



## Improving Pain Management

*While the MDS may help with assessing the effectiveness of overall pain management, assessment tools are needed to drive the daily management of pain.*

**A**MONG THE KEY FACTORS WHEN it comes to improving pain management for long-stay and short-stay nursing facility patients are three critical areas: a commitment to improving pain outcomes throughout the organization, clear and well-communicated protocols for care, and an acknowledgement of the barriers to pain assessment and treatment.

### Measuring Outcomes

Determining the intensity or severity of pain is a crucial factor in adequately treating it. The intent of the assessment of pain symptoms in the minimum data set (MDS) sections J2a and J2b is to record the frequency and intensity of signs and symptoms of pain.

For care-planning purposes, these items can be used to identify pain as well as to monitor the patient's response to pain management interventions. Providers can chart their progress through the use of the quality measures (QMs) reported on the Centers for Medicare & Medicaid Services' Nursing Home Compare Web site.

The chronic pain QM (long-stay) reflects the percent of patients with either a moderate level of pain occurring every day or excruciating pain at

any frequency (J2a = 2 and J2b = 2 or J2b = 3).

Because the accurate assessment of pain may be more difficult in residents with cognitive impairments, there is a risk adjustment, or resident-level

differences, however, should not distract from quality improvement efforts.

### Success Factors, Barriers

Accurate coding of the MDS items that impact the pain QMs (J2a and J2b and B4-decision making) can be one of the barriers to assessment, treatment, and accurate measurement of progress toward meeting the pain management goals.

In a recent investigation of the accuracy of MDS pain items in a national sample of nursing facilities, it was found that the best predictor of an MDS pain outcome (in this case the MDS-based pain scale) was the previous MDS. Meaning, J2a and J2b most often didn't change from one assessment to the next.

This finding is consistent with previous studies and has its highest prevalence in facilities that use a "copy over" feature in the MDS soft-

### ADVANCING EXCELLENCE PAIN MANAGEMENT GOALS

The Campaign for Advancing Excellence for America's Nursing Homes, a coalition of long term care providers and stakeholders, is entering the second of its two-year mission. The campaign's pain management goals are:

#### Goal No. 3: Improving pain management in long-stay patients

- National average at or below 4 percent;
- 30 percent of nursing facilities have rates below 2 percent;
- No nursing homes with rate above 20 percent; and
- 40,000 fewer patients with moderate to severe daily pain.

#### Goal No. 4: Improving pain management in short-stay patients

- National average at or below 15 percent;
- 30 percent of nursing facilities with rates below 10 percent;
- No nursing facility with a rate above 46 percent; and
- 130,000 fewer post-acute patients with moderate to severe daily pain.

Source: LTCQ



covariate indicator, of independence or modified independence in daily decision making on the prior assessment (covariate = 1 if B4 = 0 or 1 and covariate = 0 if B4 = 2 or 3).

The post-acute pain QM reflects the percent of short-stay patients who have moderate pain daily or excruciating pain at any time on the 14-day assessment (J2a = 2 and J2b = 2 or J2b = 3).

It is important to note that the pain QMs are slightly different from the pain QM/quality indicators (QIs). The

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ware. In the “Long Term Care Facility Resident Assessment Instrument User’s Manual,” pp. 3-141, CMS recently clarified that “...few residents on pain management measures will not have some level of breakthrough pain during the seven-day assessment period that should then be coded on the MDS.”

Even the best-cared-for residents will have pain; a facility with “zero pain” is unlikely. Clinicians should remember that an MDS assessment should reflect the highest level of pain reported by any staff member during the assessment period, not just the assessment of the professional completing the MDS.

Additionally, MDS coding should not rely solely on the medication administration record.

A PRN (as needed) pain medication might be used in anticipation of a painful event. Its administration does-

## An MDS assessment should reflect the highest level of pain reported.

n’t automatically mean that the resident experienced pain, just as a routine medication properly given doesn’t automatically mean the resident was pain free.

### Other Ways To Measure Pain

Relying on the MDS for pain outcome measurement can have its limitations. Daily mild pain is not counted in the QM or QM/QI, and one episode of excruciating pain can be misleading if not taken in context of the entire assessment period.

Pain is often best detected by carefully monitoring other patient outcomes. For example, a long-stay patient with untreated pain may:

- Lose weight (QM/QI 7.1 weight loss);
- Experience decline in mobility or fall (QM/QI 9.1 Loss Activities of Daily Living [ADLs] and QM/QI 1.2 Falls);
- Experience depression or decreased activity (QM/QI 2.1 Depression and QM/QI 11.2 Activity);
- Become confused, restless, or agitated (QM/QI 2.2 Behavior Restlessness [B5 or E1]);
- Exhibit verbal or nonverbal expressions of distress, sleep disturbances, or withdrawal from activities of interest (E1);
- Exhibit behaviors such as resisting care (E4);
- Show a functional decline in ADLs (G);

## N.J. Group Reduces Pressure Ulcers 70 Percent

A coalition of 150 hospitals, nursing facilities, and home care agencies have reported a 70 percent reduction in the incidence of new pressure ulcers after nearly two years of utilizing shared best practices and standardized preventive techniques, according to the New Jersey Health Care Association (NJHA).

“The results show that we were able to achieve measurable, significant improvements in the quality of care provided to patients with respect to pressure ulcer prevention across care settings,” said Aline Homes, NJHA senior vice president of clinical affairs.

Participating organizations met regularly for educational and information-sharing sessions with nationally recognized experts in the field and then took proven best practices back to their facilities to lead their wound care

teams and continue the work with their partners in other health care settings, according to NJHA.

Common improvement techniques used by staff at hospitals, nursing facilities, and home care settings included complete skin evaluation within eight hours of admission; evaluation of the risk of skin breakdown using the internationally respected Braden scale; implementation of preventive strategies, such as proper positioning and use of assistive devices; and ongoing observation of the condition of patients’ skin, particularly for those identified as being at high risk for developing a pressure ulcer.

Following completion of the study, 48 participants had recorded no new pressure ulcers for a period of three months or more, while other data revealed that the prevalence of existing

pressure ulcers as patients moved from one care setting to another was reduced by 30 percent.

NJHA President Gary Carter suggested that the initiative’s success was due to participants putting aside their competitiveness and openly sharing their experiences with each other. “That type of communication and cooperation led to everyone benefiting in the long run,” he said.

According to Theresa Edelstein, NJHA’s vice president of continuing care services, the cooperation and teamwork between health care professionals across the various settings allowed for more seamless transitions in care as the patients moved across different care settings. “This give-and-take was a huge part of the project’s success,” she said.

— Meg LaPorte

- Acquire new diagnoses (I1-I3);
- Have accidents (J4); or
- Develop pressure ulcers or other lesions (M).

A post-acute (short-stay) patient may express untreated pain by:

- Appearing delirious;
- Experiencing depression;
- Losing weight; or
- Not meeting projected therapy minutes.

#### Assessment Tools

While the MDS may help with assessing the effectiveness of the patient's pain management, pain assessment tools are needed to drive the daily management of pain. There are multiple options for pain scales, including, but not limited to, numerical rating scales, verbal descriptor scales, faces scales (Wong-Baker and other), and color scales.

## ■ Having a few scales as part of the policy and procedure is key.

Whichever scale is selected, it is essential that it be used as intended by the authors. Simple changes—such as changing the numbering, images, font size, or horizontal-vertical orientation—may seem harmless, yet may compromise the validity of the scale.

Faces scales are an option for assessing pain that has been used over the years and found to be effective in the adult population. This type of scale tends to also be appropriate for patients with cognitive deficits and

does not appear to be biased by social and cultural factors such as race, age, or gender.

Caregivers should remember that the Wong-Baker FACES pain rating scale has stipulations for use in terms of permission to reproduce, how to print the title, how to correctly reference, and points regarding the numbers and words and the drawings (no changes, deletions, or additions without approval of the author).

This tool uses six faces, numbered 0, 1, 2, 3, 4, 5. There is also an acceptable option of 0, 2, 4, 6, 8, 10 for those who wish to use a 0 to 10 scale

Numerical rating scales and visual analog scales can also be used for assessing pain. These scales usually range from 0 to 5 or 0 to 10, with directions for the individual to describe his or her pain, with 0 being no pain and 5 or 10 being horrible, excru-

## Focus On CAREGIVING

ciating, or the worst possible pain.

Verbal descriptor scales assess pain by asking the individual to rate his or her pain according to its “description.” On these scales, words such as no pain, mild pain, moderate pain, or severe-horrible-excruciating pain may be noted. There is no specific score or number given.

Scales that represent a “pain thermometer” and scales depicting color codes have also been used with the elderly population. There are several tools that assess behaviors in the patient with severe cognitive impairment such as the PAINAD (Pain Assessment in Advanced Dementia) and the PADE (Pain Assessment for the Dementing Elderly). Crosswalks to the MDS for some of these rating scales can be seen on the MedQIC Web site.

“One size fits all” isn’t the case with pain scales. Having a few scales as part

of the policy and procedure is key. While choice is desirable, it can create confusion in the practice of pain assessment. Offering many choices as well as different coding systems can lead to confusion along with inaccurate and inconsistent assessment of patient pain. The same scale should be used consistently for each patient, and crosswalks to the MDS from a scale with similar levels should also be consistent.

While initiatives to improve pain management in nursing facilities can offer many challenges to providers, there are resources available for assistance. MedQIC is an excellent source of information and supports providers in finding, using, and sharing quality improvement resources. Ongoing commitment to the challenge of pain management will certainly result in improved outcomes and improved

quality of life for nursing facility residents. ■

### For More Information

■ A few examples of different types of pain rating scales useful with the elderly can be found on CMS’ MedQIC Web site at [www.MedQIC.org](http://www.MedQIC.org). This Web site also provides guidelines for cross walking some pain scales to the MDS and includes examples of the Wong-Baker FACES Pain Rating Scale.

■ CMS’ Nursing Home Compare Web site can be found at [www.medicare.gov/NHCompare](http://www.medicare.gov/NHCompare).

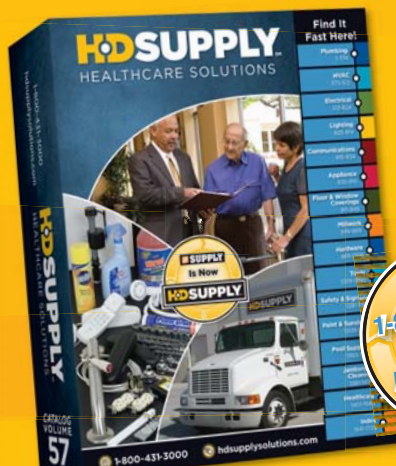
■ Recommendations for numbering of pain scales can be found on the “Wong on Web” site at [www.mosbysdrugconsult.com/WOW](http://www.mosbysdrugconsult.com/WOW).

■ Questions for LTCQ should be directed to Ann Coffou at [coffou@ltcq.com](mailto:coffou@ltcq.com).

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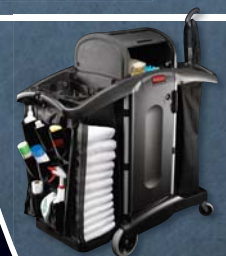
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