Codify
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MDS Alert

Assessment and Coding: Take The Pain Out Of Assessing And Coding For Section J

Erase coding errors in 6 steps.

Section J2 offers a window to residents' pain - one you can bet surveyors and consumers will be peering in to size up your facility's care.

Undercode pain and surveyors will end up holding the facility's feet to the fire if they catch the problem by interviewing residents and their families. By the same token, overcoding pain drives up your quality measures, driving away consumers and inviting F tags.

Solution: Use these six strategies for assessing pain and coding it in Section J2 and J3 to develop an accurate picture of residents' comfort levels.

1. Collect pain data from all shifts throughout the seven-day observation period. "Include all direct care staff, the resident/family, and review the medical record," advised **Regina Fink, RN, PhD, AOCN**, with the **University of Colorado Hospital** in Denver, in a **Centers for Medicare & Medicaid Services**' Webcast on improving MDS accuracy in Sections I, J and 0.

Ask the resident to describe her pain, which will provide key clues as to its cause and the best treatment approach. The types of pain include neuropathic (shooting, burning and/or lightening bolt type sensations), visceral (squeezing, cramping, pressure) and somatic or musculoskeletal pain (achy, gnawing, sharp, throbbing).

Using a pain scale, ask the resident two questions:

1. "If 0 is no pain and 10 is the worst possible pain, what is your pain now, in the last 24 hours (since mealtime yesterday) and since you last received your pain medication?"

2. "Where on the pain scale would you like your pain to be?" This is known as the person's comfort goal, said Fink.

Don't use 'one size fits all' pain scale: Select a pain scale best suited to the resident. The majority of elderly people prefer a verbal descriptor scale, according to a study by the **Agency for Healthcare Research & Quality** on pain and nursing homes, in which Fink participated. "More men chose the numeric rating scale," she adds. "And more minorities (the study included higher numbers of Hispanic/Latinos) liked the faces scale due to language barriers associated with using verbal descriptors," she added.

Offer nonverbal residents (for example, those with aphasia) writing materials and pain scales when assessing/treating their pain, Fink advised. If the person has short-term memory loss, ask her to score her worst pain since her last meal or since she received her pain med.

Tip: Patients with moderate or even moderate-to-severe cognitive impairment can often report their pain reliably if you ask them very simple, direct questions, says **Ira Katz, MD,** a psychiatrist with **Philadelphia Veterans Administration Medical Center.** "Ask the person: Are you in pain? Where does it hurt? Does your shoulder (head, hip, etc.) hurt? Does it hurt when you urinate?"

2. Observe for and document pain behaviors and attempt to validate their meaning with residents. Some

dementia residents may not be able to communicate their pain verbally. And some cognitively intact residents may be stoic and, thus, feel uncomfortable about admitting they are in pain, cautions **Pam Campbell, RNC, CRNAC,** MDS operations director for **LTC Solutions** in Camdenton, MO.

Solution: Observe all residents for pain behaviors (agitation, bracing a body part, vocalizations, withdrawal, facial expressions, resistance to care, crying out, change in activity or interaction patterns, mental status changes).

Look for the pain behaviors when the person is at rest and moving, suggested Fink. "Some residents won't display pain behaviors at rest," she cautioned. Also teach family and CNAs to observe for pain behaviors and report these to the nursing staff.

Tips: Treat cognitively impaired people who can't report pain but display pain behaviors with analgesics around the clock. If the interventions modify the pain behaviors, continue the treatment, advised Fink.

Check back with verbal residents who deny pain but display pain behaviors. Tell them they appear to be in some kind of discomfort, and educate the resident and his family about pain relief options, including nonpharmacological alternatives.

3. Code the frequency of pain in J2a (none, less than daily or daily)."If the resident has no pain, code 0, even if she is pain-free due to effective pain management," Fink instructed.

4. Code the highest intensity of pain in J2 occurring within the seven-day lookback. Using a pain scale of 0 to 10, mild pain would be a 1, 2 or 3; moderate pain, 4, 5 or 6; and severe or horrible pain, a 7 or greater, said Fink. "Pain greater than or equal to 4 interferes with daily functioning cross-culturally," said Fink. Therefore, if the patient reports pain at that level, re-evaluate the pain management plan (or if the patient's comfort goal isn't being met).

"The patient may need increasing levels of analgesia and/or you can add a nonpharmacological approach to their pain management care plan," Fink suggested.

5. Carefully assess and code the sites of pain in Section J3. "Greater than 75 percent of residents will have pain in more than one area," cautioned Fink. "Ask the resident to point to the painful area(s)," she advised.

6. Assess pain before you administer a pain medication and after the medication has had time to work, advised Webcast presenter **Rena Shephard**, **MHA, RN, FACDONA,** president of **RRS Healthcare Consulting** in San Diego. "Keep in mind the drug's onset of action," she adds.