

# Managing Pain in Long-Term Care

*New surveyor guidance under F309 puts more scrutiny on pain management*

## WHITE PAPER

- Pain is part of life for many of the nation's 1.5 million nursing home residents. Arthritis, recent surgeries, physical therapy, and wound dressing changes are all common causes of pain in nursing homes. Research published in the *Journal of the American Geriatrics Society* estimates that 45%–83% of nursing home residents experience pain.

However, research and data submitted by nursing facilities across the country suggests that long-term care clinicians tend to underestimate pain in residents and often fail to recognize pain in cognitively impaired residents who have difficulty communicating. Long-term care experts and consultants say many nursing facilities don't use appropriate pain medication regimens or allow staff members' biases to affect the way pain is treated.

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- Nursing facilities may soon find they can no longer fail to identify or treat residents' pain. The Centers for Medicare & Medicaid Services (CMS) recently released and implemented major new pain management guidance and investigative protocols for long-term care surveyors under the survey deficiency tag F309, Quality of Care. The information establishes pain management guidelines for nursing homes and directs surveyors to investigate whether facilities are following the guidelines. Nursing facilities that do not manage pain properly will be cited with a deficiency under F309.

"There has been an emphasis on pain management in long-term care since 2002, when pain management quality measures were posted on the Internet," says **Rena R. Shephard, MHA, RN, RAC-MT, C-NE**, founding chair and executive editor of the American Association of Nurse Assessment Coordinators and president of RRS Healthcare Consulting Services in San Diego.

However, surveyors did not have a pain quality indicator available for the survey process until 2005, and until now, surveyors did not have specific guidance to investigate pain management in nursing facilities, says Shephard.

Previously, nursing facilities were expected to address and manage pain, but nursing homes and surveyors did not have specific guidelines to do so, says **Marilyn Mines, RN, BC, RAC-CT**, manager of clinical services at FR&R Healthcare Consulting, Inc., in Deerfield, IL.

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- “Overall, in the industry, it’s been felt that pain has been ignored in the geriatric population, and hence, now we have a [survey] protocol that’s extremely complex,” Mines says.

To comply with F309, nursing facilities need to reexamine how they assess and manage residents’ pain, including the use of pain medications, PRN (“as needed”) medication regimens, and complimentary and alternative medicine (CAM).

### Investigating pain management under F309

Nursing facilities must assess and address pain in all residents, including the cognitively impaired, according to the pain management guidance under F309.

The guidance states:

*To help a resident attain or maintain his or her highest practicable level of well-being and to prevent or manage pain, the facility, to the extent possible:*

- *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.*

To determine whether facilities are managing pain properly, the investigative protocol under F309 instructs surveyors to identify residents with pain symptoms or potential for pain and follow these steps:

- Observe the resident for signs and symptoms of pain and how nursing home staff members assessed and responded to the pain
- Interview residents or residents’ representatives about their pain, whether they have been involved in the care planning process, whether chosen interventions match their preferences, and whether the interventions are effective
- Interview nurse aides, the caregivers who work most closely with residents, about residents’ pain and how it is treated
- Review medical records
- Interview nurses and other healthcare professionals (e.g., the attending physician, medical director, consultant pharmacist, director of nursing, or hospice nurse) who can give information about the evaluation and management of a resident’s pain symptoms

The new pain management guidance and investigative protocols enforce existing clinical practice standards for pain management rather than introduce new standards, Shephard says. Facilities that routinely address pain through the nursing process, which involves assessment, problem identification, care planning, implementation, and evaluating outcomes, should be in compliance.

“Facilities that have been doing this well aren’t going to find anything surprising, and they don’t have anything to worry about,” Shephard says.

### Barriers to identifying and managing pain

However, not all facilities are managing pain well. Research indicates pain is under-assessed in nursing facilities, which means pain management could be a potential compliance problem for nursing facilities under F309.

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● “What the literature suggests is that pain in nursing homes is a grossly under-managed problem,” says **Susan J. Caccappolo, MSSW, LCSW**, education and training associate at the Schervier Center for Research in Geriatric Care in Riverdale, NY, which recently received a grant from the New York State Department of Health to study pain in cognitively impaired residents.

Nursing homes assess and/or report a much lower incidence of pain among residents than research suggests occurs. Although research suggests 45%–83% of nursing home residents experience pain, only 4% of long-term care residents and 21% of short-stay residents are reported to have pain on quality measures nursing homes submit to CMS.

Nursing homes are most likely to underestimate pain in residents with dementia, even though these residents have similar rates of pain-causing conditions as cognitively intact residents, says **Christie Teigland, PhD**, director of health informatics and research at the New York Association of Homes and Services for the Aging and EQUIP for Quality in Albany, NY.

Even when residents with Alzheimer’s disease and dementia have diagnoses known to cause pain, such as arthritis, neuropathies, and joint disease, their pain is reported only about half as often as in cognitively intact residents with similar diagnoses, according to research Teigland presented to the Alzheimer’s Association. (See “Reported pain in nursing home residents with diagnosis known to cause pain” on p. 5.)

The discrepancy appears to be due to cognitively impaired residents’ difficulty communicating pain, Teigland says. “It’s not simple. You can’t just ask them if they have pain,” she says. “They might be grimacing when you do certain things, they might be crying, they might be holding their arm or exhibiting verbal or physically abusive behaviors. You have to look for these sometimes subtle signs of pain.”

If nursing home staff members are not trained to recognize pain, they are not likely to treat it properly, Caccappolo says.

In addition to assessing pain in residents, nursing facilities encounter other challenges when managing pain. Long-term care experts, researchers, and consultant pharmacists say common problems include:

- Using PRN medications to treat pain when an around-the-clock regimen would be more appropriate

- Failing to anticipate pain before pain-inducing activities, such as rehabilitation therapy or wound dressing changes
- Failing to anticipate and/or plan for side effects of pain medications, such as instituting a bowel management program for a resident taking narcotics
- Dismissing residents' statements of pain based on personal beliefs or attitude
- Withholding pain medication because of a desire to protect residents from addiction or out of a belief that a resident who asks for medication is drug-seeking

### Assessing pain in nursing home residents

Nursing homes can improve pain assessment by asking residents about pain more frequently.

“You can't just review the chart in pain management; you have to talk to the resident.”

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“You can't just review the chart in pain management; you have to talk to the resident,” says **Judith L. Beizer, PharmD, CGP**, clinical professor in clinical pharmacy practice at St. John's University in New York City and president of the American Society of Consultant Pharmacists.

Sometimes, residents who are on PRN regimens don't ask for medications or understand that they should ask, Beizer says.

Nursing facility staff members should anticipate when residents may experience pain, such as during therapy or wound dressing changes, Beizer says.

When performing root-cause analysis, facilities should consider pain as a possible cause for residents who decline to eat or participate in other activities of daily living, such as dressing, bathing, and ambulating, says **Frosini Rubertino, RN, CRNAC, C-NE, CDONA/LTC**, clinical services consultant at LTC Systems in Conway, AR, and an HCPro Boot Camp instructor.

Although analgesics may reduce pain and improve quality of life, nursing facilities should identify and treat the underlying cause of pain, when possible, according to the pain management guidance under F309.

To identify the underlying cause of pain, Rubertino suggests facilities:

- Conduct a thorough history of the resident, involving the resident and/or his or her family
- Complete a pain assessment that notes when pain occurs and what makes it go away
- Note staff members' observations about the pain

### Managing pain in cognitively impaired residents

F309 may place a new emphasis on identifying pain in cognitively impaired residents. Assessing and managing pain in cognitively impaired residents is challenging, but some individuals with advanced cognitive impairment can

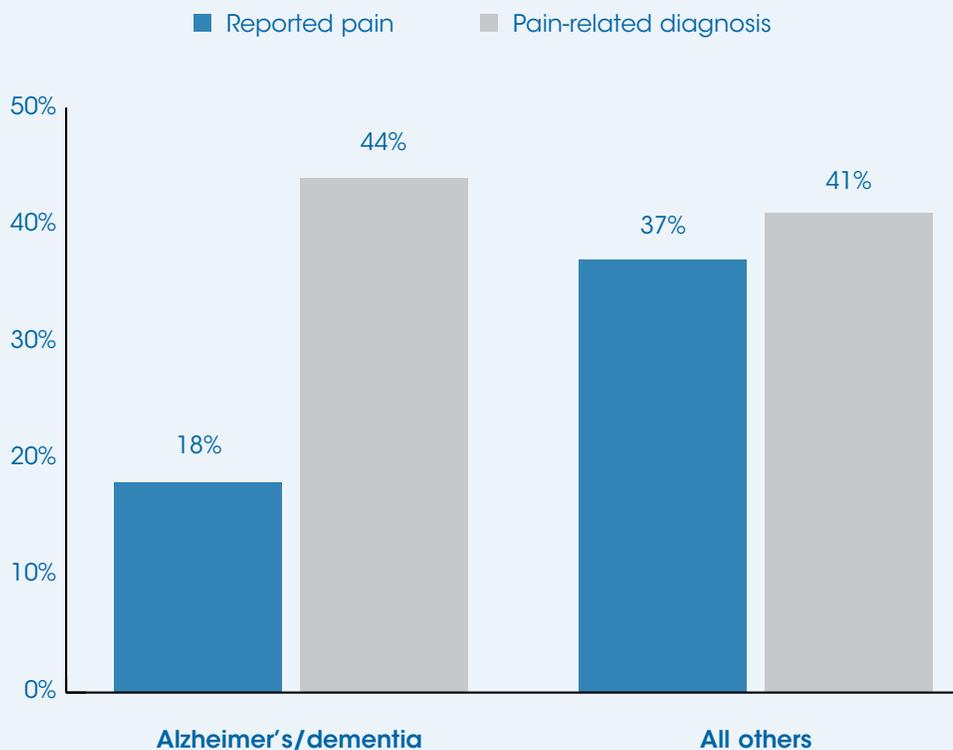
accurately report pain or respond to questions about pain, according to the guidance.

Although self-reporting is the gold standard in pain assessment, many cognitively impaired residents do not communicate pain through statements, Caccappolo says. Often, nursing facility staff members must decipher cognitively impaired residents' actions or detect changes in their behavior.

Caccappolo recounts a story about a cognitively impaired resident in one nursing facility who would occasionally slap other residents. Nursing home staff members examined the circumstances and realized the man only slapped other residents on sunny days. After reviewing the medical record, staff members discovered he had an eye condition exacerbated by solar glare—the resident slapped others because he was in pain. The facility solved the problem by repositioning the resident's chair away from the sun.

**Reported pain in nursing home residents with diagnosis known to cause pain**

Cognitively impaired residents have roughly the same types of diagnoses, but far less reported pain.



Note: Data are based on analysis of diagnosis from Minimum Data Sets that reported conditions known to cause pain, such as arthritis, neuropathies, and joint disease.

Source: "Accurate Identification and Measurement of Quality of Care Issues for Nursing Home Residents with Alzheimer's Disease," Christie Teigland, PhD, principal investigator, Final Report, Alzheimer's Association Grant IIRG-00-2180, 01/01-12/03.

Nursing home members may need to look for signs of pain in cognitively impaired residents, such as:

- Grimacing
- Bracing, guarding, or rubbing body parts that hurt
- Calling out (e.g., crying “help, help, help”)
- Jaw-clenching
- Being very still or not moving
- Being verbally or physically aggressive toward caregivers
- Not eating

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—Joseph Gruber,  
RPh, CGP, FASCP

- Nursing home staff members often misinterpret signs of pain in cognitively impaired residents as behavior problems. “If a cognitively impaired resident is screaming or acting out, our first thought should be pain, but often, the first thought is a behavior medication,” says **Joseph Gruber, RPh, CGP, FASCP**, an independent senior care pharmacist in Edwardsville, IL, and past president of the American Society of Consultant Pharmacists.

When cognitively impaired residents in pain have negative behaviors that are difficult to manage, they might be inappropriately placed on an antipsychotic medication, which is dangerous and may be considered a chemical restraint, Teigland says.

Attitudes about pain in cognitively impaired residents may be another barrier to effective pain management. Some healthcare professionals believe cognitively impaired residents do not experience pain in the same way cognitively intact residents do, although scientific evidence does not support this assumption, Teigland says.

### F309 and PRN medications

Many nursing facilities administer pain medications on an as-needed basis only, even to residents who recently had surgery.

“Many staff members are still under the impression that giving pain medication PRN is pain management,” Rubertino says.

Nursing homes may need to reevaluate pain medication regimens under the new pain management guidance. When selecting and dosing medications, facilities should consider factors such as the resident’s medical condition; current medication regimen; the nature, severity, and cause of pain; and the course of illness, according to the pain management guidance.

“Recurrent use of or repeated requests for PRN medications may indicate the need to reevaluate the situation, including the current medication regimen,” the guidance states.

According to the guidance, different approaches to pain medication regimens include:

- Administering lower doses of medication initially and titrating the dose slowly upward
- Administering medication around the clock rather than on demand
- Combining longer-acting medications with PRN medications for breakthrough pain

### Accounting for side effects and resident goals

Nursing facilities should give residents information about the side effects of pain medications and allow them to make choices.

F309 specifies that residents should be involved in pain management goals, but the goal should not necessarily be that residents be pain-free, Gruber says. Nursing facilities should give residents information about the side effects of pain medications and allow them to make choices.

“If the resident is consistently an 8 on a scale of 10 for severity of pain,” says Gruber, “he or she may say, ‘If we could reduce pain to a 3, I could handle it. I would still be clear-minded, and I could get up and go to bingo.’”

Nursing facilities need to be aware of risks and problems that can occur when certain medications are used to manage pain, Gruber says. Adjuvant analgesics are medications that are not primarily used to control pain but can potentially make routine pain medications more effective. Adjuvants such as tricyclic antidepressants and some nonsteroidal anti-inflammatory medications can be problematic for elderly people, especially those with dementia and heart failure.

“There is a lot of discussion in F309 about monitoring for adverse events that pain medication might bring on,” Gruber says. “Monitoring for medication-related problems is the hallmark of what consultant pharmacists do in the facility. This is not new, but facilities need to ensure they are relying on their consultant pharmacists.”

Nursing facility staff members need to anticipate and plan for the side effects of pain medications, Shephard says. For example, staff members should anticipate constipation as a side effect of narcotics and institute a bowel program immediately.

### Nonpharmacological interventions

Rubertino says she doesn’t necessarily see facilities using more or stronger pain medications as a result of F309. For example, she says, many nonpharmaceutical interventions, including positioning, can be used for residents with contractures (i.e., the permanent shortening of muscles).

The new pain management guidance states that nursing facilities may use nonpharmacological interventions, such as environmental changes, repositioning, and physical modalities such as hot packs and cold compresses, to manage pain effectively. The guidance states that CAM options are “evolving, as those therapies that are proven safe and effective are used more widely.” CAM includes a diverse range of treatments and practices,

such as vitamins and herbal supplements, aromatherapy, acupuncture, and acupressure.

Nursing facilities must ensure that pain recognition and management systems address the use of CAM, Gruber says, adding that many vitamins and herbal supplements are not monitored or regulated by the FDA and may interact poorly with a resident's medication regimen.

Staff members don't always know when residents are using CAM, because family members may provide vitamins or supplements. Ask residents and their families about CAM specifically, Gruber says. Residents and families may not think of vitamins or herbal supplements as medications or may fear that staff members will confiscate vitamins and supplements.

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- “Facility staff must be sensitive to this and tell the residents and families that they need to know everything the resident is taking to make sure there will be no harmful interactions,” Gruber says. “Don't present a threatening front.”

### Tips for improving pain management under F309

To comply with the pain management guidance under F309, Mines and Shephard suggest that nursing facilities involve a wide range of staff members in pain management efforts. The two long-term care consultants offered the following tips for nursing facilities that want to improve their pain management practices:

- Have your nursing home's administrator form a pain management work group, Shephard says. The group might include medical directors, consultant pharmacists, and other clinicians relevant to your facility's needs.
- Find clinical pain management practice guidelines, such as those established by the American Medical Directors Association or the University of Iowa, and use them to create your own facility guidelines, Shephard suggests.
- Use the guidance under F309 to develop your own resident assessment protocol for pain, Mines says. Then conduct an inservice to train all staff members to recognize and report signs of pain.
- Address biases about pain by reminding nurses of painful experiences such as having a tooth pulled or bearing a child, Mines says. Tell nurses that residents whose pain is well-managed exhibit fewer challenging behaviors, making nurses' jobs easier.
- Involve nursing home leadership to dissuade nurses who have biases about pain or dismiss residents' pain, Shephard says. If nurses know the administration is strictly enforcing pain management protocols, they will follow the protocols, even if they don't personally agree with them. ■