May 21, 2009

Pain Management Series

Part I:
Revised Guidance to Surveyors: *Pain Management*

Numerous facilities (and this consultant) have been exploring and discussing ways to implement meaningful, comprehensive pain management programs. CMS, in its 3/31/2009 effective *Revised Guidance to Surveyors F309 Quality of Care/Pain Management*, has defined meaningful and comprehensive (emphasis on 'comprehensive') for us!

A point to keep in mind: surveyors have already been scrutinizing and writing deficiencies related to pain management. With the revisions finalized, we can anticipate their increased attention and higher expectations for facility performance in this area. Unfair since the guidance is still brand new? The surveyors could counter that argument by citing facility conformance with current practice standards.

The regulatory language of F309 requires that *each resident must receive and the facility must provide the necessary care and service to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.*

Although deficiencies involving pain management are already cited under F309, it is interesting to note that the original guidance regarding pain management was limited to… one sentence! *Appropriate treatment and services includes all care provided to residents by employees, contractors, or volunteers of the facility to maximize the individual's functional abilities. <u>This includes pain relief and control, especially when it is causing a decline or a decrease in the quality of life of the resident.</u>*

The revised Guidance is almost 30 pages. One sentence versus 30 pages? Uh Oh!

The Guidance includes a synopsis of the requirement for Quality of Care with regard to the recognition and management of pain:

- The facility must ***recognize*** each resident ***having or at risk*** for pain and ***anticipate*** what procedures, care, or treatments might produce pain,
- ***Evaluate*** the resident regarding the ***characteristics and causes*** of the pain.
- ***Manages or prevents pain,*** consistent with the comprehensive assessment and plan of care, current clinical standards of practice and the resident's goals and preferences.

The **Intent** of these requirements is to ensure that the facility assists each resident with pain by:

- Screening for the history or presence of pain,
- Comprehensively assessing the pain,
- Identifying circumstances when pain can be anticipated
- Developing a plan using medication and/or non-medication interventions to prevent and/or manage the pain.

Below is the list of criteria to be met in order for a facility to be considered in compliance. The facility will be considered **in compliance** with F309 Quality of Care for assessment and management of pain if it has:

- Screened residents upon admission and periodically for the presence of pain.
- Recognized and evaluated residents who are experiencing pain to determine (to the extent possible) causes and characteristics of the pain, as well as factors influencing the pain.
- Developed a care plan to address the pain, consistent with the resident's goals, risks, and current standards of practice.
- Provided care and services to control the pain to the greatest extent possible or to the level defined by the resident, in accordance with current standards of practice, or explained adequately in the medical record why they could not or should not do so.
- Recognized and provided pain control measures for situations such as treatments or activities known to potentially cause or exacerbate pain.
- Monitored the effects of interventions and modified the approaches as indicated.
- Contacted the health care practitioner with pertinent information when a resident was having pain that was not adequately managed or was having a potential adverse consequence related to treatment.
- Revised the approaches as appropriate or verified their continued relevance.

Each of the above criteria will be discussed in detail as this series continues.
Stay tuned… You can't afford to miss it!

Part II:
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In the first article of this series we reviewed the Intent and Criteria for Compliance with the *Revised Guidance to Surveyors* regarding F309 Pain Management.
This week let's examine these components in more detail.

The Overview incorporates a number of key current practice philosophies from which the substance of the revisions seems to flow including:

- **Pain is not an inevitable consequence or 'normal' part of aging.**
- Studies indicate that 45-80% of nursing home residents have substantial pain that is under-treated. Among those with pain, 41% are in persistent severe pain.
- Impact of under-treated pain includes: impaired mobility, impaired function in other ADLs, impaired mood, sleep disturbance, weight loss, social withdrawal, impaired quality of life.
- Effective pain management requires an ongoing facility-wide commitment to resident comfort, identifying and addressing barriers to managing pain and to corrective the aforementioned misconceptions.

Effective pain management includes the following processes:

- Recognizing when the resident is in pain.
- Identifying circumstances when pain can be anticipated.
- Assessing the existing pain and causes.
- Managing or preventing pain, consistent with assessment, plan of care, current practice standards, and resident's goals/preferences.

Factors affecting effective pain recognition and management include:

- When residents:
  - Are stoic.
  - Accept pain as part of aging.
  - Don't think of/describe their discomfort as 'pain.'
  - Don't want to take additional medications.
  - Have cognitive impairment.
  - Have multiple medical conditions/sources of pain.
  - Present with non-specific symptoms.
- When staff:
  - Don't recognize potential pain indicators.
  - Don't anticipate potential pain triggers.
  - Don't ask the right questions during 'assessment.'
  - Harbor concerns regarding 'addiction' or 'dependence.'
  - Have misconceptions, i.e. cognitively impaired have a higher pain tolerance.

Pain Recognition: You've got to Recognize it in order to Assess it!

1. In order to recognize and address pain promptly, the guidance supports screening for pain ***at admission*** to identify the resident who is *experiencing pain* OR for whom *pain may be anticipated* during specific procedures, care or treatment.
2. It is expected that residents will be screened for pain ***periodically***, when there is a change in condition, and anytime new/exacerbation of pain is suspected.
3. Process involves multiple health care professionals and ancillary staff who observe/interact with residents in a variety of settings and under a range of circumstances.
4. Talk with the resident, family/friends, observe at rest/during movement, examine.
5. Use verbal and nonverbal indicators.

The Pain Scale: Comments

- Individual reporting is the most accurate and reliable indicator of pain.
- Mild to moderately cognitively impaired residents can reliably answer simple questions related to pain.
- There is currently no sufficiently statistically validated assessment tool for non-verbal dementia residents.
- *One pain scale is probably not appropriate for all residents in the facility. Use the pain scale that is most appropriate for the individual resident.*
- Use the same scale each time for that resident.
- Some residents don't refer to their discomfort as 'pain' but may respond to questions regarding aching, stiffness, burning, etc.
- May need to observe cognitively *intact* residents regarding behavioral indictors of pain (in addition to using observation of behavioral indicators with cognitively impaired residents): see above factors that impact effective pain recognition and management.

When the typical Pain Scales aren't right for the resident:

- Observe the resident to establish baseline behaviors.
- Observe during transfer, ambulation, repositioning, treatments, etc.
- Monitor for pain regularly using comprehensive list of behavioral indicators.
- May be challenging to determine relative intensity of pain.

Behavioral Indicators: ***It's not just about Facial Grimacing!!***

In researching current literature, there appear to be at least 6 categories of behaviors that should be considered for potential indicators of pain:

- Facial expressions: frown, frightened expression, grimacing, wrinkled forehead, closed/tightness around eyes, rapid blinking, distorted facial expression.
- Verbalizations: sighing, moaning/groaning, chanting, grunts, calling out, noisy breathing, asking for help.
- Body Movements: rigid, tense posture, guarding, fidgeting, increased pacing, rocking, restricted movements, gait/mobility changes.
- Changes in interpersonal interactions: aggression, combativeness, decreased socialization, socially inappropriate, disruptive.
- Change in activity patterns: decreased food intake, change in appetite, increased sleeping/resting, change in need for rest, increased wandering.
- Mental status changes: crying, tears, increased confusion, irritability, distress.

Each of these categories include indicators that facilities may see every day but haven't generally associated with potential pain indicators, i.e. chanting, calling out, asking for help, rocking, fidgeting, resistance to care, distressed expression, etc. It is sobering to contemplate that the cognitively impaired resident who routinely calls out 'Help me, Help me' and grabs at staff walking by may actually be in pain.

It is equally important to identify those resident behaviors that have been assessed as NOT behavioral indicators of pain for that resident – surveyors may think they are!

Part III:
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In this week's installment of the Pain Management series we will be taking a closer look at the pain *Assessment* process:

Current Assessment Pitfalls:

- The facility isn't doing one.
- The current Assessment Tool doesn't ask enough questions.
- The current Assessment Tool isn't being fully completed.
- Upon admission/readmission/the resident is currently receiving pain medication, when the resident is asked 'are you having pain?' and the resident's answer is "NO"…
    - Did the resident mean 'at that moment?'
    - As the last article discussed, some residents do not describe their unpleasant sensation as 'pain' so other descriptors may be necessary to elicit accurate resident response, i.e. aching, burning, stabbing.
    - End of assessment!
- An assessment is not revisited when pain medication is initiated and/or when an additional pain site is identified.

The Effective Assessment Process:

1. Residents may experience pain from several different causes. Understanding the cause or source of pain is an important step in determining approaches to manage pain symptoms.
    a. Pain Recognition Scale/behavioral indicator results.
    b. Current medical conditions, co-morbidities, contributing factors, current medications, allergies, history of substance abuse.
    c. Physical Exam including the pain site, the nervous system, and physical/psychological and cognitive functioning.
        i. This should lead to diagnostic tests if/as indicated.

2. Thorough pain history: 'PQRSTAS"
    a. **P**recipitating/**P**rovocative/**P**alliative factors: what makes worse/what makes it better (non-medication strategies).
    b. **Q**uality of pain: burning, stabbing, aching.
    c. **Q**uality of life impact, i.e. functioning, sleeping, appetite, mood, etc.
    d. **R**egion of body affected.
    e. **R**adiation: where it spreads from point of origin.
    f. **S**everity/Intensity of pain
    g. **T**iming of pain: time of day, frequency, duration, etc.
    h. **T**reatments tried previously and their relative effectiveness.
    i. **A**ssociated symptoms. i.e. nausea
    j. **S**atisfaction with current pain management.

k. Non-verbal Dementia residents: Research suggests to anticipate and assume the presence of pain based upon pathology, injury, treatments, etc. if the aforementioned could be anticipated to cause pain for others.

3. Determination of the resident/family's goals for pain management.

Part IV:
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In this week's installment of the Pain Management series we will be taking a closer look at the pain management *Care Plan* process:

In anticipation of Care Plan development, it is essential that the facility elicit the resident's/family's wishes and preferences for pain management. These may range from the desire to:

- Be pain free.
- Reduce the pain level to allow for increased functioning in areas specified, i.e. increased mobility, increased ability to pursue diversional activities of interest, improved quality of sleep, etc.
- Achieve a tolerable pain level with minimal sedation and/or adverse consequences.

The resident's/family's wishes and preferences then become the basis for the Care Plan goals, i.e. examples:

- The resident will achieve and maintain pain-free state.
- The resident will be able to, i.e. maintain the ability to walk to the bathroom independently and access timely in respond to urge to void.
- The resident will be able to participate in and maintain concentration on (specify activity of choice).
- The resident will achieve six hours of sleep uninterrupted by pain/discomfort.
- The resident will be maintained at tolerable levels of pain/discomfort, identified by the resident as pain level up to '3' with minimal sedation.

Interventions to achieve Care Plan goals will generally include:

- Medications including scheduled doses and/or prn analgesics, adjuvant medications, anti-anxiety medications, etc.

- Non-pharmacological interventions, i.e.:
    - Environmental modifications: adjusting room temperature, tightening/smoothing linens, using pressure redistributing mattress and positioning, comfortable seating, assistive devices, etc.
    - Physical modalities: cold/heat packs, TENS, massage, baths, acupuncture, etc.
    - Exercises to address stiffness and prevent contractures.
    - Cognitive/Behavioral: relaxation techniques, diversional activities, music therapy, coping mechanisms, education about pain, etc.

- Complimentary and Alternative Medicine (CAM): group of diverse medical and health care systems, practices, and products that are not presently considered to be a part of conventional medicine.

- Time frames and approaches for monitoring the status of resident's pain/response to interventions, i.e. Effective as evidenced by…'
- Identification of potential medication-related adverse consequences and the plan to prevent/minimize/address.
  - Example: some groups of analgesics are known to commonly cause constipation. Proactively identify this potential effect and develop interventions to monitor for, prevent, minimize, etc.

Monitoring the Effectiveness of the Pain Management Care Plan interventions:
This phase of the resident-specific pain management process requires on-going observation of the resident by licensed personnel, input from CNA staff, and feedback from the resident/family. Remember, *effectiveness* needs to be measured in terms of the resident's/family's pain management wishes/preferences as stated in the Care Plan goals. The determination of *effectiveness* cannot be limited to assessment of the pain level *after* administration of medication, as the first two examples demonstrates

Example: The resident's/family's wishes are for the resident to achieve and maintain pain-free status. The physician has ordered analgesic medication every 6 hours prn. When the nurse approaches the resident regarding administration of the 'prn' the resident accepts the medication.

Issues: In order to determine effectiveness of the pain management regimen (effectiveness, in this case, equals maintenance of pain-free status), it is necessary for the nurse to assess for the presence or absence of pain, i.e. by asking the resident to 'rate' their pain or to observe for behavioral indicators of pain. If the resident indicates or appears to be having pain PRIOR to the administration of the prn analgesic, then the pain management prn regimen as it currently exists has not been effective in maintaining the resident at a pain-free level.
It may then be necessary to discuss with the physician a modification to the 'prn' schedule, consider scheduled dosing, changing the medication, adding non-pharmacological interventions, etc.

Example: The Care Plan goal (read as resident's/family's wishes and preferences) is to maintain the ability to walk to the bathroom independently and access timely in response to the urge to void. The resident is on scheduled dosing of the analgesic medication. The resident reports not making it to the bathroom in time in the early mornings but is able to do so later on and throughout the day.

Issues: In order to determine whether pain/pain level is affecting the resident's ability to ambulate to the bathroom timely in the early morning, it is important to assess the resident's pain level at that time versus at various other times throughout the day. If the resident 'rates' their pain level higher in the early morning hours than at other points during the day, it may be necessary to consider adjusting the administration schedule, increasing the early morning dose, adding a non-pharmacological intervention, i.e. massage, stretching prior to attempting to ambulate, etc.

Example: The resident has periodic pain that affects their ability to fall asleep and maintain uninterrupted sleep. The Care Plan goal is for the resident to be able to fall asleep and maintain at least 6 hours of sleep uninterrupted by pain. The resident has a 'prn' analgesic medication ordered.

Issues: It is important to assess the resident's pain level prior to medication administration in order to determine if the level is in its customary range versus more or less intense. If the resident demonstrates a pattern of increased levels of pain, it may be necessary to have the resident evaluated by the physician to determine if there has been an exacerbation of the existing condition or a new condition is present. If a reported/observed pattern of decreased pain levels is noted, it may be possible to reduce the prn medication dosage, change the type of medication or promote sleep through non-medication interventions. Following medication administration, the benchmark of *effectiveness* for this resident is the ability to fall asleep and maintain sleep uninterrupted by pain. Therefore the nurses' documentation on the back of the MAR regarding the 'effect' of the prn should refer to whether or not the resident was able to fall asleep and stay asleep.

As is evident from the above examples, effective pain management monitoring should incorporate the following:

- The resident's pain level is assessed by the nurse BEFORE and AFTER the medication is administered
    - Discuss modifications to the MAR that incorporate room to document pain levels with your pharmacy services provider.
- The pain management Care Plan Goals become the criteria for evaluation of 'effectiveness.'
- Presence/absence of associated adverse consequences, i.e. constipation, sedation, etc. is routinely observed for and charted.
- Establish a timeframe/frequency and assign responsibility to review resident-specific pain management trends/patterns and evaluate effectiveness in terms of the resident-specific Care Plan Goals.
    - Consider a 'Pain Log', i.e. plot information from the MAR documentation weekly so that pain levels before/after medication administration, impact of non-pharmacological interventions, presence/absence of adverse effects, etc. can be clearly evaluated.
    - Routinely communicate findings from 'Pain Log' review with the physician and adjust the pain management regimen as clinically indicated.

Part V:
Revised Guidance to Surveyors: *Pain Management*

In the previous articles of this series we reviewed the recognition, assessment, care planning and monitoring expectations set forth within the *Revised Guidance to Surveyors* regarding Pain Management. This week, in the final article of this series, let's examine what the Guidance has in store for us during a survey… The Investigative Protocol!

Surveyors are expected to determine:

- If the facility screens, assesses and provides ongoing monitoring of each resident who is either currently experiencing pain or may have a condition/receives care in which pain may reasonably be anticipated.
- If the facility provided resident-centered care and services to address and manage pain and to support the resident's highest practicable level of physical, mental, and psychosocial functioning.

The Investigative Protocol is to be used for a sampled resident:

- Who either states or displays symptoms of pain.
- Who has a condition that can reasonably be anticipated to cause pain.
- Who receives treatments that can be anticipated to cause pain.
- Whose assessment indicates the resident experiences pain.
- Who receives or has orders for pain treatment OR has elected the Medicare Hospice benefit.

(Let's pause for a moment and review what the Guidance has to say about the election of the Hospice benefit: *"When a resident elects the hospice benefit, the facility remains his/her primary care provider but the hospice assumes professional management responsibility for assessing, planning, monitoring, directing and evaluating the resident's pain management program and other symptoms related to terminal illness."*
The facility and hospice are jointly responsible for developing a coordinated care plan.
The plan must be consistent with the hospice philosophy of care, including directive for managing pain. Procedures should be in plan to assure timely administration of medication and treatments for optimal palliation. Hospice works with the facility to monitor the effectiveness of treatments related to pain and symptom control as well as undesirable side effects. **The facility is ultimately responsible for a resident's overall care and comfort. The facility is responsible for notifying the hospice when the resident experiences a change in condition, is experiencing uncontrolled, increased or breakthrough pain, or is in pain.)**

Procedures:
Observations: Surveyors are instructed to observe the resident during various activities, shifts and interactions with staff to determine whether: the resident exhibits or verbalizes the presence of pain and whether the pain appears to affect the resident's function; staff have planned and implemented plans to address pain during care/services which reasonably could cause pain; how staff respond when advised by others that a resident is experiencing pain; staff compliance with the resident's pain management program.

Interviews:

- Resident Interviews: Surveyors are expected to interview the resident/family to the degree possible to determine whether: the resident experiences pain and, if so, the characteristics of the pain; who has been told about the pain; whether the resident/family has been involved in the development of the pain management program; whether the interventions are helpful, etc.
- Direct Care Staff Interviews: The purpose of staff interviews is to determine whether staff are aware of residents' complaints of pain, to whom they would report complaints or symptoms of pain, and whether they are aware of and implement the identified interventions.

- Nurse Interviews: The purpose of nurse interviews is to determine the mechanisms and frequency used to identify resident pain, how the facility objectively assesses pain, whether a pain management plan has been developed, how staff monitor the benefits and risks of the interventions, frequency of PRN requests, communication with the physician, and coordination with hospice.

Record Reviews:

- Assessment: Surveyors are instructed to evaluate the assessment process to determine whether it includes:
    - Accurate and comprehensive reflection of resident's current condition.
    - Identification of causes, risks and contributing factors related to pain.
    - Identification of a previous history of pain, effectiveness of prior interventions, and prior adverse consequences.
    - Identification of the characteristics of the pain.
    - Identification of whether pain has adversely affected function and quality of life.
    - Consistent use of a resident-specific valid instrument/scale to evaluate pain.
    - Identification and evaluation of appropriate dosing and frequency.
    - Identification of factors that increase or effectively reduce pain.
- Care Plan: Surveyors will be looking for specific interventions, measurable objectives and timetables, risks and causes, and their relevance to the resident.
    - Pertinent non-medication and medication interventions.
    - Identified pain management goals that reflect the resident's/family's pain management wishes/preferences.
    - Monitoring outcomes of the interventions.
    - Potential medication related adverse consequences.
    - Non-medication interventions as applicable.
    - If the resident is on Hospice, one common care plan utilized by both providers is acceptable. The care plan should reflect the identification of a common problem list, palliative interventions, palliative outcomes, responsible discipline and responsible provider.

Scope and Severity assignments can range from Level 2 (D) to Level 4 (Immediate Jeopardy) based upon the degree of impact on the resident's optimal level of functioning/well-being and the intensity/frequency of the pain. The failure of the facility to provide appropriate care and services for pain management places the resident at risk for more than minimal harm. Therefore, Severity Level 1 does not apply for this regulatory requirement.

Although most facilities have already begun to use a pain scale and assessment tool (although not all assessment tools currently in use incorporate all areas included in the *Guidance*), this alone does not an effective pain management program make! Surveyors are already scrutinizing pain management more closely. For facilities who delay in implementing a comprehensive pain management process, the resulting survey deficiencies could be *painful!*

About the Author:

Dorrie J. Seyfried is Vice President of Method Management, Risk Management & LTC Consultants, now part of Insurance Program Managers Group, based in St. Charles, Illinois. Under her directions, the Method Management team provides the risk management services to LSN's Workers Compensation Trust and LSN's liability insurance Risk Retention Group as well as a comprehensive array of consultation services to long to term care providers including mock surveys, plan of correction & informal dispute resolution development, incident management, and leadership development and a 24-hour risk management hotline exclusively for LSN members.

For questions about the contents of this newsletter, contact Jacque Thornton, at the Aging Services of Georgia office at 404-872-9191.