MDS Alert

CARE PLANNING :Tap the MDS and Survey Guidance to Create a Pain RAP

Standardize and individualize care planning with this approach.

The lack of a pain RAP can make care planning residents' pain a bit of a hit-and-miss endeavor. Developing your own doesn't have to be a daunting task, however.

Facilities can come up with triggers and decision trees for analyzing pain assessment information and deciding whether to dig deeper.

One option for developing a RAP is to use the F309 survey investigative protocol as a guide, advises **Marilyn Mines, RN, RAC-CT, BC**, manager of clinical services for FR&R Healthcare Consulting in Deerfield, Ill. The protocol goes into many aspects to consider regarding pain assessment and the effects of treatment, etc. (See the Web address for the survey guidance at the end of this article.)

Don't miss: The survey guidance identifies the following risk factors for pain: "Diabetic neuropathy, immobility, amputation, post stroke, oral health conditions, urinary tract infections, pressure ulcers, or venous and arterial ulcers. Many treatments and procedures are also associated with pain such as dressing changes, ambulation, exercises, and range of motion."

Also take a look at the site of pain coded in J3: For example, if you coded at J3d that the resident has headaches, when did they start, and are they getting worse? Did the person have a recent fall where he could have hit his head? "A new onset or worsening headaches can have many causes, from needing new glasses to something much more serious, such as a tumor," says **Sue LaBelle, RN, RAC-CT, MSN**, a consultant with PointRight Inc. in Lexington, Mass.

If you've coded mouth pain in Section K, is the person losing weight due to the pain? asks LaBelle. Has the person received a dental evaluation?

"If you're assessing [and coding] back pain, bone pain, or joint pain, how is the pain affecting the person's mobility?" asks LaBelle. "Residents with chronic pain may not complain about it, but it may be slowing them down or affecting their sleep."

Check These Additional MDS Items

Consider reviewing the following as potential triggers for further investigation or care planning:

Depression indicators. "If a person has had chronic pain for some time, he's going to be depressed," says **Nathan Lake, RN, BSN**, a long-term care and MDS expert in Seattle. "And if someone's depressed, his perception of pain may be much greater than it would be if he weren't depressed." Thus, "you can't really tease the two conditions apart. You should assess for and treat the depression and the pain," Lake emphasizes.

Watch for: You may see certain E1 indicators trigger for a person in pain even if he isn't depressed. Look for social isolation, for example.

"A sad, worried expression or stressed look can be due to pain," says LaBelle.

Behavioral symptoms. You may see more agitation and restlessness, repetitive movement, or angry outbursts, says LaBelle. The person may also resist personal care because it hurts to be touched or move.

Napping and activities (**Section N**). You may see the person is napping more, says LaBelle. Also look for a decrease in the amount of time spent in activities.

Anger and unsettled relationships in Section F2. When people are in pain, they tend to lash out more at others or be unhappy with everything. "Pain touches on everything," notes Lake.

Wounds (Section M). Pressure ulcers can cause considerable pain, as can surgical wounds, Labelle reminds.

Unexplained weight loss in Section K or ADL decline (G9).

Diagnoses in Section I. Does the resident have painful conditions coded in this section, including cancer, arthritis, Parkinson's disease, etc.? Compare those diagnoses to his pain assessment to identify potential discrepancies.

Also: Take a close look at residents on hospice care (P1ao) to see if they need better pain management.

Resource: Download an advance copy of the revised F309 survey guidance at www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCletter09-22.pdf.