENTING THE PAIN MANAGEMENT MODEL

When setting up a MDT, it is important to be aware of the potential barriers to implementing changes to practice. Through a series of regular meetings with the MDTs in Intervene Phase 2, the co-researchers identified the following contextual barriers and strategies to address these barriers:



Table 2: Possible barriers and mitigating strategies to implementing the pain management model

BARRIERS	STRATEGIES TO ADDRESS BARRIERS
Inconsistent managerial support	Consistent managerial support is an essential precondition for the establishment and success of teams focused on pain management. Expectations for management support of the program need to be negotiated by presenting expected benefits.
Existing hierarchical role arrangements and professional boundary issues with other professionals	Clarify and communicate purpose of the MDT, their role and the collaborative nature of the project.
Inadequate capabilities to perform the role of a MDT member	Use capacity building activities (e.g. on-boarding activities of education on underpinning theory).*
Knowledge and power asymmetry of MDT members and/or external facilitators (if used)	There should be an effective on-boarding process involving workshops and training, which asserts roles and responsibilities to shift this power dynamic.
Territorial issues of the MDT role with other professionals	Providing clarity around the role definition and communicating this to the staff through awareness raising of the aims of the initiative; including promotion of the benefits of the MDT.
Lack of staff support for MDT	Selecting MDT candidates with suitable personal traits (e.g. motivation, enthusiasm, desire to improve skills), who will act as positive role models.

*Further details and references are available in the Intervene Phase 2 Report. <https://www.dementiacentre.com/intervene>.

GUIDING PRINCIPLES FOR MDT MEETINGS

The conduct of the regular MDT meetings is essential in achieving positive outcomes. Therefore the MDT need to consider some guiding principles for meeting format and conduct. For example:

- A clear statement of the objectives of the group
- A schedule of meetings
- A set of guidelines on how MDT members will communicate within meetings, between meetings and to other members of the staff. This may include who can contribute to the meeting agenda, how meetings are minuted, how and where minutes are distributed
- A MDT code of conduct may also be useful. The code outlines expectations, such as punctuality, confidentiality, respect between members etc.

STEP 3: BUILDING ONGOING SUPPORT AND ENGAGEMENT

Once the MDT is established and operational, it is important for the team to continue to build support and engagement with other staff at their sites. This engagement can be facilitated via the following methods:

- Site management could communicate and demonstrate to staff their support for the intended changes
- The MDT could look for another RAC initiating the same or similar changes for inter-organisational collaboration

INTER-ORGANISATIONAL COLLABORATION

In order to foster collaboration, increase knowledge sharing and reduce professional isolation, the RAC could seek to work with other RACs that are looking to achieve the same objectives. This expands the supportive peer network. The partner organisations could be from another provider and/or state. Such collaboration can be extremely valuable for sites which are geographically isolated e.g. sites located in the rural areas.

During Intervene Phase 2, three face-to-face inter-organisational workshops were conducted. The interaction fostered collaboration, creativity and sharing of implementation ideas that maintained the motivation of some MDTs who felt they were running low on ideas. Over and above this, the sites also held video conference meetings to share their progress and challenges.

5. EVALUATION OF THE MODEL

'Plan, Do, Study, Act' action cycles have an inbuilt evaluation within, each study part of the 4 step cycle encourages evaluation and reflection on the plan and the success of its initial implementation. However, it is important to step back and take a broader view of the success of the model at your service. This can inform further improvements.

The evaluation involves determining if the outcomes and goals set by the MDT for improving pain management of people with dementia were achieved.

This can be achieved by collecting follow up data after implementing the model, and comparing it to the data collected before implementing the model. Measures for evaluation could include:

- Improved documentation of pain episodes by staff
- Increased involvement of all staff in pain management along the whole pathway (identification, assessment, intervention and evaluation)
- Increased confidence of staff in implementing the pain management protocol
- Improved communication about pain in residents with dementia and pain management interventions between staff.

Below are two cases derived from the Intervene Phase 2 Project which outline how the interplay of the various considerations outlined in this model impacts on the implementation of MDT-initiated pain management strategies.

CASE STUDY 1

At one site, staff have an average tenure of 5 years. Throughout the Intervene Phase 2 Project, this site has had the same care manager and consistent staffing. The site has a wing dedicated to dementia-specific care. Staff report a high level of confidence in their leadership and organisational culture.

The MDT at this site identified key issues of a lack of a clear pain management pathway and varied understanding of how to complete an Abbey Pain Scale as impeding evidence-based pain management practice at their site.

Amongst other interventions, the group used the 'Pain Protocol' and 'Pain Education Videos.' The intervention components were implemented consistent with the action plans and 57% of staff at this site completed the education program.

After the intervention, results from surveys showed increased staff involvement and confidence in pain management. Confidence in their leadership and culture remained high. Moving forward, the MDT aim to work closely with their care manager to sustain positive changes to their pain management practice.

CASE STUDY 2

A second site has 11 MDT members. By project close, only 2 remained. Staff at this service have an average tenure of 1.5 years. Throughout the Intervene Phase 2 Project, this site has had three changes in care managers and high staff turnover. The site has dementia-specific beds. Staff report low to moderate levels of confidence in their leadership and culture.

The MDT identified key issues of competing priorities and lack of a clear pain management pathway as impeding evidence-based pain management practice at their site. Due to management changes, implementation of interventions was delayed by three months and was modified from the action plan. Amongst other interventions, the group used interventions of the 'Pain Protocol' and 'Pain Education Videos.'

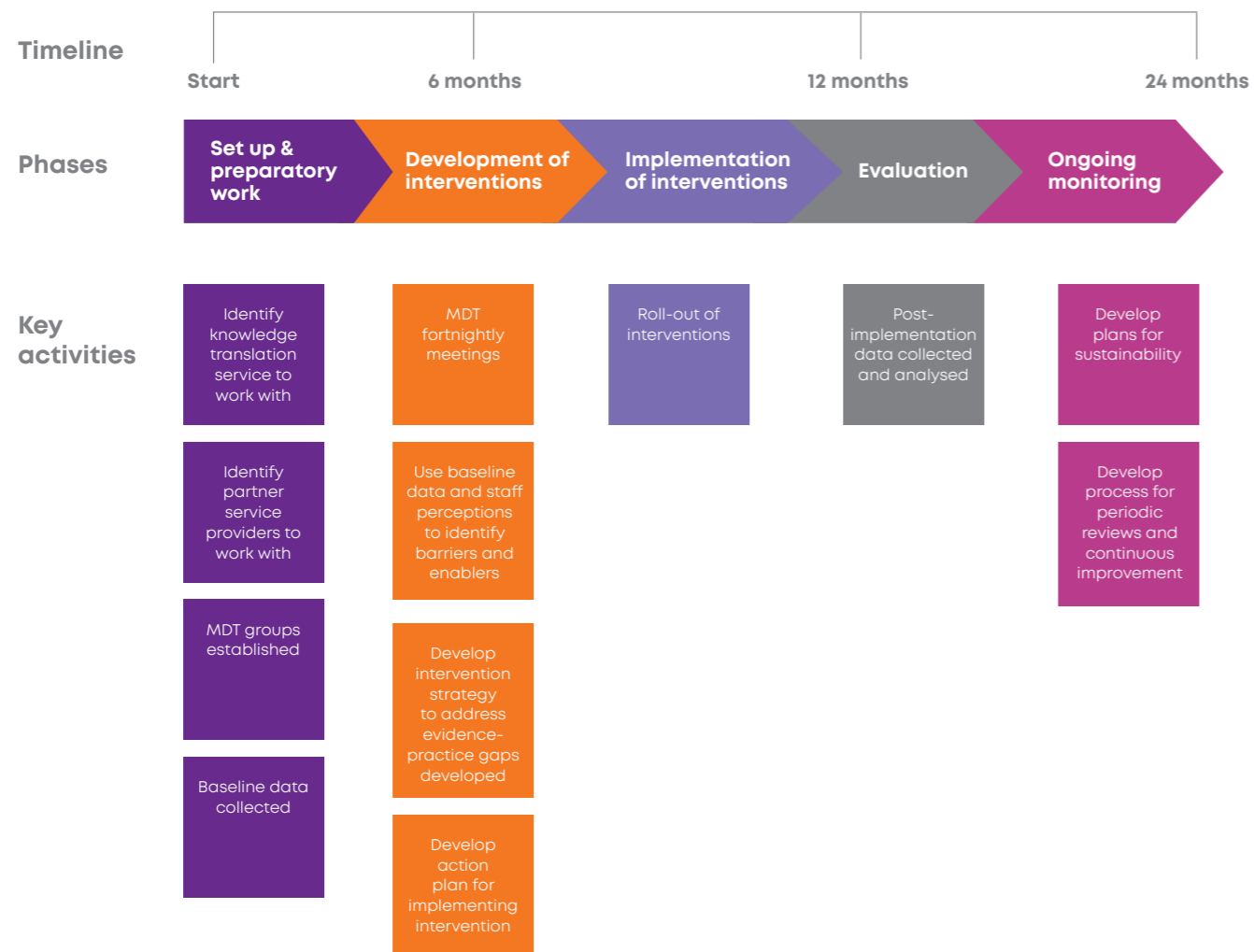
While more than 50% of staff completed the education program, most staff who had been employed by the service at the commencement of the project had been replaced by new staff.

After the intervention, staff showed decreased staff involvement and confidence in pain management. Confidence in their leadership and culture remained low to moderate. Remaining MDT members indicate that sustaining the changes in this context will be challenging. At the final MDT inter-organisational workshop, staff felt that inclusion of pain management at staff orientation would have assisted in maintaining continuity and interest.

6. MILESTONES

The process of establishing a MDT, developing and implementing pain management interventions requires time. This process was completed over 24 months in the Intervene Phase 2 project.

Based on the roll-out of the Intervene Phase 2 Project, below are suggested milestones for such a process.



7. STRENGTHS AND LIMITATIONS OF THE MODEL

The model is robust and well supported by evidence as an effective vehicle for translation of evidence into practice. It is an egalitarian approach that underscores the mantra that 'pain is everyone's business.'

The model is strengthened by encouraging RAC services to develop strategies to address issues that are of concern to their local context. This more directed approach promotes ownership by the MDT and therefore is more likely to succeed.

The approach of iterative action cycles which underpins the implementation of this model emphasises the importance of adaptation to local context. Furthermore, this flexibility in the model allows for wider application and adaptation to other areas of care.

That implementation of this model takes a couple of years makes it more likely that there will be a change in site management over the course of implementation. Our experience of Intervene Phase 2 was that the key 'single point of failure' was with management, particularly changes of care managers at RAC services, and subsequently a change of care priorities and a lack of support for MDT activities. Incorporation of the MDT within existing organisational structures (e.g. quality, safety and risk activities) may assist in longevity of the MDT.

8. CONCLUSION

The interactive nature of the MDT is a process that can respond to a constantly changing aged care sector but is currently under-explored as a way to foster change in practice where it is most needed to reduce pain in people with dementia living in RAC.

This pain management model provides a practical pathway for the improvement of pain management practices in RAC through the establishment of a collaborative MDT, who have knowledge of the local context. Therefore, the MDT can be best viewed as a conduit to evidence-based pain management that links all the players, resources and organisational constructs to strategically drive translation of pain management knowledge into practice. However, this only applies where it is truly representative of staff in the RAC and must have appropriate support at a managerial level.

If given appropriate management support, the MDT can have a direct and positive influence on organisational policies and procedures for long term delivery of evidence-based pain management for people living with dementia.

9. ADDITIONAL RESOURCES

Resources that were developed as part of the Intervene Phase 2 Project that may also be useful to another RACs looking to achieve the same outcomes can be found at <https://www.dementiacentre.com/intervene>.

These resources include:

- Educational videos
- Pocket reference cards
- Posters
- The pain management protocol
- A flip chart for reference in RAC

The pain management model (**figure 6**) was co-developed by the research team and the MDT from the project sites. It provides a stepwise guide for staff to use for pain management.

EXPRESSION OF INTEREST – MULTI-DISCIPLINARY TEAM

Intervene Phase 2 – Best practice in pain management in residential aged care for people living with dementia.

You are invited to apply to be a member of the Multi-Disciplinary Team for your care home.

The selection criteria for team members includes the following:

- **RAC service staff** such as Registered Nurses, Enrolled Nurses, Personal Care Workers, Diversional Therapy/Lifestyle and Leisure/Life Engagement staff, allied health assistant staff:
 - Will need to have worked at the facility for more than 3 months,
 - Will be employed full-time, part-time or regular casual hours (minimum of 3 shifts per week - further detail as specified by service)
 - Are responsible for providing direct care to people living with dementia (physical, emotional and/or psychosocial).
- **Allied health** staff, such as physio and occupational therapy (employed either by the RAC service) or other visiting allied staff will need to work at the facility for a minimum of 3 days per fortnight.
- **General Practitioners** will need to regularly attend the aged care service (at least one visit per week)
- All members of the MDT will have an interest in and strong motivation to improve the provision of pain management for people living with dementia in residential aged care services

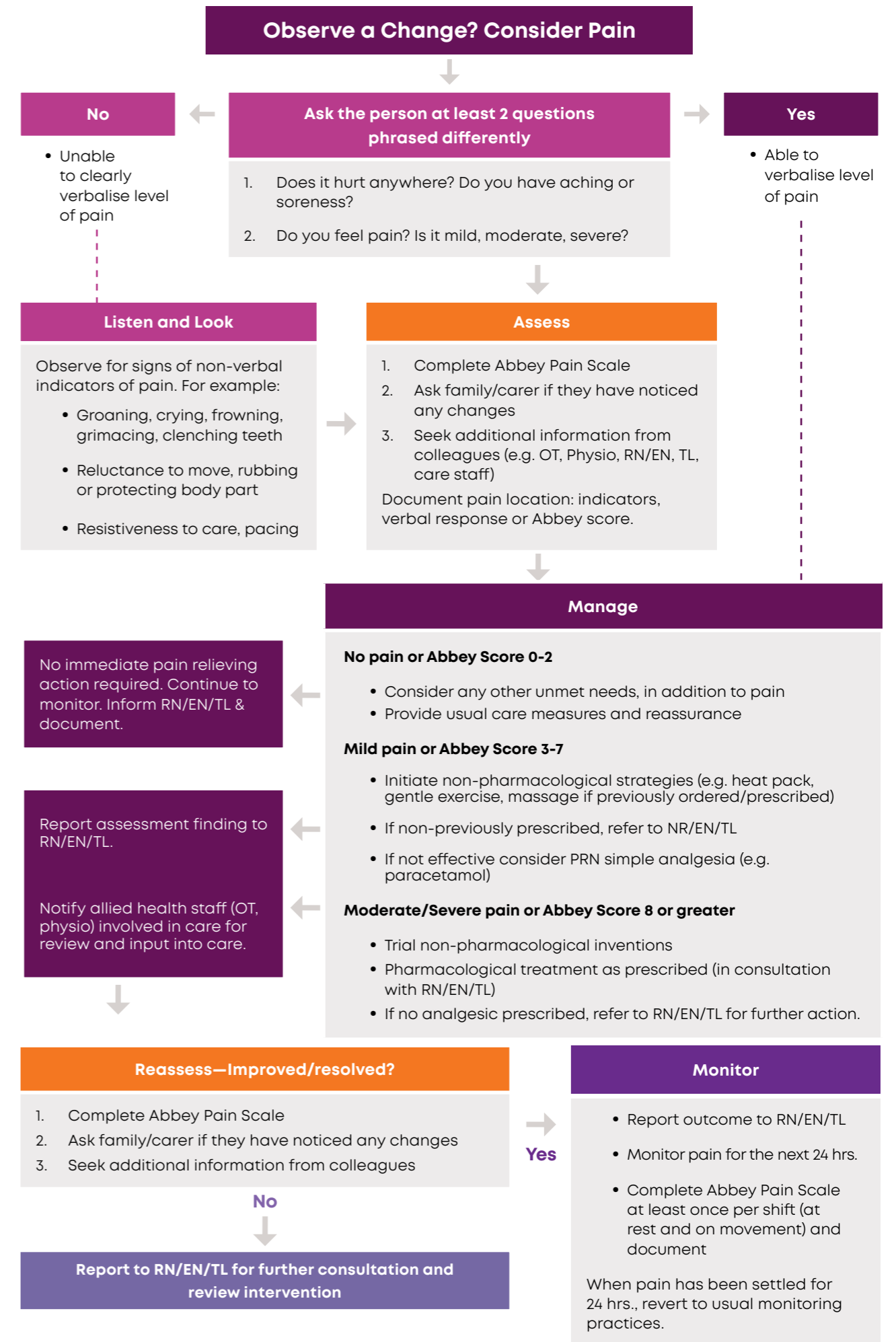
If you would like to be considered for this role, please provide your details below:

Name: _____ Role: _____

Phone: _____ Email: _____

Please note that this project is supported by management at your facility and will require you to be released from your duties for regular project meetings and to undertake project activities. Therefore, we will be discussing with the facility manager those staff members who register an interest to participate in this role.

Figure 6: Pain management protocol



ACTION PLAN FOR IMPLEMENTING INTERVENTIONS AT THE RAC

Example of a detailed action plan for the implementation of interventions. The plan includes questions which will allow for more specific details to be completed for the plan.

TARGET GROUP FOR CHANGE:

- 1. Improvement of assessment and monitoring processes:** The focus of this intervention is on care staff, as they are the people who are most likely to recognise a change in a resident. However, the below intervention components are also applicable to clinical staff.
- 2. Improvement of assessment and monitoring processes:** All staff providing direct care to people living with dementia at the Home

INTERVENTION COMPONENTS:

The intervention contains a number of key components:

• Educational Program:

- Hosted on a web-based platform so that staff can access it on work computers.
- Comprises 4 videos – each which address a key topic in the pain management pathway (1. Identification, 2. Assessment, 3. Management strategies and 4. Monitoring).
- Each video 4-6 minutes + activity time.
- Videos are framed around the pain protocol document (see next dot point).

• Addition of pain management resources:

Pain protocol flowchart and pocket reference card contains a simplified pain protocol diagram (side 1) and an Abbey Pain Scale (side 2).

• Prompting to encourage pain assessment and communication:

- TLs/RNs prompt and encourage care staff to undertake an assessment if a change in a resident's behaviour or pain is reported or a PRN medication is requested.
- Addition of a column to staff handover sheet that titled "pain" – to prompt staff to address the issue of pain at each handover.

• Feedback:

from RN/TLs on outcomes of pain assessments at handover.

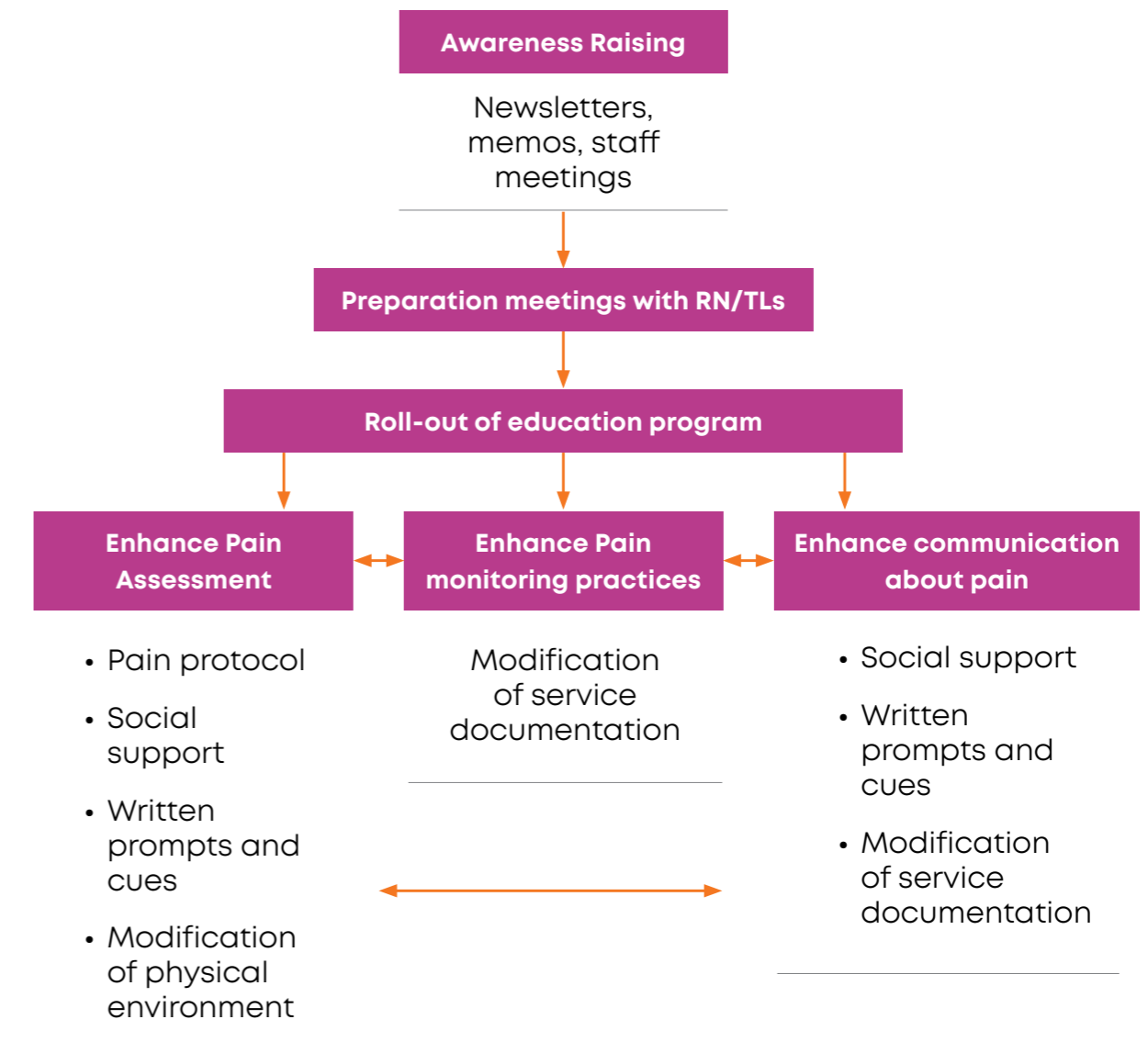
• Modification of the physical environment:

provide hard copies of the pain assessment tools and pain protocol in easily accessible locations so that staff have them at hand when needed.

• Information (newsletters, posters):

to encourage staff to think about pain and pain assessment.

IMPLEMENTATION STRATEGY



The MDTs advised that implementation would most likely be successful if it occurred only on one unit at a time, especially given current staffing arrangements and availability of MDT members.

1. Awareness Raising

- Project newsletter to all staff to inform them of the intervention via email and hard copy.
- Briefing information provided at staff meetings and after staff handover.
- Memos placed in memo folder.

2. Preparation meeting with RN/ENS

Meetings to be held with the RN and ENS of the service to:

- Introduce the intervention components
- Highlight the importance of RN/EN support in encouraging and prompting care staff to complete pain assessments if there is a change in a resident's behaviour or pain is reported or a PRN medication is requested.
- Discuss documentation changes and role of RN/ENS in promoting communication about resident pain at handovers.
- Who can organise these staff meetings? Who should provide the information? (It needs to come from a trusted and credible source).

3. Roll-out of education program and pain protocol to care staff:

- The education program will be rolled-out through a facilitated approach.
- The roll-out will be led by the workplace trainer
- The roll-out will occur over a 4 week period with an additional two weeks to capture any staff who have either not completed or not been able to attend their allocated sessions.
- The education will be implemented on 'unit name' first.
- The workplace trainers will use an approach which is similar to that used for elder abuse training – which was found to be successful.
- Small groups of staff will come off the floor, during their work hours, with the workplace trainer to complete the four short education sessions.
- All staff working on 'unit name' will be allocated into small groups by the workplace trainers based on their shift patterns. These small groups will then complete the education program over a one week timeframe. Each staff member will attend 4 session of approx. 6-10minutes each over this one week period. (See Diagram 1 for the roll-out plan based on example of 40 staff).
- The workplace trainers will keep a record of those staff that have completed the education.
- At the completion of the last session the workplace trainer will:
 - provide staff with a pocket reference card and a hard copy of the pain protocol,
 - inform staff that a MDT member will provide one to one support.

- MDT members will be provided with a list of staff names at the end of each week of education to follow up for one-to-one support the subsequent week.
- MDT members provide **one-to-one support/mentoring** for those staff that have completed the education program. This will involve meeting with the staff member at an agreed time during their shift to review their use of the protocol, pain checklist cards and encourage staff to complete assessments/reinforcing key messages.
- Who will provide one-to-one support to clinical staff to encourage them to prompt care staff to complete assessments and use the pain protocol?

4. Increasing communication about pain at handover:

- Staff handover sheet will be amended so that it contains a column headed "pain" where staff can document assessments/PRNs/non-pharmacological. Addition of the column will prompt staff to address resident pain at each handover.
- Does the RN have a handover sheet that they fill in which could address pain? Who will be responsible for amending the handover sheet? Who will make changes to the master copy and ensure it is available in the unit?

5. Written information to prompt and cue staff:

- Posters developed in collaboration with the MDT
- Observe change: consider pain – Do an assessment
- Don't forget to talk about resident pain at handover!
- Laminated hard copies of the pain protocol document will be placed in key locations (e.g. the nurses' stations). These written materials will remind and support staff to do an assessment.
- Who will be responsible for ensuring that the posters and pain protocol are in the correct location?

6. Modification of the physical environment to ensure access to pain protocol and assessment forms:

- Hard copies of the Abbey Pain Scale and verbal pain inventory will be placed in a folder near the photocopies with all other forms.
- Who will be responsible for ensuring this and monitoring that there are enough assessment forms?

7. Modification of service documentation

- For residents who cannot verbalise their pain, staff complete an Abbey Pain Scale during each shift - one at rest and one during movement.
- For residents who can verbalise their pain, staff complete a General Pain Assessment form.
- Who would be responsible for making the changes to the documentation?

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For more details regarding this research, see the Final Report to the CDPC via <https://www.dementiacentre.com/programs/intervene>.

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Additional Resources

This resource is an output of the Intervene Project (Phase 2). Results from Intervene, as well as other project outputs can be downloaded for free at: www.dementiacentre.com/programs/intervene

The Australian Pain Society Guidelines can be found at: www.apsoc.org.au/publications

The Pain Australia Website contains further information: www.painaustralia.org.au

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