

Long-Term Care Quality Improvement (QI) Community of Practice (Ontario)



Host: Holly Finn, PMP

Presenters: Tracey Human, RN, CHPCN (C) &
Disa Clifford, RN, MN, CHPCN (C)

Date: June 04, 2025

Territorial Honouring



The Palliative Care ECHO Project

The Palliative Care ECHO Project is a 5-year national initiative to cultivate communities of practice and establish continuous professional development among health care providers across Canada who care for patients with life-limiting illness.

The Palliative Care ECHO Project is supported by a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.



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LEAP Long-Term Care

- Interprofessional course that focuses on the essential competencies to provide a palliative care approach.
- Case studies contextualized to the long-term care setting.
- Delivered online or in-person.
- Ideal for any health care professional (e.g., physician, nurse, pharmacist, social worker, etc.) working in long-term care and nursing homes.
- Accredited by CFPC for **27.5 Mainpro+ credits** (online) and **26.5 Mainpro+ credits** (in-person).



Learn more about the course and topics covered by visiting

www.pallium.ca/course/leap-long-term-care

Introductions

Host:

Holly Finn, PMP

Senior Manager, Program Delivery

Presenters:

Tracey Human RN, CHPCN(C) | Director | Consultant

Palliative Care Pain & Symptom Management Consultation (PPSMC) | Toronto Program

Disa Clifford RN, MN, CHPCN(C) | Consultant

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Disclosure

Relationship with Financial Sponsors:

Pallium Canada

- Pallium is a registered charity
- Funded by Health Canada

This program has received financial support from:

- Health Canada in the form of a contribution program
- Generates funds to support operations and R&D from Pallium Pocketbook sales and course registration Fees

Disclosure

Host/ Presenters/ Panelists:

- Holly Finn: Senior Manager, Program Delivery at Pallium Canada.
- Tracey Human: Nothing to disclose
- Disa Clifford: Nothing to disclose

Mitigating Potential Biases:

The scientific planning committee had complete independent control over the development of program content.

Welcome and Reminders

- Please introduce yourself in the chat! Let us know your role is in the Long-Term Care setting.
- Your microphones are currently muted. There will be time throughout this session for questions and discussion, including breakout rooms
- You are welcome to use the chat function to ask questions, if you have any comments or are having technical difficulties
- This session is NOT being recorded.
- Take comfort in knowing this is a safe space to share your thoughts and stories.
- Remember not to disclose any Personal Health Information (PHI) during the session

Overall Learning Objectives of this COP

Upon participating in this COP, members should be able to:

- Describe how quality improvement methodologies can support successful integration of a palliative care approach in long-term care homes
- Describe relevant metrics, change ideas and lessons learned from quality improvement initiatives implemented by peers
- Recall case discussions that demonstrate strategies to address challenges to a palliative approach to care
- Recall how to access resources to support QI work

Overview of Sessions

Session #	Date/ Time
Session 1	January 29, 2025 from 12 to 1pm ET
Session 2	April 22, 2025 from 12 to 1pm ET
Session 3	June 4, 2025 from 12 to 1pm ET
Session 4	October 1, 2025 from 12 to 1pm ET
Session 5	November 26, 2025 from 12 to 1pm ET

Agenda for today's session

- Pain in Dementia through a QI lens
- Breakout Groups
- Bring it all together

From Recognition to Relief:
Enhancing Pain Management in
Dementia through Quality Improvement

What are we trying to Achieve?

Quality in Pain Care

Palliative Care Quality Statement 6: People with identified palliative care needs have their pain and other symptoms managed effectively, in a timely manner. (Ontario Health, 2024)

- Pain care quality indicators are measurable aspects of pain management practices that help assess the quality of care. They can be used to evaluate the effectiveness of pain management by looking at the structures, processes, and outcomes of care.
 - Key areas assessed by pain care quality indicators:
 - **Structure:** This refers to the environment in which care is provided, including resources, organizational characteristics, and operational factors.
 - **Process:** This focuses on how care is delivered, such as the methods used for screening, assessment, treatment plans, and resident/family interactions.
 - **Outcome:** This examines the results of care, including resident's pain levels, functional abilities, behaviours, and overall health status.

Pain in Dementia



- Pain is underrecognized and undertreated in people with dementia
 - Receive less pain medication than cognitively intact residents (67% less often; 45% not at all)
- It is a myth that people with dementia cannot self report their pain and/or you cannot trust their report
 - No deficiency in the identification, screening, and assessment domains of pain care
 - Requires accurate and effective use of 3-step best practice model and appropriate tools
- Moderate to severe cognitive impairment can impair the resident's ability to remember they have pain, understand that what they are feeling is pain
 - **Does NOT impair their ability to have or feel pain**

RESPONSIVE & REACTIVE BEHAVIOURS

Expressions

Defensive; resistive to care; verbal; physical, sexual

Psychosis

Delusions; hallucinations; misidentification; paranoia

Agitation

Dressing/undressing; pacing; wandering; repetitive actions; restless/anxious

Depression

Anxious; guilty; hopeless; irritable/screaming; sad/tearful; suicidal

Mania

Euphoria; irritable; pressured speech

Apathy

Amotivation; lacking interest; withdrawn



AUTOMATIC PAIN RESPONSES

Facial expressions

Frowning; grimacing; distorted expression; rapid blinking

Vocalization

Sighing; moaning; calling out; yelling; asking for help; verbal abuse

Body movements

Rigid; tense; guarding; fidgeting; pacing/rocking; changes in mobility (inactivity or motor restlessness)

Mental status change

Crying; increased confusion; irritability; distress

Changes in activity patterns

Appetite change; sleep change; sudden change in routine

Interpersonal changes

Responsive behaviour; resistive to care; disruptive; withdrawn

The Pain – Behaviour Link

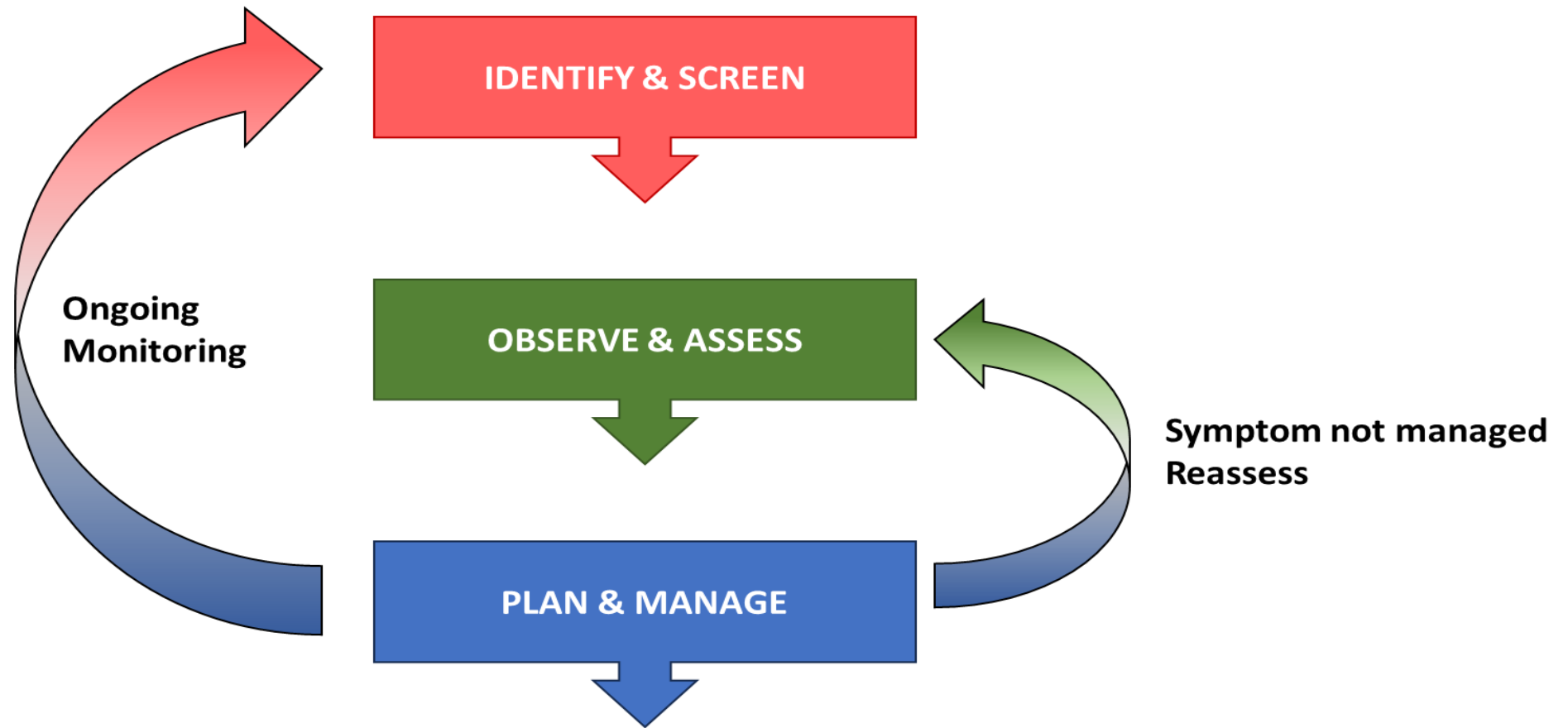
Pain Care is essential to Successful Behavioural Care

- Behaviours typically assigned to dementias look exactly like pain response behaviours in chronic pain sufferers
- Pain behaviours ARE responsive behaviours

How will you differentiate?

Rule out pain first!

3-Step Best Practice Model



Pain Identification & Screening Tools

Numeric Rating Scale (E.g. ESAS)

- Limitations

The image shows the Edmonton Symptom Assessment System (ESAS) form, a numeric rating scale used for assessing various symptoms. It includes a header with the title and version, followed by instructions to circle the number that best describes how the patient feels now. The form lists 11 symptoms: No Pain, No Tiredness, No Drowsiness, No Nausea, No Lack of Appetite, No Shortness of Breath, No Depression, No Anxiety, Best Wellbeing, and No Other Problems. Each symptom is rated on a scale from 0 (No symptom) to 10 (Worst Possible). At the bottom, there are fields for Patient's Name, Date, Time, and a section for completion by Patient, Family caregiver, Health care professional caregiver, or Caregiver-assisted. A note indicates to see the BODY DIAGRAM on the reverse side.

Verbal Descriptor Scale

- E.g. 4-point pain scale
- Using words to describe pain

The image shows a 4 Point Pain Scale diagram. It is a horizontal line with four points labeled: No Pain, Mild Pain, Moderate Pain, and Severe Pain. Below the line, a table provides the pain score and severity of pain for each point. The table is as follows:

Pain score	Severity of pain
None	No pain
Mild	Pain reported in response to questioning only, without any behavior signs
Moderate	Pain reported in response to questioning and accompanied by a behavioral sign, or pain reported spontaneously without questioning
Severe	Strong verbal response accompanied by facial grimacing, withdrawal of the hand, or tears

Behavioural Observation Tool (E.g. Abbey Pain Tool, PAINAD, etc.)

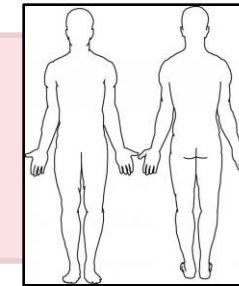
- For non-verbal or moderate-severe cognitive impairment

The image shows the Abbey Pain Scale form, a behavioral observation tool used for measuring pain in patients who cannot verbalize. It includes a header with the title and version, followed by instructions to observe the patient and score questions 1 to 6. The form lists six questions: 01. Vocalization, 02. Facial expression, 03. Change in body language, 04. Behavioral change, 05. Physiological change, and 06. Physical changes. Each question is scored from 0 (Absent) to 3 (Severe). At the bottom, there are fields for Name and designation of person completing the scale, Date, Time, and a section for adding scores for 1-6 and recording the Total Pain Score. A note indicates to see the BODY DIAGRAM on the reverse side.

Pain Identification & Screening Tools

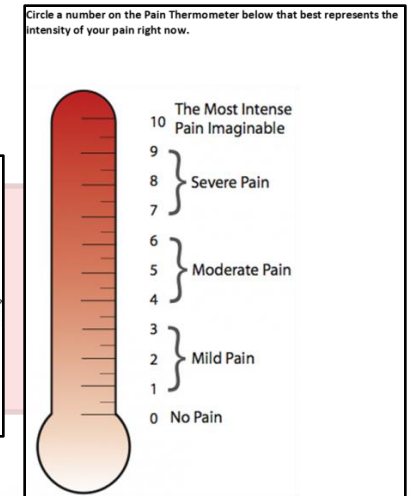
Visual Analogue Scale

- For deaf residents



CPS NAID (Behavioural Observation Tool)

- For residents with intellectual or developmental disabilities



Chronic Pain Scale for Nonverbal Adults With Intellectual Disabilities (CPS-NAID)

Please indicate how often each person has shown the signs related to the items 0 to 3 in the past 3 months. Please circle a number for each item. If an item does not apply to the person (for example, this person cannot reach with his/her hands), then indicate "not applicable" for that item.

0 = Not present at all during the observation period. (Note: if the item is not present because the person is not capable of performing that act, it should be scored as "NA").
1 = Seen or heard rarely (hardly at all), but is present.
2 = Seen or heard a number of times, but not continuous (not all the time).
3 = Seen or heard often, almost continuous (almost all the time); anyone would easily notice this if they saw the person for a few moments during the observation time.
NA = Not applicable. This person is not capable of performing this action.

0 = Not at all	1 = Just a little	2 = Fairly Often	3 = Very Often	NA = Not Applicable	
1. Moaning, whining, whimpering (shilly calls)	0	1	2	3	NA
2. Crying (excessively loud)	0	1	2	3	NA
3. A specific sound or word for pain (e.g. a word, cry or type of laugh)	0	1	2	3	NA
4. Not responding, irritability, withdrawal	0	1	2	3	NA
5. Less interaction with others, withdrawn	0	1	2	3	NA
6. Looking confused or distressed	0	1	2	3	NA
7. Being difficult to distract, not able to satisfy or pacify	0	1	2	3	NA
8. Nervous, tense	0	1	2	3	NA
9. A change in eyes, including: squinting or eyes opened wide, eyes tearing	0	1	2	3	NA
10. Turning down of mouth, not smiling	0	1	2	3	NA
11. Lips puckering up, tight, pointing or quivering	0	1	2	3	NA
12. Clenching or grinding teeth, clenching or thrusting tongue out	0	1	2	3	NA
13. Not moving, less active, quiet	0	1	2	3	NA
14. Not, excited, tense, rigid	0	1	2	3	NA
15. Clenching or touching part of the body that hurts	0	1	2	3	NA
16. Protecting, guarding or guarding part of body that hurts	0	1	2	3	NA
17. Flinching or moving the body part away, being sensitive to touch	0	1	2	3	NA
18. Moving the body in a specific way to show pain (e.g. head back, arms down, curls up, etc.)	0	1	2	3	NA
19. Shivering	0	1	2	3	NA
20. Change in colour, pallor	0	1	2	3	NA
21. Sweating, perspiring	0	1	2	3	NA
22. Tears	0	1	2	3	NA
23. Sharp intake of breath, gasping	0	1	2	3	NA
24. Breath holding	0	1	2	3	NA
Subtotal:					
For each subject write the number of times each value was chosen					
0	1	2	3	NA	
Add each subject to find the total score					
0	1	2	3	NA	
Total					

Scoring:
1. Add up the scores for each item to compute the total score. Items marked "NA" are scored as "0" (zero).
2. Check whether the score is greater than the cut-off score.
A score of 0 (zero) means that there is a 50% chance that the person has pain.
A score of 1 or lower means that there is an 87% chance that the person does not have pain.

1. Identify | Screen



2. Observe | Assess



3. Plan | Manage

O Onset

P Provoking /
Palliating

Q Quality

R Region /
Radiation

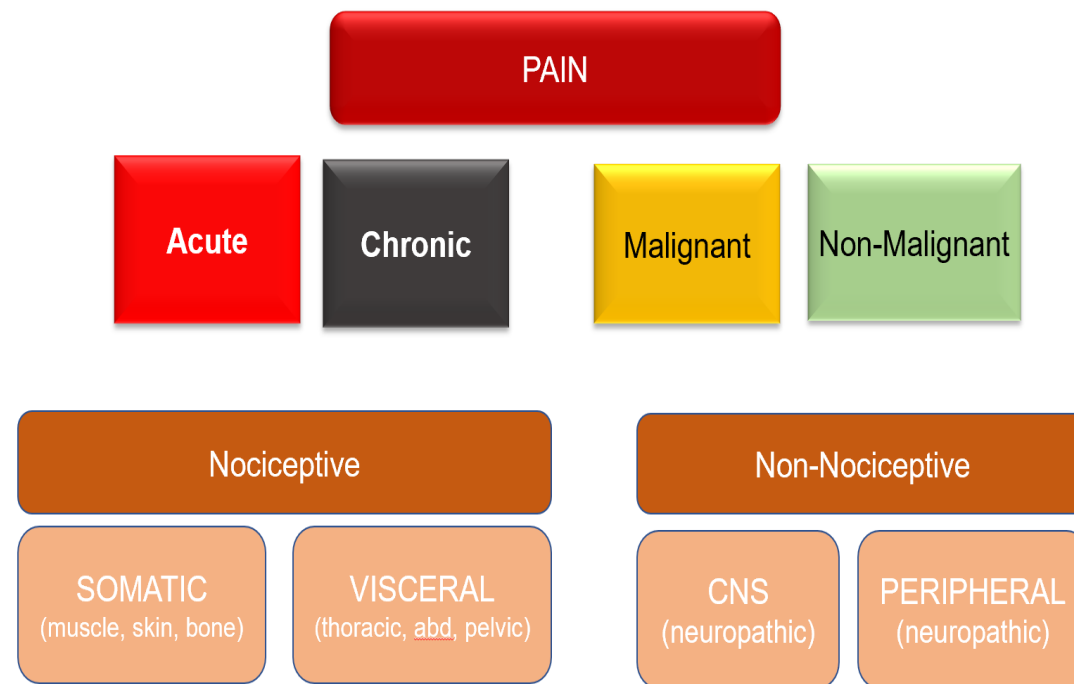
S Severity

T Treatment

U Understanding/
Impact on You

V Values

Pain Types (PAIN DX)

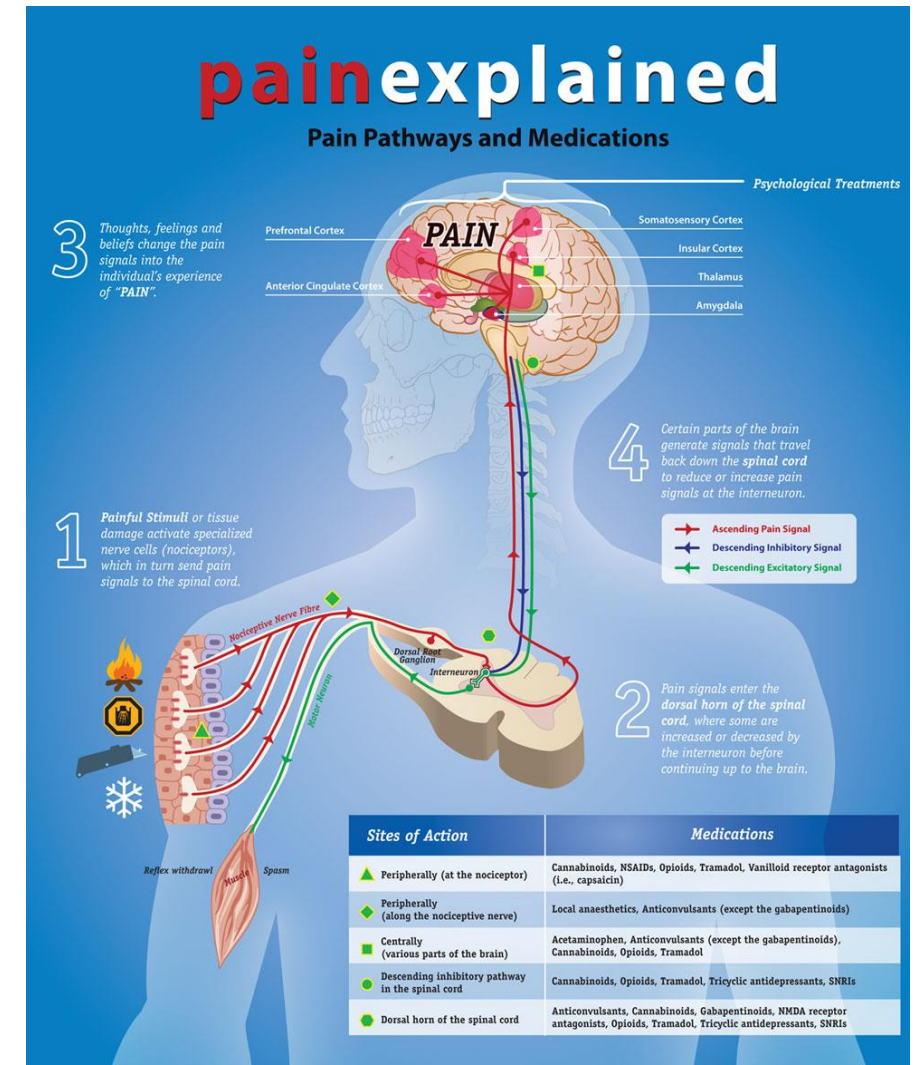


Goal is to block or smooth transmission of pain signal at different places along the pathway:

- Ascending
- Centrally
- Descending

Different analgesics interrupt pain signals in different places & at different receptors.

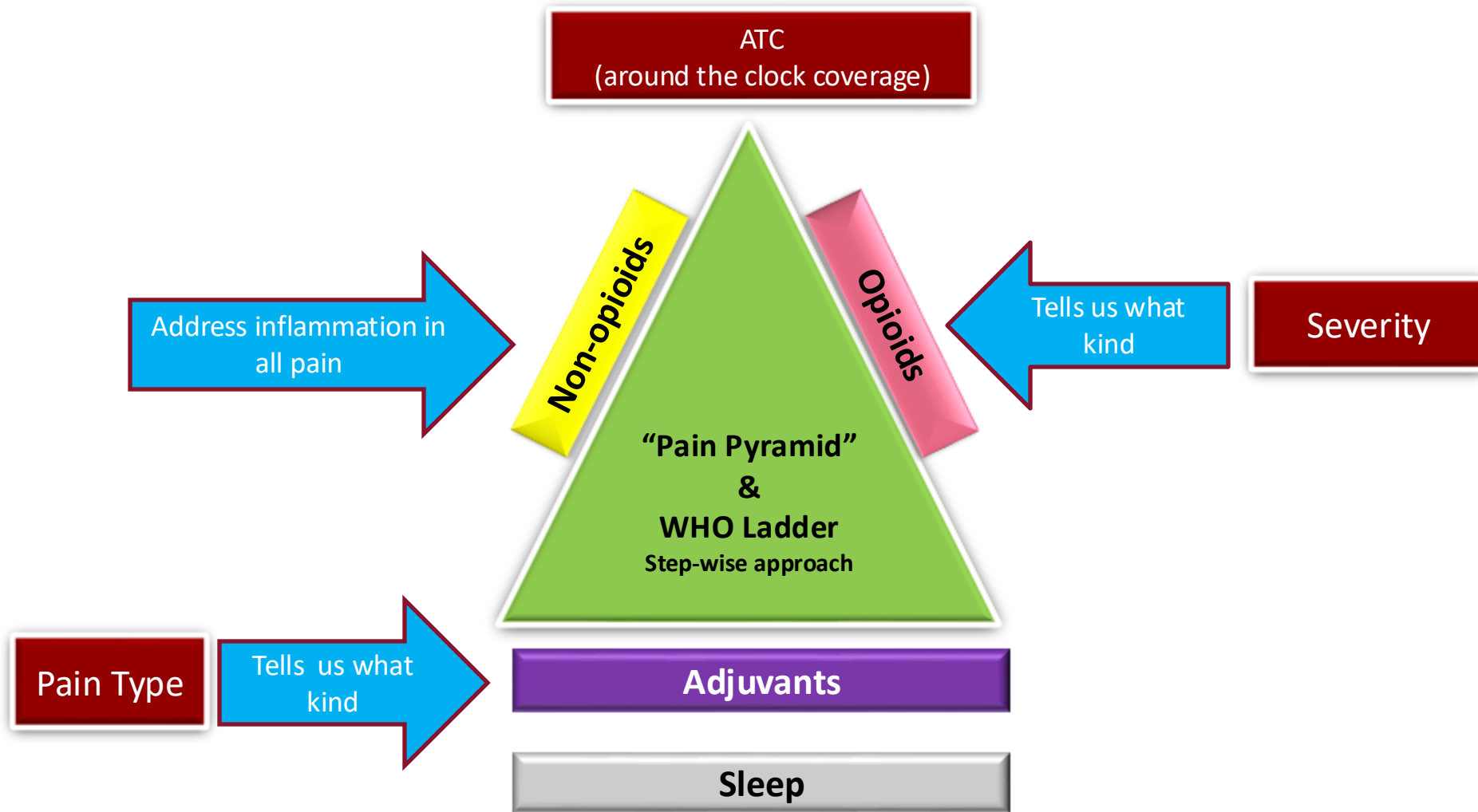
This gives the best opportunity for optimal relief



For additional information, visit:



Medication Selection Pain Care

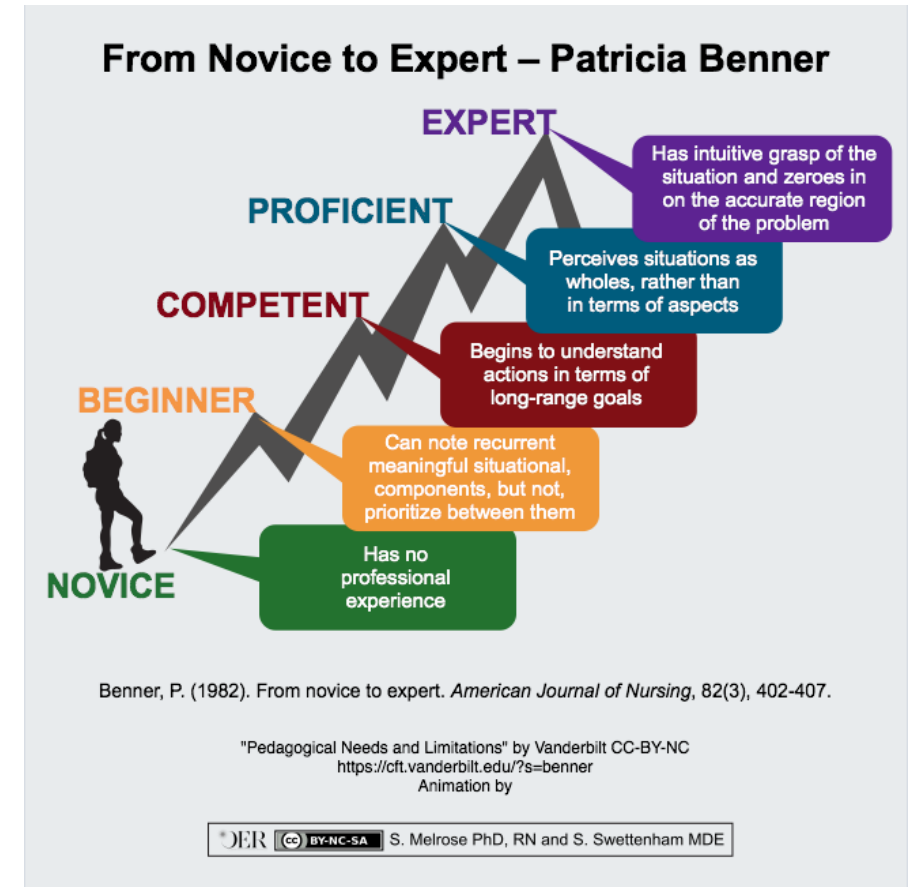


Right Drug(s) - Right Route - Right Dose - Right Frequency - Right Time

How will we know change is an improvement?

Measurable Improvement

- Team more skilled in 3 step model (use quickly to not add increased workload)
 - Efficiently, effectively, communicate across the team, drive orders
- Positive Resident outcomes
 - Resident reports relief (verbally, non-verbally)
 - Decreased behaviours
 - Improved quality of life
- Increased Resident and/or Family satisfaction



Breakout Groups

What actions can/will you do to make your quality improvements in pain care?

Share with your breakout groups what you may already have in place that is working well & what can you add to improve pain care in your LTCH?

Bringing it all together

Questions? Comments...

- How will you practice differently tomorrow?
- What QI initiatives can you start to implement in your LTCH to improve pain care for residents with dementia?
- Is this all you need to know? No!



Session Wrap Up

- Please fill out the feedback survey following the session! Link has been added into the chat.
- Join us for our Fourth Session that will be held on **October 01, 2025 from 12 to 1pm ET**
- A copy of these slides will be emailed to registrants within the next week.
- Thank you for your participation!

Thank You



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