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Long-Term Care Survey Alert

SURVEY MANAGEMENT: 6 Ways to Make the Revised F309 Survey Guidance More Painless

Cover these bases and you'll be in good shape for your next survey.

If facilities were looking for an exact "how to" guide in the revised F309 for managing pain, they didn't get one. The good news is that the guidance does provide a framework for improving and standardizing pain management -- and keeping a long list of F tags at bay.

The final guidance differs from the draft guidance, which provided more details about when to do screening and assessments, observes **Rena Shephard, MHA, RN, RAC-MT, C-NE**, president and CEO of RRS Healthcare Consulting in San Diego, and founding chair and executive editor of the American Association of Nurse Assessment Coordinators.

Yet, facilities should have an organized pain management program, and a procedure and policy so that staff knows how they should assess and manage pain, Shephard stresses. "They need to have that and follow it."

Incorporate These Elements

1. Adequate pain screening and assessment. Make sure the facility has a comprehensive pain assessment.For example, the Illinois Council on Long Term Care has a pain protocol for long-term care with an assessment that not only goes into the location, intensity, etc., of pain, but also a pain medication history, diagnoses or procedures that could have caused or be causing the pain, and changes in ADLs due to the pain, etc. It also includes behavioral indicators of pain if the person isn't alert or cognitively intact to communicate the pain verbally, reports **Susan Gardiner, BSN, RN**, director of clinical services for the council.

The facility also needs to dictate the frequency of screening and reassessment, advised Shephard in a presentation on F309 at the March 2009 AANAC conference in Kansas City, Mo. She recommended reassessing residents within a reasonable amount of time after instituting pain measures, and when the resident has a change in condition or has new pain or a change in his existing pain. Staff should also check on pain as part of vital signs and when doing routine assessments, she advised.

2. Pain risk identification andmanagement. Surveyors will be looking at how well a facility identifies risk factors to prevent pain, whether it's a pressure ulcer or whatever,says **Marilyn Mines, RN, RAC-CT, BC**, manager of clinical services for FR&R Healthcare Consulting in Deerfield, Ill.

Invitation for IJ: The survey guidance directs surveyors to cite immediate jeopardy when they see a resident "experienced recurring, episodic excruciating pain or incapacitating distress related to specific situations where pain could be anticipated (e.g., because pain has already been identified during dressing changes or therapies) and the facility failed to ... try to minimize the pain."

3. Attempts to identify the etiology of pain. Failure to do this is where Shephard sees facilities being most vulnerable under the revised F309. For example, "if the resident has just undergone hip surgery, the cause of the pain may be more obvious, but you should still do a full assessment," she says.

Real-world example: In one case, a patient in the SNF following a knee replacement began to complain of increasing pain, Shephard noted in her AANAC presentation. The nursing staff gave him pain medication, assuming he was talking about knee pain. But he was really experiencing chest pain -- and "there wasn't a positive outcome," relayed Shephard, noting the case resulted in a lawsuit.

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Dementia-care tip: One nursing facility has a policy where staff gives confused residents acetaminophen when they suddenly became agitated or aggressive, reports Mines. If the behavior improves, the staff assumes the resident may be having pain, and gets the physician on board to identify potential underlying causes.

4. Adequate treatment of continuing pain. Anyone with ongoing pain should receive a routine pain medication to maintain a consistent level of comfort in keeping with his desired level of alertness, etc.,Shephard emphasized in her AANAC talk. However, some nurses and physicians still harbor fears about giving residents opioids, including the idea that they are saving the person from addiction, Shephard noted. She relayed a clinical example where a post-op patient was asking for a PRN pain medication every six hours. The staff felt the woman just wanted drugs. In talking to the patient, however, Shephard found that the woman was embarrassed by asking for the medication and wouldwait until the pain got so bad that the PRN never really took care of it.

5. Use of non-pharmacological interventions. Include activities staff in non-pharmacological pain management strategies, advises Gardiner.

"Exercise can help pain in some cases, as can relaxation therapy, distraction, deep breathing, and light massage," she says.

Creative idea: A lot of facilities have a pain cart that has books, aromatherapy, music therapy, etc., to take to residents' rooms, says Gardiner. "The goal is to reduce anxiety and improve mood and a sense of control."

6. An evaluation process. Assess and document what effect the pain management has on the resident, advises **Nathan Lake, RN**, **BSN, MSHA,** a long-term care and MDS expert in Seattle. "Is the person better able to do his own self care and participate in activities, etc.?"

Also consider implementing pain management satisfaction surveys that ask residents and families to evaluate the facility's efforts, suggested Shephard in her AANAC talk.

Ask the non-nursing staff, such as the social worker, to administer the survey, as residents may feel uncomfortable complaining to the nurses who are involved in their pain management, she advised.

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