Long-Term Care Survey Alert

Quality of Care: Check The Fifth Vital Sign In Wound Assessment

Stay on top of wound pain - or your facility will be in pain on its next survey.

Just as you record patients' temps as part of wound assessment, don't forget to assess and quantify their pain.

"Assessing pain as part of wound care has been the standard of care for many years," says **Kathleen Thimsen, RN ET MSN**, president of **RARE Consulting Group** in Bella Vista, AR. And pain management will also be high on surveyors' checklist as a new focus of revised F314 (pressure ulcer) survey guidelines.

Ditch this myth: Some practitioners still think Stage 3 and 4 pressure ulcers are largely painless due to damage to the nerve endings. To the contrary, "most pressure ulcers are painful," says **Karl Steinberg, MD, CMD**, a geriatrician and medical-legal consultant with **Stone Mountain Medical Associates Inc**. in Oceanside, CA.

"Approximately half of people will rate their Stage 3 or 4 pressure ulcer as being a 3 out of 10 on a pain scale when the wound is covered and not being disturbed," Steinberg adds. "But when someone touches the wound, that pain level goes up."

And even if the wound has destroyed some of the local sensory nerves, the patient will often have discomfort around the wound edges, Steinberg continues. "The resident can also experience periosteal pain with Stage 4 ulcers."

Quantify, Document Pain Levels

Ask patients with pressure ulcers to stage their pain on a Likert scale of 1 to 10 or use a smiley face and unhappy face scale, Thimsen advises. "If the resident is unable to communicate, assess for nonverbal signs of pain, such as moaning/groaning, wincing, twitching or excessive movement with dressing changes or re-positioning. Also look for behavioral changes and loss of appetite in wound patients who can't communicate pain."

Make sure to document your ongoing pain assessments, especially related to dressing changes and debridement. Generic notes, such as "Patient in no apparent distress," to describe someone with a big ugly pressure ulcer won't cut the mustard in legal arenas, Steinberg says. "The family may testify in a lawsuit that their loved one moaned throughout a dressing change," but the nursing notes don't even mention a pain assessment.

The bottom line: "Nursing and medical staff should do everything in their power to determine if the resident is in pain - and if the person cannot communicate, give them the benefit of the doubt and assume the wound is painful," advises Steinberg.

"Be proactive in anticipating and treating wound-related pain unless the patient definitely says he is not in pain or refuses treatment," Steinberg adds.

Example: A diabetic with peripheral neuropathy and poor sensation in the feet may not need pain management for a heel wound he says doesn't hurt, says Steinberg.

MDS coding tip: If the patient reports wound pain, make sure to code the location of the pain in Section J3h (soft tissue pain) to show surveyors you're aware of the resident's wound pain. The care plan and documentation should tell the rest of the story in terms of what the facility is doing to manage the pain -and how the resident is responding.

Determine Need for PRN or 24/7 Pain Relief

The selection of medications to treat pressure-ulcer pain depends on when the pain occurs - for example, only during dressing changes or repositioning or all the time, says **Parulekar Manisha, MD,** with **Hackensack University Medical Center** in Hackensack, NY.

Clinical tip: "If the person has pain all the time, look for signs of wound infection," says Manisha. "Unless you treat the wound infection, in addition to providing analgesics, the pain won't improve."

To treat pressure-ulcer pain, the prescribing clinician can start with a medication like Tylenol, says Manisha. "If the patient can't communicate verbally, give the medication around the clock, instead of waiting for the person to start showing signs of discomfort," Manisha advises.

Drug safety tips: Good candidates for acetaminophen therapy include those with mild to moderate pain and good liver function with no history of hepatitis, heavy alcohol use or liver toxicity from drugs or environmental/occupational exposure, says **Rhonda Nichols, RN, MS, CNS,** a pain expert in San Francisco. You'd definitely want to question Tylenol therapy for a diagnosed alcoholic with a history of hepatitis, for example.

Play it safe: "Before you go down the path of chronic, high-dose Tylenol therapy, obtain baseline liver function tests and a good clinical history," Nichols adds.

Also make sure the patient receiving Tylenol isn't getting extra acetaminophen in drugs such as Darvocet-N, Vicodin and Ultracet, or OTC headache and cold remedies. "The ceiling for acetaminophen in a healthy liver is no more than 4 grams a day, and some [experts] may recommend 3 grams," advises Nichols.

If Tylenol doesn't alleviate the resident's behavioral symptoms - or the resident says it doesn't provide adequate pain relief - move up the pain management ladder to Ultram or to opioids, depending on the severity of the pain, advises Manisha.

If the patient requires opioid meds to manage pain, Steinberg strongly recommends giving a PRN med, such as Vicodin, an hour before dressing changes or wound treatments. Patients who have significant pain even when the wound is not being manipulated or dressed may find relief with a long-acting opioid or Duragesic (fentanyl) patch, Steinberg adds.

"Duragesic patches appear well tolerated in the elderly and in those with less robust renal function due to the lack of active metabolites with this opiate compared to others," says Nichols.

Facilities have reported success treating pain associated with larger wounds by applying lidocaine transdermal patches around the wound's periphery, following the prescribing clinician's and drug manufacturer's directions. "But don't get the lidocaine in the wound - particularly not in the elderly who have cardiac risk factors, as lidocaine is an antiarrhythmic agent," cautions Nichols.

Assess the effect of the pain management regimen on the cognitively impaired, verbally noncommunicative resident's behavior, advises Steinberg. "For example, is he participating more in activities, eating better, sleeping well, appearing more comfortable?"

Tip: Evaluate pain management as a process in your facility - see chart, later in this issue.