Pain points in long-term care: Assessing, coding, and treating residents’ pain
Dear reader,

With the public eye and the government’s attention now increasingly focused on pain management, nursing homes may have some changes to make to ensure that they’re handling residents’ pain properly. That’s why we’ve created this special report on assessing, coding, and treating pain in long-term care residents.

Inside you’ll find an abundance of guidance to improve your pain management program—including how to educate staff on assessing and treating pain, how to use the Joint Commission on Accreditation of Healthcare Organizations’ pain management guidelines, different pain scales you can use to assess residents, how to manage pain in the cognitively impaired, and more. We’re hoping you’ll find it an indispensable tool for your nursing home’s pain program.

So here’s to making pain management a less painful topic in your facility.

Sincerely,

Noelle Shough
Managing Editor

PPS Alert for Long-Term Care

Acronym guide

CMS . . . The Centers for Medicare & Medicaid Services
MDS . . . Minimum Data Set

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Pain comes to RAPs

As CMS gears up for the next version of the MDS and the Resident Assessment Instrument in general, be assured that pain will become a bigger player on the assessment scene.

The agency is busily working on a way to put the spotlight on resident pain during the assessment process—through a new resident assessment protocol (RAP) that will be tied to the MDS Version 3.0. Providers are anticipating the next version of the MDS to come out in 2004.

In 2001, CMS introduced a draft version of a completely new RAP on pain. “I’m really impressed with it,” comments Rena Shephard, RN, BA, FACDONA, president of both RRS Healthcare Consulting Services in San Diego and the American Association of Nurse Assessment Coordinators. “CMS has put together some very good instructional material and up-to-date information on how to manage pain [in the new RAP].”

In the MDS Version 2.0, there’s only one small area in Section J, health conditions, that specifically deals with pain. Statistics show, according to Shephard, that pain can be lessened or relieved in residents 90% of the time, but many still receive no pain management. 

Pain comes to RAPs
Look differently at pain assessment and treatment

*Do away with old thinking to manage residents’ pain in an effective manner*

Multiple studies suggest that 45%–80% of nursing home residents have untreated substantial pain, said Regina Fink, RN, PhD, FAAN, AOCN, a research nurse scientist for the University of Colorado Hospital in Denver, when she spoke at an American Association of Nurse Assessment Coordinators conference.

Additionally, an MDS study conducted through Brown University indicates that 41% of elderly residents in pain upon admission to the nursing home still experience moderate to severe pain 60–180 days later, said Fink.

According to Fink, properly assessing and treating pain may require you to give up some of your old ways of thinking. “We need to stop adhering to rules like only giving pain medications every four to six hours as needed,” she advised.

And as a nurse, you are the most likely member of the staff to recognize pain. “We need to own pain as nurses because no one else is going to own it,” Fink said. This can translate to educating other staff members or talking to clinicians who may be reluctant to order adequate pain medication—due to concerns about addiction, dependence, tolerance, and side effects.

To properly understand pain, clinicians should be familiar with the leading causes of pain in long-term care residents. Here is a list of the most common painful conditions occurring in long-term care residents:

- Degenerative joint disease
- Rheumatoid arthritis or osteoarthritis
- Osteoporosis
- Fractures
- Muscle pain/stiffness
- Neuropathies
- Post-stroke pain
- Skin or pressure ulcers
- Immobility

Additionally, there are special populations that may not typically receive adequate pain management, said Fink.

When assessing for pain, be extra vigilant about uncovering discomfort and suffering in these residents:

- Residents who are minorities.  

Sure, you can ask residents whether they are experiencing any pain. But sometimes—for various reasons—you won’t get the accurate picture. That’s why you have to be alert to nonverbal pain indicators in residents. Here are some examples:

- Facial grimacing
- Nonverbal vocalizations, i.e., moaning or groaning
- Rubbing or guarding body parts
- Restlessness
- Verbal vocalizations such as saying “ouch” or cursing

According to Regina Fink, RN, PhD, FAAN, AOCN, a research nurse scientist for the University of Colorado Hospital in Denver, here are some other symptoms that may show up in a resident’s daily life that are indicators of pain:

- Depression
- Emotional distress
- Decreased socialization
- Disturbed sleep and appetite
- Reduced mobility and ambulation
- Slow rehabilitation
- Agitated behavior
- Slowed healing
- Falling off in grooming habits

Symptoms of pain

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<th>Symptoms of pain</th>
<th>Colorado Hospital in Denver, here are some other symptoms that may show up in a resident’s daily life that are indicators of pain:</th>
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<td>Decreased socialization</td>
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<td>Falling off in grooming habits</td>
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Pain points in long-term care
Residents with a history of substance (i.e., alcohol or drug) abuse. “These people have a high tolerance for some medications and may need more than the average residents,” Fink pointed out.

Residents with a history of chronic pain.

Residents with a psychiatric history.

Residents with high expectations for optimal pain management.

Residents with more than one source of pain.

Residents having a better performance status than others, i.e., those who are more able.

When breaking down old barriers to properly assessing and treating pain, consider what you can do to educate residents about pain treatment. Make sure residents are not buying into any of the following ideas about pain medication:

Fear of addiction

Fear that if they take their medications too early, the treatments won’t work later

Feeling that pain is inevitable with aging and they just need to bear it

Thinking that if their pain is worsening, it means that they are getting sicker

Worry over constipation and sedation from pain medication

Thinking that the physician or nurse is too busy to deal with the resident’s pain

Fear that too much pain medication will shorten their lifespans

What is WILDA?

To address what she saw as a lack of understanding about how to assess pain, Fink developed her own system. Her method, called the WILDA approach, is based on five important factors in a resident’s pain. (See the Pain Assessment Guide on p. 5 for more on WILDA.)

Here are the WILDA factors with instructions on how to use them to ensure better pain assessment in your facility:

Words used to describe the pain. Chances are, residents will be able to tell you a lot more about the pain they are experiencing if they have a good number of descriptors to choose from. Ask them to describe their pain using words.

Additionally, staff should be familiar with the word for pain in the appropriate languages that reflect your resident populations. Fink has also included a helpful list of those on the card.

Intensity on a 0–10 scale. Use a scale where zero equals no pain and 10 is the worst pain possible.

There is also a verbal descriptor scale, which uses six possible answers—no pain, mild pain, moderate pain, severe pain, very severe pain, and the worst possible pain. ‘Many residents prefer the verbal descriptor scale,” said Fink.

Another option, especially for nonverbal residents, is a faces scale. And don’t just ask residents about their current pain status—ask them about their pain in the last 24 hours and comfort goals, too, she recommended.

Location of the pain. Most residents have multiple painful sites. Having them point to troubled spots is key.

Duration of the pain. Ask residents the following questions, Fink recommended, to get a better idea of what’s causing their pain and how best to treat it:

- Is the pain always there?
- Does the pain come and go, i.e., do you experience breakthrough pain?
- Do you have both types of pain?

Instead of prescribing the old standby “prn” pain medication (only per the resident’s request), try a different method to treat pain, Fink said. “Schedule the medication around the clock, and then they can refuse it if they want.”

Aggravating and alleviating factors. To be fully informed about residents’ pain, ask them what makes their pain better and what makes it worse, advised Fink. Some contributing factors could include visits from family members, therapy, relaxation, massage, positioning, certain activities, heat or cold, music, or even watching television.

Editor’s note: To contact Regina Fink, please e-mail her at regina.fink@uch.edu.
# PAIN ASSESSMENT GUIDE

**Tell me about your pain**

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<tr>
<th>Words to describe pain</th>
<th>How does the pain affect</th>
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<td>Aching</td>
<td>Sleep</td>
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<td>Throbbing</td>
<td>Relationships</td>
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<td>Stabbing</td>
<td>Appetite</td>
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<td>Gnawing</td>
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<td>Tender</td>
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## Pain in other languages

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<th>Ho —Japanese</th>
<th>dolor —Spanish</th>
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<tr>
<td>tong —Chinese</td>
<td>doleur —French</td>
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<tr>
<td>dau —Vietnamese</td>
<td>bolno —Russian</td>
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</table>

## Intensity (0–10)

If 0 is no pain and 10 is the worst pain imaginable, what is your pain now? . . . in the last 24 hours?

## Location

Where is your pain?

## Duration

Is the pain always there?  
Does the pain come and go? (Breakthrough pain)  
Do you have both types of pain?

## Aggravating and alleviating factors

What makes the pain better?  
What makes the pain worse?

## Are you experiencing any other symptoms?

- Nausea/vomiting
- Constipation
- Itching
- Sleepiness/confusion
- Urinary retention
- Weakness

## Things to check

- Vital signs
- Past medication history
- Knowledge of pain
- Use of noninvasive techniques


Source: © 1996 Regina Fink at the University of Colorado Health Sciences Center. Used with permission.
When the Nursing Home Quality Initiative was first introduced in the form of the six-state pilot project, providers weren’t sure what to expect.

And for staff at the John Knox Village Medical Center in Tampa, FL, the quality measure (QM) data hit them with an especially hard jolt—they scored higher, meaning worse, in pain management than both the state average and the average for all six pilot states.

This was especially startling in light of the fact that John Knox was one of seven nursing homes nominated by a state panel to receive a Gold Seal as one of the best Sunshine State facilities.

The facility’s administrator/director Suresh Pai, MBA, NHA, gives these tips for how his facility cleaned up its pain management data.

In what’s a catch-22 for nursing homes, facilities doing a good job assessing and identifying problems such as pain and pressure sores may have higher QMs. “We have an excellent pain management program,” Pai says. Yet John Knox’s QM for residents with pain was at 40%, higher than the state average of 13% and the six-state average of 14%.

Another reason for the high rate is the way staff at John Knox had been coding pain on the MDS, which the facility is now reexamining. “If you are providing medications that control a resident’s pain, do you code it that the resident is still having pain?” Pai says. That’s what staff were doing in the past.

Experts say this a common misconception and the answer is no—if a resident’s pain is under control, you should not continue to code for pain on the MDS. That’s a change that will likely bring down John Knox’s pain QM.

If your MDS coordinators have coded items incorrectly, don’t point fingers—correct the problem. You may need to reeducate staff about MDS coding, particularly on item J2, which deals specifically with pain management. This area of the MDS is a section many people have not paid much attention to in the past.

Editor’s note: See the article on p. 9 for more about properly coding pain on the MDS.

How will the new QM for pain be triggered?

With pain management being such a hot topic in all health care settings, it’s no wonder that the focus on assessing and treating pain in long-term care has sharpened.

To evaluate pain management for both postacute (short-term) and chronic (long-term) care residents, CMS will use the pain questions located in Section J of the MDS, health conditions, reports a senior policy analyst for the agency.

Specifically, the agency will use items J2a and J2b, which refer to pain frequency and intensity.

Either of the following factors can trigger this quality measure (QM):

- A resident experiencing moderate pain at least daily (J2a=2 and J2b=2), OR
- A resident experiencing horrible/excruciating pain at any frequency (J2b=3)

The CMS analyst explains that short-stay residents will be those who are expected to stay in the facility for fewer than 90 days.

The postacute QM will be calculated from those residents’ five-day and 14-day MDS assessments.

Long-term care residents are those who are expected to stay for more than 90 days.
By now, long-term caregivers are used to the increased emphasis on pain assessment and treatment. But they may not be as skilled in assessing pain in the cognitively impaired.

Nursing homes typically house a fair number of residents who can't describe their suffering because of cognitive impairments, such as Alzheimer's disease, or physical disabilities, such as strokes. So how do you know whether a person is in pain when he or she can't tell you?

That's one area that the American Geriatrics Society (AGS) has addressed in its pain management guidelines. The group hopes the guidelines will help CMS monitor pain management in nursing homes under its quality measures program, says AGS President Jerry Johnson, MD.

When the AGS unveiled its guidelines in May at a Washington, DC, symposium, Keela Herr, PhD, RN, of the University of Iowa, outlined the new recommendations for assessing pain in cognitively impaired older people.

Health care professionals need to adapt existing tools and come up with alternative assessment strategies for those who are unable to reliably communicate their pain, she said. Herr outlined ways to assess pain in both people with mild to moderate cognitive impairment, as well as those with nonverbal or severe impairment.

**For mild or moderate impairment**
The AGS provides the following principles and recommendations to assess pain in residents with mild to moderate cognitive impairment:

1. **Direct your query about pain to the resident.** Those with mild to moderate impairment can usually respond to simply phrased questions, said Herr.

2. **Use the report of a surrogate (a family member or caregiver) only if the resident cannot reliably communicate.** The best report about pain will come directly from the person experiencing it.

3. **Use terms synonymous with pain.** For instance, if you ask a resident whether he or she is in pain, the person might say no. But if you ask about any aching, discomfort, or soreness, you may find out he or she does have a problem related to pain.

4. **Use a standard pain scale, if possible.** Health care institutions commonly use the 0–10 numeric scale to measure pain. Most older adults can use the number scale and Herr recommended that you start with this tool. However, have alternative pain scales, such as the “faces” scale or “pain thermometer” scale available if the person needs help conceptualizing a pain rating. See p. 10 for various pain scales that may be appropriate.

5. **Make sure the resident understands the use of the pain scale.** Give the resident time to grasp the task and respond. You may have to repeat the directions.

6. **Ask about present pain and what the resident feels in the here and now.** Because of memory concerns, don't ask the person to compare the pain with how he or she felt earlier in the week, or even a couple of hours ago, Herr said.

7. **Ask about and observe for verbal and nonverbal pain-related behaviors and changes in usual activities or functioning.** These kinds of changes can indicate pain.

**For tougher cases**
Assessing pain can be a tougher task in residents who are nonverbal with moderate to severe cognitive impairment.

In these instances, you must rely on direct observation of the resident or a pain history from a caregiver for evidence of pain-related behaviors. This becomes an essential part of the evaluation process, Herr said.

Observe the person during movement, not just at rest, she said. You are more likely to see behavior changes from pain while the person is active, such as when he or she is being transferred from the bed or chair, or bathing or walking.

Keep in mind that in cognitively **continued on p. 8**
When they can’t tell you

impaired residents, pain-related behaviors are subtler, Herr said. Unless you are looking for them, you may not consider some of the signs as evidence of pain. So what should you look for? Here are her suggestions:

- **Facial expressions of pain, such as grimacing.** But less obvious signs can include a slight frown, rapid blinking, a sad or frightened face, or any distorted expression.

- **Vocalizations, such as crying, moaning, or groaning.** Less obvious signs can include grunting, chanting, calling out, noisy breathing, or yelling for help.

- **Body movements, such as guarding.** Less obvious signs can include rigid or tense posture, fidgeting, increased pacing, rocking, restricted movement, gait/mobility changes such as limping, or resistance to moving.

- **Changes in interpersonal interactions.** These can include combative/aggressive behavior, resisting care, decreased social interactions, socially inappropriate behavior, disruptive behavior, or withdrawn behavior.

- **Changes in activity patterns/routines.** Watch for a sudden cessation of common routines, increased wandering, difficulty sleeping, more periods of rest, refusing food, or an appetite change.

- **Changes in mental status.** These can include increased irritability or distress, increased confusion, agitation, crying, or tears.

**Know your resident**

It is important to recognize that each resident has a unique “pain signature,” Herr said.

“You have to know the person’s baseline. What are they normally like? What are their activity patterns? If a person is very active and becomes withdrawn, it is a clue.” Likewise, be suspicious of pain if a person is usually withdrawn and becomes very active.

“It’s very difficult to apply a standard assessment because there is so much individual variability. These factors all need to be on the radar screen,” she said.

**Editor’s note:** Go to www.americangeriatrics.org to learn more about the AGS guidelines or to view a Webcast of the pain symposium.

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**Rhode Island hospice provider knows pain**

A Rhode Island hospice group has helped about two dozen nursing homes in the state improve their pain management practices. The group, Hospice Care of Rhode Island, located in Pawtucket, also has helped move a number of terminally ill nursing home residents into hospices, said Joan Teno, MD, Hospice Care’s associate medical director.

Hospice Care’s 16-month-long project to improve the quality of pain management in skilled nursing homes has helped some facilities devise ways to measure pain and pain relief, Teno said. She spoke during a teleconference sponsored by Last Acts, a Washington-based palliative care advocacy group. Teno also serves as medical director of Hospice Care’s palliative care consulting service.

Facilities now use several methods to increase pain awareness among staff members, Teno said, including the following:

- Reminders or stickers on patient charts
- Buttons that say, “Pain as a fifth vital sign”
- New flow sheets
- Pain-measurement rulers

Several providers now give residents a round-the-clock, non-opiate pain medication. Since they began doing so, they report that they have had to use less antipsychotic medication, Teno said.
Pain coding and assessment can be a sore spot
Here’s what you need to know about pain for Section J2 of the MDS

As CMS steps up its campaign for pain treatment, you can expect more scrutiny of your records—especially of Section J2 of the MDS, where you assess a resident’s pain symptoms. In this new era of pain-awareness, you’ll need to make sure your methods of documentation and assessment are up to par by using the following tips:

Coding

It is true that if you have a 100% effective pain management program in place for a resident—and the resident has not experienced any pain during the seven-day assessment reference period—then you should code the MDS as such (J2a=0). But if the resident experiences pain, you code item J2a, pain frequency, and J2b, pain intensity, to reflect what the resident experienced—even when you are treating the resident’s pain.

“You can have the most effective pain regimen in place but if the resident experienced pain, you still must indicate that [on the MDS],” says Steven Littlehale, MS, RNC, CS, chief clinical officer of LTCQ, Inc, a consulting firm in Bedford, MA.

As long as the medication record reflects that there’s been ongoing assessment and treatment of pain, you should be in the clear, adds Rena Shephard, RN, BA, FACDONA, president both of the American Association of Nurse Assessment Coordinators and of RRS Healthcare Consulting Services in San Diego. “If residents have mild pain and surveyors see in your documentation that when they first came they had horrible pain, but you did all these things to treat it—well, that’s a good thing,” she points out.

Assessment

To code pain correctly, you have to assess pain correctly, and this is the more difficult requirement of the two. “It’s well accepted that the MDS is an inadequate assessment when it comes to pain,” says Littlehale. Therefore, you need to have an alternative pain assessment program, he advises.

Shephard mentions that in California, pain has been declared the fifth vital sign by the state board of nursing. “That means that every time you take the resident’s vital signs, you’re going to find out what the resident’s pain level is.”

And when you assess pain that routinely, it’s easier to come up with an individualized treatment plan for each resident. “Find out what makes it hurt more, what relieves it, what time of day it hurts the most, and develop your plan based on those needs,” she suggests.

Pain education for staff

Littlehale says when he consults with a facility about pain assessment, he always starts with the certified nursing assistants (CNAs) because they’re the ones who are on the front line. If a resident doesn’t look right, is holding his arm at a funny angle, or is sitting quietly with her eyes shut tightly, a CNA is in the position to observe this before anyone else does.

Conduct inservices to teach CNAs signs, symptoms, and comfort measures they can take to help residents in pain. Littlehale recommends that you first ask CNAs what they do when they’re in pain to find out about cultural and individual differences. Once you’ve started an open dialogue, then you can explain the culture in your facility and that pain does not go untreated.

Additionally, make sure your nurses are educated about pain. Littlehale says he has observed cases in which nursing staff were reluctant to give an analgesic to a resident because they feared that it would cause respiratory depression—a common misperception. As a result, the resident’s pain went untreated. That’s why it’s important to teach your staff about pain medications, he advises.

Shephard finds that some facilities are not yet beyond treating pain on a “prn” basis at the resident’s request, instead of giving around-the-clock treatment.

“Sometimes the pain is not manageable without keeping [a] constant pain medication level going,” she says. You may have to educate your nurses that this is a necessary way of treating pain, and not only in the case of cancer patients. Consider a “reverse prn” order where the resident has the right to continued on p. 10
refuse the medication, but otherwise receives it regularly. It’s also important to explain to the residents that they need to speak up about pain because they might mistakenly think that the nursing staff already know about their pain and can’t do anything about it. Or in some cases, a resident may have been dealing with pain for many years and believes it’s just a fact of life. “Work on developing a healthy, open dialogue to break down those myths,” Littlehale advises.

Residents may be afraid of receiving extra pain medication because they’re worried about becoming addicted. You need to tell them that there’s a difference between addiction and tolerance, says Littlehale. “Residents might develop higher tolerances to their medications and require more of the drugs—that’s not the same as addiction.”

You’ll want to educate your residents to ask for pain treatment before their pain reaches its peak. “Ask the resident not to wait until the pain is really bad, but to tell you before so you have a higher success rate when treating it,” says Shephard. And try the pain scales above to measure the amount of pain they are experiencing.

Quality assurance
Although the MDS isn’t a great tool for pain assessment, it can be very handy as a quality assurance strategy to make sure you are addressing pain. For example, if you indicate that the resident has a painful condition, such as arthritis or a recent fracture, and is not receiving an analgesic, then you would expect the MDS to show that the resident experienced pain in the past seven days, Littlehale points out. “If you do indicate that the resident has pain and there’s no diagnosis or condition to justify that, then perhaps another area of your MDS is lacking,” he says.

In another case, you might see an MDS that indicates a

Pain coding  continued from p. 9

The following scales can help all of your residents communicate with you about the pain they have and the kind of pain management being achieved using the medications and other techniques prescribed to them. Finding ways to characterize pain can be particularly difficult when you’re dealing with cognitively impaired residents or those with a limited English vocabulary. If residents are unable to respond verbally, show them the pain rating scale #2.

1. Resident/patient or nurse shade in the area(s) of pain.

Source: Adapted from form supplied by Anne Dean Associates. Reprinted with permission.

2. Explain to the resident that each face is for a person who feels happy because he has no pain (hurt) or sad because he has some or a lot of pain. Face 0 is very happy because he doesn’t hurt at all. Face 2 hurts just a little bit. Face 4 hurts a little more. Face 6 hurts even more. Face 8 hurts a whole lot. Face 10 hurts as much as you can imagine, although you don’t have to be crying to feel this bad. Ask the resident to choose the face that best describes how he or she is feeling.

3. Indicate severity of the resident’s pain by circling the number, 0 being no pain and 10 being the worst possible pain.

0 1 2 3 4 5 6 7 8 9 10

Document in the nurse’s note: type, severity, origin, and precipitating factors of pain. Document whether or not medication was effective.
When it comes to treating pain, follow the JCAHO’s lead

Staff should know the ins and outs of pain to avoid survey trouble

If your facility is paying inadequate attention to the assessment and relief of residents’ pain, your organization could end up in survey trouble.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has already made pain management a major survey priority with the scoring of pain standards that started in 2001. The failure to adequately assess pain in residents remained the number one problem standard in long-term care surveys by the JCAHO the year before.

Health care consultants Brenda Gail Summers, MBA, MHA, MSN, RN, CNAA, and Steve W. Bryant addressed the issue in the audioconference “JCAHO’s pain management standard: Satisfy your patients’ rights to have their pain assessed and managed,” which was sponsored by The Greeley Company, a division of HCPro, in Marblehead, MA.

The following are some of the tips they offered participants when it comes to proper pain assessment and management:

- Always respect a resident’s culture and religion when you offer pain management initiatives. You will want to manage pain within the context of personal, cultural, ethnic, and spiritual beliefs and values, said Summers. “Some patients truly believe that pain is a punishment they have to endure for religious, spiritual, or personal reasons,” she said.

- The JCAHO’s resident right standards RI.1 and RI.2.6, found in the Comprehensive Accreditation Manual for Long-Term Care, state that residents have the right to participate in care decisions—including managing pain effectively—and that they have the right to have their pain appropriately assessed and managed.

- If you haven’t already done so, update your printed resident rights materials to include the right to pain assessment and management.

- You will want to educate residents and document the education you provide, said Summers. The intent of standard RI.2.6 says organizations should educate residents and families, when appropriate, on their roles in managing pain as well as the potential limitations and side effects of pain treatments.

- When it comes to assessing pain, long-term care organizations must ask every resident about pain during the initial assessment on admission to the facility to comply with JCAHO standard PE.2.1.10. This is the most problematic standard during Joint Commission surveys in long-term care organizations. When assessing pain, remember to include: its origin, location, severity, alleviating and exacerbating factors, and current treatment and response to that treatment.

- You may want to consider pain as... continued on p. 12

Pain points in long-term care
the “fifth” vital sign, recording pain intensity ratings during the admission assessment along with temperature, pulse, respiration, and blood pressure. The JCAHO standards call for “regular reassessment” of pain. Your staff members will need to complete further reassessments for residents identifying pain or at risk for pain.

Consider this two-step process, Summers advised. First, ask the question, “Are you having pain or discomfort?” If the resident says no, there is no need for an assessment, as there is nothing to assess, she said. But if a person indicates pain, you must then do a comprehensive assessment, she advised.

It is up to your organization to determine what will “trigger” reassessments for pain, Summers said.

You may choose to use time triggers, such as reassessing pain on every shift or every third visit. There are also event triggers, such as reassessing pain if there is a change in care setting or in the level of care, or following any procedure.

Remember that medication is not the only intervention to control pain. Other alternatives include acupuncture, chiropractic medicine, biofeedback, aromatherapy, and therapeutic touch.

One participant in the audioconference said her facility was concerned about providing pain medications that made residents dizzy or caused cognitive problems. Summers advised talking with the pharmacy and physician to see whether other interventions might work. “There is a world of interventions out there that don’t involve medications,” she said. Or a physician may prescribe other medications with less potential to create those side effects.

There are also strategies, such as reminding residents to change positions slowly when going from a lying to a standing position. Residents may also want to avoid certain activities immediately after taking medication, she said.

Consider working with a hospice organization in managing end-of-life pain, when strategies for pain management may be different, Summers advised. Most hospices adhere to the philosophy that no patient/resident should die in pain. Hospice organizations are often the best experts in the management of pain at end of life, Summers said.

Don’t forget to examine the effectiveness of your pain management efforts. JCAHO standard PI.3.1 in the Improving Organization Performance chapter of the manual suggests organizations monitor the appropriateness and effectiveness of pain management.

“Go back and see whether it’s making things better,” Summers said. You might ask about pain management in resident satisfaction surveys or in focus groups to measure the effectiveness of your efforts.