MDS Alert

Pain Management: Turn the MDS Into A Pain Audit Tool

These MDS items can flag residents with undetected or under treated pain.

Sherlock Holmes would have seized the opportunity: an instrument riddled with clues to read residents who can't or won't say they are in pain.

Facilities can use their MDS data more proactively to identify residents with hidden or under-treated pain, affirms **David Gifford**, principal clinical coordinator at **Rhode Island Quality Partners** (the Rhode Island quality improvement organization). In other words, you don't want to wait until your QMs come in at 26 percent and panic. "It's best to identify who has significant pain while the residents are in the facility, which isn't usually going to happen if you wait for your QM scores," he cautions.

Software programs allow you to pull all the MDS records with certain items coded in a certain way, Gifford notes. "That way, the facility can produce a list of patients who need closer assessment for pain," he says.

Start With Section J. "Facilities should keep an eye on MDS items J2a and J2b (pain frequency and intensity), which drive the QMs and can tell you who needs a more in-depth pain assessment," says **Rena Shephard**, president of the **American Association of Nurse Assessment Coordinators** and president of **RRS Healthcare Consulting Services** in San Diego.

Yet the way the QM is calculated using these two MDS items can be a little deceptive, so don't look at Section J and jump to conclusions that a particular resident has a problem, Shephard cautions. "For example, you can have a resident who has had mild pain for six days and on the 7th observation day, he has moderate pain which means he will be included in the numerator for the pain QM," she notes. Yet someone on an intense pain management regimen who has moderate pain only once in the lookback may or may not have a problem -- especially if the episode occurred during attempts to wean the patient to a milder analgesic. **Tip:** The intensity of pain should correlate to standardized pain scale so everyone is on the same page.

Look for the 'Rest of the Story'

While they don't directly assess pain, these MDS sections can clue you in to residents who have hidden or under treated pain:

1. Section B. The cognitive section might show the resident has increasing confusion. Acute pain can also cause delirium (Section B5).

2. Section E. Look for sleep cycle issues, sadness and anxiety, or resisting care. "Resisting care should be a big red flag that a resident with cognitive impairment who may not be able to report that he or she is experiencing pain is hurting," says Shephard. Section E might also identify a cognitively intact resident who is reluctant to admit he has pain due to cultural or spiritual beliefs, notes **Cheryl Field**, director of clinical and reimbursement services for **LTCQ Inc.** in Lexington, MA.

3. Section F. This section, which looks at the resident's interactions with others, may flag a resident in pain, especially when you also see a change in Section E.

4. Section G. A decline in activities of daily living function may be a sign that a resident in pain has stopped moving. In particular, review functional limitation at G4 in range of motion or a decline in ADL function at G1.

5. Section I. Look for diagnoses or a medical history known to be painful, such as rheumatoid arthritis or osteoarthritis, recurrent urinary tract infection, interstitital cystitis, multiple sclerosis, musculoskeletal injury, etc.

6. Section K. Explore weight loss (K3), because it could be that pain is causing a decrease in appetite. "An obvious problem is mouth pain at K1 and oral/dental status at L1," says Shephard.

7. Section M. Don't overlook wounds and foot problems recorded in this section. Wounds can be very painful and may require skillful pain management. (See the guide to pain management for various types of wounds, "Clip 'n Save: Guide to Treating Wound Pain".)

   As part of your pain audits, look at pain flow sheets and medication administration records (MARs) daily or biweekly to see if residents identified as having pain are being treated for it - and if the medication is working, suggests Gifford. Enlist CNAs and weekend or evening nurses to do the audits. "That strategy also gets more staff involved - the DON and unit nurses are often too busy to do the QA reviews," Gifford notes.

   Tip: Use the MDS to look for side effects of pain management regimens that need to be managed, such as constipation, delirium, confusion, lack of appetite, falls, change in activity status, etc. (Editor's Note: See the pain management tool in this article for residents with dementia .)