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MDS Alert

QUALITY IMPROVEMENT: Stay Out of a Survey Bind: Tighten Up Pain Assessment

4 strategies lay the groundwork for staying a step ahead of F309 tags.

With tougher F309 guidance now at hand, surveyors may be taking greater pains to see how accurately you're coding residents' discomfort in Section J. The good news is that you can distill a more accurate picture of residents' pain -- and avoid getting stuck with F tags -- by following these cardinal rules.

1. Know the definitions for coding pain intensity in Section J. For example, you should code a "3" for intensity of pain when the resident has the worst possible pain, says **Marilyn Mines, RN, RAC-CT, BC**, manager of clinical services for FR&R Healthcare Consulting in Deerfield, Ill. The RAI User's Manual notes that this type of pain usually interferes with daily routines, sleep, and socialization.

Yet Mines has seen instances when an MDS nurse codes a 5 or 6 on a 1 to 10 scale as a "3" at J2b even though the pain intensity doesn't meet the RAI definition.

Best practice: Facilities should figure out how they will code pain intensity based on the manual instructions and make sure everyone is doing it that way, advises Mines.

Also ask the resident questions to make sure you aren't over- or under-coding, Mines counsels. For example, "if the person says his pain is mild (a possible 1 to 3 on a 1 to 10 scale), the nurse or other caregiver could ask the person if the pain is interfering with his sleep and activities -- or if the pain is so great that the person is having trouble going to [rehab] therapy."

2. Don't drop the ball on pain screening and assessment. The last thing you want surveyors to see is that you only assess pain during the seven-day MDS lookback. Instead, make pain the fifth vital sign where you regularly assess pain on a daily basis, suggests **Sue LaBelle, RN, RAC-CT, MSN**, senior healthcare specialist with PointRight in Lexington, Mass.

And remember, "not every resident will tell you he has pain unless you ask him," says LaBelle. She recalls one situation where an MDS coordinator doing the MDS assessment asked a resident if he had any pain. He answered that he'd been in pain since admission, but she was the first person to ask him about it.

Also ask about pain during medication rounds, advises LaBelle. If the resident starts requesting PRN medication for breakthrough pain more often, contact the physician to re-evaluate the situation, she adds.

Tool: The Illinois Council on Long Term Care has developed a screening form that facilities use on every resident. If someone indicates he is in pain, then the staff moves to the full, comprehensive pain assessment, says **Susan Gardiner, RN, BSN**, director of clinical services for the Council (see the tool on p. 58).

Tip: Consider using the draft MDS 3.0 pain interview, which really gets into how the pain is affecting the resident's sleep and activities, advises LaBelle. (The MDS 3.0 has been delayed until October 2010 -- see p. 52 -- but experts agree that the instrument's draft interviews for pain, depression, and cognition, etc., provide helpful assessment tools.)

3. Share to improve care. "The facility's pain policies and procedures should make clear that not only the nursing staff but also rehabilitation therapists and other disciplines should report pain," advises **Ron Orth, RN, NHA, CPC, RAC-MT**, president of Clinical Reimbursement Solutions LLC in Milwaukee.

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Having the different disciplines compare notes on a resident's pain improves MDS accuracy and care planning. For example, in one case, a rehab patient admitted after a total knee replacement repeatedly told nurses that he had no pain, reports **Shehla Rooney**, a physical therapist and principal of Premier Therapy Solutions in Cookeville, Tenn. But the therapists reported that the patient was in a great deal of pain. It turns out that nurses were asking the patient about his pain levels when he was in the bed and not moving the affected limb, Rooney explains. And the rehab therapists were asking the patient if he had pain during exercises and activity. Once everyone got on the same page, the care team rescheduled the patient's pain medication to help him participate in therapy more effectively.

4. Assess and code pain sites. In addition to documenting the frequency, intensity and nature of the person's pain, make sure to note its location. And then translate that information to the MDS. Section J3 asks you to code all the sites where the resident had pain during the lookback. Also, code mouth pain at K1c, and foot pain at M6a, which includes pain among other foot problems. (See the related article on pain on p. 51 of this issue.)

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