Long-Term Care Survey Alert

Compliance: Avoid the Hurt of a Painful Survey: Here's the Scoop on Effectively Managing Your Residents' Pain

Follow these tips to avoid noncompliance citations at F309 and F329.

Your residents' pain levels could put you in a world of hurt come survey time if you're not adequately recognizing, evaluating and managing their pain. To avoid getting stung with a noncompliance citation for tag F309, you need to make sure that your facility is identifying and documenting residents' pain and pain interventions, **William D. Smucker, MD, CMD**, medical director of the Altenheim Nursing Home in Strongsville, Ohio, warned at AMDA's annual meeting in March.

"We are supposed to get our residents to the highest practicable level of physical, medical and psycho-social well-being and that includes pain control," Smucker emphasized during his presentation, "Taking the Pain Out of Pain Management." The investigative protocols for pain management in the State Operations Manual (SOM) direct surveyors to determine if there is evidence of pain or the potential for pain symptoms related to conditions or treatments.

Which residents have pain?

In addition to the pain item sections of the MDS (items J0300-J0600), the SOM notes that other sections such as sleep cycle (items D0200C, D0500C), change in mood (items D0100-D0600), decline in function (items in Section G), instability of condition, weight loss, and skin conditions (items in Section M) can be potential indicators of pain. "Any of these findings may indicate the need for additional and more thorough evaluation," the SOM states.

"If there is evidence of pain, the surveyors will want to know if it has been assessed and whether you have identified and implemented interventions to prevent or address the pain, and whether you have evaluated the status of the resident's pain intervention," Smucker notes.

What are the causes behind the pain?

"When you are treating pain, you really need to understand what is causing it in the first place," emphasizes **Peter Winn, MD , CMD**, medical director of VistaCare Hospice in Oklahoma City, Okla. "If you have someone with abdominal pain, it may not be a question of giving them more analgesics to relieve the pain. You need to be asking, 'What is causing the abdominal pain?' Is it urinary retention? Fecal impaction? If so, there may be a more appropriate intervention than pain medication. You need to think behind the symptom," he advises.

Hidden culprits: "Other, less common causes of pain may be improper positioning or restraints, either physical or pharmacological," Winn noted. "Gout and pseudogout may manifest as pain in the wrist," Winn added. "If someone has an acute, swollen, painful wrist, you'll certainly want to rule out a fracture by doing an x-ray, but the most common site of gout or pseudogout in an older person is not in the knees, it's actually in the wrists," Winn explained.

By identifying the cause behind the pain, you can more effectively treat the pain. As the SOM states, "Addressing underlying causes may permit pain management with fewer analgesics, lower doses, or medications with a lower risk of serious adverse consequences."

Is the resident's pain being managed?

Providers should make certain that they have clearly identified measurable pain management goals for each of their residents' experiencing pain, emphasizes Smucker. These goals should take into consideration different circumstances and reflect the resident's individual preferences. "Talk to your residents about what pain level they want to go to. Ask

them, 'What's a tolerable pain level for you?'," Smucker suggests.

For a number of reasons, it may not always be possible to completely eliminate a resident's pain, and so the pain goal may be a reduction in pain levels. "You may be able to get a 50 percent reduction in pain, and bring a resident down to a moderate or mild level of pain. You've got to tell your patients where they're headed and what you're shooting for," he explains. The SOM recognizes that a resident may accept partial pain relief in order to experience fewer significant adverse consequences, e.g., desire to stay alert instead of experiencing drowsiness/confusion.

Pain goals should also take into account a resident's desired level of activity. "There are some residents who don't move, but most people in our facilities should be able to get up and move around, and their pain goals should reflect this," Smucker notes. For most patients, it's not acceptable to have no pain only if they don't move. It is particularly crucial to make certain that your short-term rehab patients have good pain control, he says, because if they don't, they won't be able to do their rehab.

Providers also need to include time-frames and approaches for monitoring their residents' pain levels. "How often are you checking on your residents to assess their pain? Once a week? Once a day? Every shift? Every time you give a med?" Smucker asked. "I recently took over the care of a patient with uncontrolled pain and I asked the facility staff to tell me what they knew about this patient's pain levels over the past two weeks. And I got a long silence . . . now if the state surveyors had walked in that day and talked to the DON and found out there were no pain ratings available, this facility would have been in trouble," he warned.

Are medication-related side effects being managed?

Potential adverse side-effects of pain medications, especially opioids, can include constipation, nausea, sweating, confusion, falls, urinary retention, delirium and confusion, notes Winn. State surveyors are going to be looking to see that a facility has anticipated adverse consequences related to analgesics and tried to reduce or prevent them.

In particular, constipation is a frequent side-effect suffered by patients on opioid pain medications and providers need to be proactive about managing this. Whenever an opioid order is written, a bowel regimen should also be written, says Smucker. "Staff should always be asking patients who are being administered an opioid about constipation. When they ask them about their pain, they should also ask them about their bowels."

Residents on opioids should be put on a toileting schedule and offered the toilet after meals. "Try to make sure that they are going every 2-3 days and make sure it's being documented," Smucker recommends. He says the most effective management of opioid-induced constipation is a combination of senna and sorbitol, lactulose or PEG. In contrast, he maintains, stool softeners and metoclopramide typically are of only limited benefit in managing opioid-induced constipation.

Providers also need to put in place a respiratory-depression monitoring plan for their residents on opioids, Smucker notes. "In humans, opioids cause respirations to slow and become irregular, and then in escalating doses leading to cypercapria and hypoxia." Staff should be told to notify a physician whenever the respiration rate of a patient on opioids falls below 8, plus the patient cannot be aroused to his/her usual level of consciousness and has a pulse ox of less than 92 percent.

It's important for providers to establish baselines on these measures prior to administering opioids. "I say, let's make sure we have the respiratory rate, pulse ox, and agreement on what this resident's level of consciousness is now. Let's do their baseline and then set notification parameters," Smucker says.

If staff thinks a resident is having respiratory depression, the first thing to do is see if you can arouse them. "Sedation always precedes respiratory depression and if you can't get them to come around, then take their vitals. If they are unarousable and hypoxic, you should call the doctor," Smucker advises.

Are your residents receiving unnecessary medications?

Providers are also required to monitor their residents' medications to make sure that they are free of unnecessary medications or risk being cited for noncompliance with tag F329. According to the SOM, an unnecessary medicine is an

excessive dose or one without adequate monitoring, notes Smucker. "So it might be the right dose, but if you're not monitoring it, or if you're giving it in a dose that's inappropriate, that's considered an unnecessary drug," he warns.

Winn notes that nonpharmacological treatments such as RICE (rest, ice, compression, elevation), occupational and physical therapy, TENS, and massage, may also be helpful in alleviating the doses of medications used.

Residents and their families may also request the use of complementary and alternative medicine for pain such as therapeutic tough, acupuncture, herbal supplements, and aromatherapy. "You certainly don't want to be treating side-effects of medications with other medications that may also have side-effects themselves," Winn warns.