



## Facility-wide System for Pain Management

### Executive Summary

Pain is not a normal part of aging. Pain is often under-recognized and under-treated leading to national attention on the management of pain in nursing homes. Initiatives such as the public reporting of pain quality measures, quality campaigns related to pain and most recently surveyor guidance addressing pain management in the long-term care setting focus on this important care area.

Take action.

- Analyze pain practices and programs. Take a systems approach that adheres to current standards of practice.
- Identify misconceptions and barriers that increase the challenge of treating pain in the long-term care setting.
  - Recognize that both staff and residents may hold social attitudes towards pain that impact care. Organization-wide education can help to provide the facts about managing pain and can result in counteracting myths such as the following:
    - acknowledging chronic pain is a personal weakness
    - chronic pain means death is near
    - the elderly and cognitively impaired cannot accurately self-report pain
    - the elderly cannot tolerate medications
    - addiction is likely in elderly residents
- Monitor your pain quality measures through your facility's QA&A process. Set goals and trend your progress. Implement and audit processes to ensure practices follow a comprehensive pain program based on current standards.

### Surveyors are Now Investigating Pain Under F-309:

Federal surveyor guidance for F-Tag 309 Quality of Care, revised and implemented in April 2009, incorporates guidelines for residents who have pain symptoms, are being treated for pain, or who have the potential for pain symptoms related to conditions and treatments. The intent is to investigate the "*Recognition and Management of Pain*" and the objective is for the facility to help a resident attain or maintain his/her highest practicable level of well-being and to prevent or manage pain.

To the extent possible, the facility:

- Recognizes when the resident is experiencing pain and identifies circumstances when pain can be anticipated,
- Evaluates the existing pain and the cause(s), and
- Manages or prevents pain, consistent with the comprehensive assessment and plan of care, current clinical standards of practice and the resident's goals and preferences.

This protocol will be used for a resident:

- Who states he/she has pain or discomfort
- Who displays possible indicators of pain that cannot be readily attributed to another cause
- Who has a disease or condition or who receives treatments that cause or can reasonably be anticipated to cause pain
- Whose assessment indicates that he/she experiences pain
- Who receives or has orders for treatment for pain and
- Who has elected a hospice benefit for pain management

There are 4 steps for facility-wide Pain Management

1. Recognize Pain through Screening Process
2. Assess Pain
3. Manage Pain
4. Monitor Pain

### **Pain Resources:**

American Geriatrics Society, Clinical Practice Guidelines. The Management of Chronic Pain in Older Persons: AGS Panel on Chronic Pain in Older Person. JAGS 1998; 46: 635-641

American Medical Directors Association. Chronic Pain Management in the Long Term Care Setting Clinical Practice Guideline. Columbia, MA: AMDA 1999. Available online: [www.amda.com](http://www.amda.com).

MedQIC: <http://www.qualitynet.org/dcs/ContentServer?pagename=Medqic/MQPage/Homepage>

Quality Measures Resource Manual, January 2004, Version 4.0, 6E: 1. Last accessed 11/3/2004  
<http://www.medqic.org/content/nationalpriorities/nursinghome/nhMeasures.jsp?topicID=413>

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities; F309- §483.25 Quality of Care  
[http://www.cms.hhs.gov/manuals/Downloads/som107ap\\_pp\\_guidelines\\_ltcf.pdf](http://www.cms.hhs.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf)

WHO Analgesic Ladder – <http://www.chcr.brown.edu/commstate/PDF/FASTFACTS3.pdf>

### **Step 1: Recognize Pain through a Screening Process**

Screening for pain should be efficient and prompt, occurring on admission, readmission, with each MDS assessment and with each change in condition. Screening involves the participation of multiple facility staff that have contact with the resident (both clinical and non-clinical such as CNA, dietary, activities). Consistency of caregivers with familiarity with the resident's behaviors allows for subtle pain-related behaviors to be recognized in cognitively impaired individuals.

Pain is "whatever the person experiencing pain says it is". – McCaffery and Bebee 1989

- Listen... and believe the resident and family
- Ask about pain, using words that they use
- Let the elder describe the pain in their own terms (i.e. throbbing, burning, aching, etc.)

Believe what they say, but listen to what they don't say. Residents in pain may:

- Groan, cry, whimper, scream or call out
- Open eyes wide, close eyes tightly or blink eyes
- Have facial expressions of grimacing, frowning, fright, clenched jaw, or biting lower lip
- Have change in function or ability such as gait changes, limping, loss in ADL ability
- Show physical movements such as rubbing a specific location of the body, guarding a limb or other body part, rocking the body or moving the head side to side
- Show behaviors such as resisting care, hitting or biting, distressed pacing, irritability, depressed mood
- Suddenly stop common routines and activities

Pain may be experienced from several different medical conditions simultaneously:

- Arthritis
- Diabetes with neuropathic pain
- Immobility
- Pressure ulcers
- Herpes zoster "Shingles"
- Amputation
- Post-CVA
- Venous and arterial ulcers
- Multiple sclerosis
- Cancer
- Back and nerve problems
- Headache
- Oral health conditions

- Infections

Common procedures can also cause pain:

- Physical or occupational therapy
- Dressing changes
- Turning and repositioning

## Step 2: Assessment of Pain

A comprehensive assessment for pain is done when pain has been identified at screening, for new symptoms of pain, worsening pain and ongoing pain. Section J2 of the MDS Pain Symptoms, does not remove the facility's responsibility to document a more detailed assessment of the resident's pain. An evaluation of pain based on clinical standards of practice minimally involves the following areas:

History of pain and its treatment

Characteristics of pain:

- Intensity of pain (measured on a standardized pain scale)
- Description of pain (burning, stabbing, tingling, aching)
- Pattern of pain (constant or intermittent)
- Location and radiation of pain
- Frequency, timing and duration of pain
- Factors that exacerbate or alleviate pain
  - Impact of pain on quality of life such as sleeping, functioning, appetite, mood
  - Physical examination including medical conditions and medications
  - Resident's goal for pain management and satisfaction with current level of pain control

Key Points:

- Various Pain Scales can be used for Cognitively Intact Residents
  - Visual Analogue Scale (VAS)
  - Verbal Numeric Rating Scale
  - Wong-Baker FACES Pain Rating Scale
  - Verbal Descriptor Scale (customize to resident)

Cognitively impaired residents may have difficulty expressing when they have pain or participating in verbal pain assessments.

- Tools are available that assist in assessing pain by observation of behaviors such as the *Pain Assessment in Advanced Dementia Scale (PAINAD)* and others found on MedQIC or other pain management sites.
- Consider using MDS Pain Intensity Scale Guide/Crosswalks to ensure adequate coding on the MDS.  
<http://www.qualitynet.org/dcs/ContentServer?c=MQTools&pagename=Medqic%2FMQTools%2FToolTemplate&cid=1110810303399>

### **Step 3: Management of Pain**

A pain management plan needs to involve the resident with acknowledgement of his/her choices, and the interdisciplinary team (including the attending physician). Individual targets should be set according to the resident's unique situation. Goals must respect resident wishes and be realistic and measurable. Interventions may be pharmacologic and non-pharmacologic.

Non-pharmacological interventions:

- Comfort Measures
  - Repositioning, room temperature, special mattress, assistive devices
- Cognitive Interventions
  - Relaxation, reminiscing, psychotherapy, diversions, music therapy, education about pain, peer support groups
- Physical Modalities
  - Hot or cold packs, massage, baths
  - TENS, acupuncture, chiropractic, rehabilitation therapy
  - Exercises to address stiffness and prevent contractures

Pharmacological interventions:

Selection of analgesic drugs is influenced by many factors such as the resident's current medication regimen, nature and cause of pain, and the course of illness. Remain aware that analgesics help to manage pain but may not address the underlying cause of the pain.

#### **Key Points**

- "Start low and go slow"- start dosing low and increase until desired level of relief is reached
- Administer medications "around the clock" or scheduled, "on demand" or PRN, or a combination of both according to the description, intensity and frequency of pain
- Recurrent use of PRN medications may indicate the need to reassess the pain plan
- Conditions may require using different analgesics and/or adjuvant medications such as antidepressants or anticonvulsants together
- Prescribing medications should follow pain guidelines such as the AMDA Clinical Practice Guidelines and the WHO pain ladder
- Adhere to standards of practice and manufacturers' guidelines when selecting and dosing analgesics (non-opioids, mild opioids, strong opioids,

adjuvant medications) in order to optimize effectiveness and lessen adverse consequences

- Ensure documentation reflects the ongoing communication between prescriber and staff

#### **Step 4: Monitoring**

Effectiveness of the plan in controlling pain requires ongoing monitoring, reassessment and care plan revision.

- If the pain management plan does not adequately control the pain, reassess the approaches.
- If pain cannot be adequately controlled by the facility, other resources may be appropriate (pain center, hospice)
- Monitor for adverse drug reactions and side effects
- If pain is resolved, the facility is expected to work to discontinue or taper the dose
- Revise or supplement the pain plan according to findings
- Update the care plan with changes

#### **Key Points**

- Use standardized pain assessment tools, appropriate for each resident, on a regular basis.
- Implement interventions to minimize side effects of medications
- Follow the principles of consistent assignments to allow staff to be familiar with the resident
- When monitoring outcomes, think of the “Four A’s” (AMDA Pain Guidelines):
  - Analgesia - Is pain relief meaningful?
  - Adverse events - Are side effects tolerable?
  - Activities - Has functioning improved?
  - Aberrant drug-related behavior

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