Understanding the Critical Elements for Pain Management in the Quality Indicator Survey

Course Objectives
This course will clearly explain the different aspects of the Critical Elements for Pain Management, which is a Stage 2 investigative tool in the Quality Indicator Survey.

Upon completion of this course, learners will:

- Review the main components of the Quality Indicator Survey and how it is carried out by surveyors
- Identify the key federal tags that relate to and help surveyors assess compliance with Pain Management regulations
- Understand the role of resident, family and staff interviews and observations in Quality Indicator Surveys (QIS)
- Review the probes within the Critical Elements for Pain Management, which are used to guide investigations in Stage 2 of QIS

Pain Management
Pain is described as an “unpleasant sensory and emotional experience that can be acute, recurrent or persistent.” Acute pain is generally abrupt and of limited duration, and is often associated with adverse stimulus like surgery, trauma or illness. Incident pain refers to pain that is predictable and is typically associated with a precipitation event, such as walking or debridement during wound care. Breakthrough pain is episodic in nature, sometimes called a flare-up, because the pain breaks through whereas it is typically managed by the current pain management regimen. Persistent pain, on the other hand, refers to pain that continues for a prolonged period of time or recurs intermittently.\(^1\)
Federal Tag 309 focuses on Quality of Care. It requires that each resident receive the necessary care and services—from the nursing home—to attain or maintain the highest practicable physical, “physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.” Federal Tag 309 also includes, but is not limited to, care such as end-of-life, diabetes, renal disease, fractures, congestive heart failure, non-pressure-related skin ulcers, pain, or fecal impaction. In fact, the regulation was recently updated to include specific language related to pain and pain management, in April 2009.

In order to help a resident attain or maintain his or her highest practicable level of well-being and to prevent or manage pain, F309 requires that the facility:

- Recognize when the resident is experiencing pain and identifies circumstances when pain can be anticipated
- Evaluates the existing pain and the cause(s)
- 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.

The regulation requires that the facility ensure that residents obtain optimal improvement or not deteriorate within the limits of the resident’s right to refuse treatment and within the limits of recognized pathology and the normal aging process.
Surveyors will use the Critical Elements for Pain Management to investigate whether a facility is providing care to prevent and/or manage pain for a sampled resident, who states that he or she is experiencing pain or discomfort (including moth or facial pain), indicates potential pain, such as moaning, crying or pained facial expressions or triggers due to moderate or excruciating pain. The CE Pathways are unique to the Quality Indicator Survey, but are similar in format to CMS' current investigative protocols used for traditional state surveys.

This course will explain the process by which surveyors should investigate Pain Management if this Care Area—using the Critical Elements for Pain Management—is triggered for further investigation in Stage 2 of the QIS. The

What is the Quality Indicator Survey?
The Quality Indicator Survey is a computer-based, two-staged investigative tool used by the Centers for Medicare and Medicaid (CMS) to determine how well it’s certified nursing homes comply with federal standards. Unlike traditional state surveys, each state and each surveyor follows the same structured process for assessing compliance with federal regulations during the QIS.

QIS was designed to achieve several objectives:

- Improve the consistency and accuracy in quality of care and quality of life problem identification by using a more structured process
- Enable the systematic review of requirements and investigate regulatory problems objectively
- Enhance documentation through automation
- Focus survey resources on largest number of quality concerns
- Enable timely and effective feedback
- Provide tools for continuous improvement

QIS surveyors are rigorously trained to ensure consistent review and investigation of quality of care and quality of life across 51 care areas and 128 Quality of Care and Life Indicators, or QCLIs.

QIS refers to the same federal regulations and interpretative guidance as traditional state surveys. It is currently the state survey of record in numerous states, and all states—plus the U.S. Virgin Islands and Puerto Rico—will shift to QIS as their state survey of record as surveyors are trained.
One main objective of the Quality Indicatory Survey is to improve consistency and accuracy in quality of care and quality of life problem identification by using a more structured process.

Although the traditional state survey process draws from the same set of CMS regulations and interpretive guidance as the QIS, the conduct of traditional annual surveys has differed greatly from state to state and from surveyor to surveyor. In the traditional state survey process, surveyors have greater latitude in selecting Care Areas for investigation and surveyors do not always participate in all aspects of the annual state survey. These types of divergent practices have made it difficult for CMS and state agencies to accurately identify problem areas on a nationwide basis.

QIS Resident Samples
Stage 1 of the Quality Indicator Survey involves an initial quality assessment of targeted residents, selected randomly by the QIS Data Collection Tool on a wide range of Care Areas covered by federal regulations.\(^{vii}\)

In the QIS, three distinct samples of residents are selected for Stage 1 of the survey process:

1) The Census Sample of 40 Residents
2) The Admission Sample of 30 Residents
3) The MDS Data Resident Pool

The Census Sample emphasizes Quality of Care and Quality of Life (QCLI); it includes 40 randomly selected residents, who reside in the nursing home at the time of the survey. The Admission Sample, which includes 30 recent admissions—from the previous six months, emphasizes post-acute patients and long-term stay admissions on critical issues such as re-hospitalization, death or functional loss. This may include both current and discharged residents for a focused chart review.\(^{viii}\) Information supplied via Minimum Data Set (MDS) is also used to create the resident pool from which Stage 1 samples are randomly selected.\(^{ix}\) The MDS Sample includes facility reported information for all residents who had an MDS assessment, excluding Discharge or Re-entry assessments, at anytime within the 180 days prior to the extraction date.

Surveyor-initiated Samples
The QIS may also include residents from outside the initial sample. At any time during the QIS, a surveyor may initiate a resident review at their discretion.\(^{x}\) A Surveyor-initiated Sample is comprised of residents specifically chosen by the surveyor for further evaluation in Stage 2—and not from the randomly selected sample generated by the QIS Data Collection Tool (or DCT). There are no Stage 1 activities for the residents included in a Surveyor-initiated sample.
A surveyor may choose a resident for inclusion in this sample based on resident-specific information obtained during other tasks, such as the offsite part of the survey during which off-site complaints or ombudsman information is reviewed. Surveyors may also initiate an investigation based on information gained onsite from their observations and/or interviews at the facility.

Residents from the surveyor-initiated sample are automatically added to the Stage 2 investigation for an in-depth Care Area review.

**Data Collection Tool**

Let’s take a moment to review the QIS Data Collection Tool or DCT. The QIS DCT plays an important role in the QIS process and is a customized software application, which surveyors use during the course of surveys from their Tablet PCs.

The DCT software facilitates data collection and surveyors will input relevant findings into it during the QIS process. The DCT processes MDS data, draws the Stage 1 and Stage 2 samples, merges data collected and calculates QCLIs rates. The DCT also provides a review of potential citations and assignment of each citation’s scope and severity.

**Stage 1 Resident Interviews**

In the QIS survey, each of the residents randomly selected for the Census sample is assessed using a combination of resident observations, interviews and clinical record reviews.

Cognitive residents, for example, are asked about choices, abuse, pain, personal property, food, restraints and a variety of other issues which help give an indication of the quality of care and quality of life that they receive at a particular nursing home.

One critical set of questions in the resident interview process revolves around choices. Residents are asked is “is this acceptable to you” in regard to some choices, such as the choice of wake times and dining preferences.

In the traditional state survey process, residents were also interviewed but the conduct of the interviews could vary dramatically and they were often of a conversational nature. With the QIS process, surveyors are training and utilize the DCT to help guide their reviews and investigations, which should help to ensure consistency and accuracy.

In the QIS, resident-centered assessment plays an important role in Stage 1, and also in Stage 2, if further investigations are warranted. Studies have shown that asking residents directly about their condition and preferences helps to show respect for the individual and promotes a high quality of life. The increased resident interviews also provide a broader picture of what the residents are experiencing in the nursing home and what problems or concerns they may have.
Stage 1: Pain Related Interview Questions
During the Resident Interviews and Observations that take place during Stage 1 of the QIS, surveyors will specifically ask cognitive residents about discomfort or pain:xii

\[
\text{Do you have any discomfort now or have you been having discomfort such as pain, heaviness, burning, or hurting with no relief?}
\]

- No
- Yes

Surveyors are also instructed to observe and note the following for both cognitive and non-cognitive residents:xiii

- Were any of the following observed?
  - a) Vocalization of pain: constant muttering, moaning, groaning
  - b) Breathing: strenuous, labored, negative noise on inhalation or expiration
  - c) Pained facial expressions: clenched jaw, troubled or distorted face, crying
  - d) Body language: clenched fists, wringing hands, strained and inflexible position, rocking
  - e) Movement: restless, guarding, altered gait, forceful touching or rubbing body parts
  - f) None of the above

Surveyors will include the resident’s response to these questions and their observations of the resident into the DCT.

Stage 1 Family & Staff Interviews and Observation
Resident family members, or a representative who is familiar with the resident’s preferences, and facility staff are also interviewed in Stage 1.

Information provided from the residents themselves, family members, nursing home staff and from surveyor observation are all entered into the DCT. This includes information that surveyors gather as they perform the seven Mandatory-Facility Level tasks during Stage 1. These seven facility-level tasks range from reviewing the facility’s Infection Prevention and Control measures to observing and reviewing Dining Room and Food Service operations. To complete these seven tasks, surveyors will conduct interviews, review policies and procedures and observe care in action.
The Seven Mandatory Facility-Level Tasks are:

1) Liability Notices & Beneficiary Appeal Rights Review

2) Dining Observation

3) Infection Control

4) Kitchen/Food Service Observation

5) Medication Administration Observation

6) Quality Assessment and Assurance Review

7) Resident Council President/Representative Interview

There are no indicators for the pain Care Area in the Family and Staff interviews.

**QCLI Rates**

The results from Stage 1 of the QIS provide the survey team with a set of potential facility and resident care problems and preliminary information, which they will use in Stage 2 investigations.

After completing Stage 1 tasks, surveyors will use the QIS DCT to calculate Quality of Care and Quality of Life Indicator (QCLI) results. The QCLI results are reported as a rate for the facility for each QCLI. This rate is then compared to an established threshold, which is based on the distribution of rates across facilities for each QCLI. The prevalence rate of a QCLI for a facility is compared to the prevalence rate of other facilities. When the rate of a QCLI exceeds a nationally set benchmark or threshold, the QCLI will trigger a Care Area for further investigation in Stage 2.

There are three QCLIs associated with Pain Management, not including Surveyor-initiated or Facility-Level Tasks:

1) Resident Interviews

2) Resident Observation

3) MDS Sample

Surveyors will conduct Resident Interviews and Observations during Stage 1 of the QIS. In the Stage 1 resident interview, surveyors will specifically ask cognitive residents about discomfort or pain and make observations regarding pain in the DCT, to calculate the QCLI rate for this Care Area.
The threshold for pain varies depending on the data source.\textsuperscript{xix}

<table>
<thead>
<tr>
<th>QCLI # &amp; Name</th>
<th>Data Source</th>
<th>Sample</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>QP255 Pain</td>
<td>Resident Interview</td>
<td>Census</td>
<td>&gt;15.8%</td>
</tr>
<tr>
<td>QP129 Pain</td>
<td>Resident Observation</td>
<td>Census</td>
<td>&gt; 6.0%</td>
</tr>
<tr>
<td>QP125 Pain Prevalence</td>
<td>Most Recent MDS</td>
<td>MDS</td>
<td>&gt;39.0%</td>
</tr>
</tbody>
</table>

However, just because a Care Area, like Pain Management, is triggered for investigation in Stage 2, does not necessarily mean that the facility will be cited as deficient in that area. A complete Stage 2 investigation must be performed first to determine whether or not a deficient practice exists.

**Stage 2**

In addition to the seven Mandatory Facility-Level Tasks that surveyors will begin reviewing in Stage 1, there are five additional triggered tasks that surveyors may investigate if triggered. In Stage 2, surveyors will conduct in-depth reviews of residents whose related Quality Care Indicators exceed the thresholds set for that Care Area.

The DCT helps to identify Care Areas to investigate in Stage 2 of QIS. In addition to these in-depth reviews, triggered facility-level tasks are conducted and compliance decisions are determined.\textsuperscript{xx}

There are five different triggered tasks that surveyors may investigate based on Stage 1 data. Surveyors will only investigate these tasks if data collected in Stage 1 of the survey exceeds the threshold set by CMS for a particular care area. In other words, these five tasks are only performed if enough QCLIs in Stage 1 trigger these tasks for investigation in Stage 2.

1) Abuse Prohibition

2) Admission Transfer & Discharge

3) Environmental Observations

4) Personal Funds

5) Sufficient Staffing Requirements

Care Areas identified in Stage 2 have a set of associated Critical Elements (CE), developed to guide the surveyor and the investigation in a consistent, organized and systematic review of the triggered Care Area and the associated regulatory
requirements. The CE Pathways are similar in format to CMS’ current investigative protocols used for traditional state surveys. For Stage 2 investigations, there are 16 CE Pathways pertaining to specific Care Areas and a General CE Pathway to assist surveyors in investigating a resident with a care issue not addressed in the other 16 CE Pathways.

The Care Area Investigation Key (see Figure 2) lists the 16 different Critical Element Pathways available to QIS surveyors. Where no specific CE Pathway exists, surveyors may use the general CE Pathway to investigate that Care Area.
### Figure 2: Stage 2 Care Area Investigation Key

<table>
<thead>
<tr>
<th>Guidance to Surveyors</th>
<th>General CE Pathway</th>
<th>CE Pathway</th>
<th>Facility Worksheet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse</td>
<td>Accidents</td>
<td>Activities</td>
<td>Abuse Prohibition</td>
</tr>
<tr>
<td>Choices</td>
<td>Fecal Impaction</td>
<td>ADL, ROM, Grooming &amp; Positioning</td>
<td>Admission, Transfer and Discharge Review</td>
</tr>
<tr>
<td>Colostomy, Ureterostomy, Ileostomy</td>
<td>General Critical Element Pathway</td>
<td>Behavior and Emotional Status</td>
<td>Demand Billing Review</td>
</tr>
<tr>
<td>Dignity</td>
<td>Infections (non-UTI)</td>
<td>Bowel &amp; Bladder/Use of Catheter</td>
<td>Dining Observation</td>
</tr>
<tr>
<td>Enteral Feedings</td>
<td>Skin Conditions</td>
<td>Communication / Sensory / Hearing / Vision</td>
<td>Environmental Observations</td>
</tr>
<tr>
<td>Food Quality</td>
<td></td>
<td>Dental</td>
<td>Extended Survey</td>
</tr>
<tr>
<td>Foot Care</td>
<td></td>
<td>Dialysis</td>
<td>Infection Control &amp; Immunizations</td>
</tr>
<tr>
<td>Notification of Change</td>
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<td>Hospice and End of Life</td>
<td>Kitchen/Food Service Observations</td>
</tr>
<tr>
<td>Parenteral Fluids</td>
<td></td>
<td>Hospitalization and Death</td>
<td>Medication Administration Observation / Drug Storage</td>
</tr>
<tr>
<td>Participating in Care Planning</td>
<td>Nutrition, Hydration and Tube Feeding</td>
<td></td>
<td></td>
</tr>
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<td>Personal Property</td>
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<td>Pain Management</td>
<td>Quality Assessment &amp; Assurance Review</td>
</tr>
<tr>
<td>Privacy</td>
<td></td>
<td>Physical Restraints</td>
<td>Resident Council President / Representative Interview</td>
</tr>
<tr>
<td>Prosthesis</td>
<td></td>
<td>Pressure Ulcers</td>
<td>Sufficient Nursing Staff Review</td>
</tr>
<tr>
<td>Resident Room - Access to Corridor</td>
<td></td>
<td>Psychoactive Medications</td>
<td></td>
</tr>
<tr>
<td>Resident Room - # of Residents per Room</td>
<td></td>
<td>Rehabilitation and Community Discharge</td>
<td></td>
</tr>
<tr>
<td>Resident Room - Size</td>
<td></td>
<td>Ventilator</td>
<td></td>
</tr>
<tr>
<td>Resident Room - Window to Outside</td>
<td></td>
<td>Unnecessary Drug Use</td>
<td></td>
</tr>
<tr>
<td>Respiratory Care</td>
<td></td>
<td></td>
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<tr>
<td>Social Services</td>
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<tr>
<td>Tracheal Suctioning</td>
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<tr>
<td>Tracheostomy</td>
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<tr>
<td>Unnecessary Drug Use</td>
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</tbody>
</table>
Critical Elements of Care
The five Critical Elements of Care that are assessed by a CE Pathway are:

- **Comprehensive assessments**: Did the facility conduct an assessment regarding the risks and/or problems the resident has related to the diagnosis and/or condition? (F-tag 272)

- **Comprehensive care plan**: Did the facility develop a care plan to address the care and treatment related to the clinical diagnosis and/or the identified condition? (F-tag 279)

- **Care and services meet professional standards**: Did the facility implement practices that meet professional standards of quality? (F-tag 281)

- **Care plan revisions**: Did the facility revise the plan of care as needed? (F-tag 280)

- **Provision of care and services**: Did the facility provide care and services in accordance with the comprehensive assessment and plan of care that meet Care Area regulation? (Various F-tags that are specific to a Care Area)

The objective of the CE Pathways is to help assess whether a facility meets the five Critical Elements of Care for Care Areas that have exceeded the threshold in Stage 1. A facility can assess their own five Critical Elements in a Care Area by using the CE Pathways and following the structured protocol themselves.

Critical Elements for Pain Management
If this Care Area is triggered for Stage 2 investigation, surveyors will review the assessment, care plan and order to identify facility interventions and to guide observations to be made. They will also corroborate observations in interviews and during records reviews.

During Stage 2 investigations, surveyors are instructed to observe whether staff members consistently implement the care plan over time and across various shifts. Surveyors will note and follow-up on any deviations they observe from the care plan, as well as deviations from current standards of practice and negative outcomes. They will specifically observe whether the resident exhibits signs or symptoms of pain, such as frowning, grimacing, rubbing body areas, appears restless, agitated, groaning, crying or has increased breathing and perspiration. They may also observe whether the resident attends activities that he or she typically attends, and if the lack of attendance is related to pain or discomfort. They are also instructed to note whether the resident experiences a decreased range of motion, resists care or has experienced a loss of function related to pain.
Surveyors will also pay close attention to whether the resident requests interventions for pain and how staff addresses their requests. In particular, surveyors will observe how staff members evaluate the type and intensity of pain, how they determine which interventions to use, how they monitor the resident to determine the efficacy of a particular intervention. And if the intervention fails, what steps or alternative do staff members pursue to assist the resident in pain management.xxiv

Stage 2 Follow-Up Interviews
To complete their investigations, surveyors will follow up with the resident, or their legal representative, on specific issues related to the resident’s pain and pain management. Surveyors will also interview nursing assistances and skilled nursing staff to complete their investigation.

Resident Interview
During the follow-up interview with the resident, or their legal representative, surveyors will want to determine how long and how often the resident has been experiencing pain, and how the resident has treated this pain in the past. The surveyor will want to know if the pain is related to a particular activities or treatment, like wound debridement, and if the resident has communicated their feelings of pain or discomfort to nursing home staff. If the resident has communicated their experience to staff, the surveyor will want to know how long it takes staff to address resident requests for pain management and the outcome of the interventions that have been tried in the past.

Surveyors will inquire as to what impacts the pain, whether non-pharmacy alternatives have been attempted and if the resident, or their legal representative, has been involved in developing a plan of care that addresses pain management and revisions as needed.

The first step in establishing a pain management plan is to clarify the resident’s goal for his or her pain. The healthcare team, resident and their family member(s) or legal representative should be present when discussing the goal of pain management. Although completely relieving pain is a desirable goal, it may not be possible. Some examples of realistic pain-related goals are relief of pain to a tolerable level, reduced need for breakthrough pain medications, increased ability to perform daily tasks and decreased symptoms of depression. Specific pain-related goals are needed to develop relevant and effective interventions.

The goals and/or interventions may need to be adjusted over time depending on effectiveness of the overall treatment plan. During that meeting, the resident and family members also should be educated regarding the possible goals of therapy, side effects of pharmacological pain management (constipation, increased risk of falls, delirium, incontinence, etc.), and the overall treatment plan. If there is daily pain, and medication is being considered, scheduling the medication for around-the-clock rather than as
needed may optimize the effectiveness of the therapy. Goals and interventions around side effects of any pharmacological therapies also should be discussed.

**Nursing Assistant Interview**
During these interviews, surveyors will reach to a nursing assistant(s) assigned to the resident in question. They will want to determine whether the nursing assistance is:

- Knowledgeable about the resident and their pain management plan
- Aware that the resident is uncomfortable or experiencing pain
- Aware of interviews for pain management

They will also want to determine to whom the nursing assistant reports the resident’s complaints of pain and/or discomfort.

**Nurse Interview**
During these interviews, surveyors will need to determine with the resident has been assessed for pain in the past and the results of the assessment. They will want to understand what types of interventions, including pharmacological ones, were developed for the resident and how nursing staff monitor these interventions.

Since pain is often chronic, ongoing monitoring and evaluation is needed to ensure that the pain management goals established by the resident, family and healthcare team are being met by the therapies and interventions in place.

To accurately monitor changes in pain, rate the pain using the same validated pain scale that was used in the initial assessment. If someone is cognitively impaired, one of the validated observational (non-verbal) pain scales, such as the Abbey Pain Scale, can be used for the initial assessment and for ongoing monitoring of pain. Healthcare workers can observe nonverbal indicators as cues to monitor pain for both cognitive and cognitively impaired individuals. Always accept the resident’s reported level of pain, even if it seems out of proportion or doesn’t match observations.

Even though pharmacological therapies can have significant adverse effects such as constipation, urinary retention, nausea and vomiting, these symptoms also can be attributed to the new onset of illness or an underlying medical condition. It is important to monitor closely the development of any symptoms and distinguish their origin. If the symptoms are determined to be an adverse effect of the medications, the doses or medications should be adjusted to minimize complications and maximize effective pain relief.
For residents who receive routine pain medications, surveyors will inquire into how and when assessments are completed, and how often the resident requests pain medication outside of their schedule—or as needed—by the resident. Surveyors will also determine how staff members communicate and revise pain management interventions for the resident.

If the resident is in a Medicare-certified hospice program, surveyors will need to determine if the resident receives pain or symptom control medication from that source, and if so, how the needs of the resident is communicated between nursing home and hospice staff.

**Resident Assessment Instrument**

Signed into law in 1987 by President Ronald Regan, the Nursing Home Reform Act mandates that nursing homes to take numerous measures aimed at sustaining a high quality of care and meeting the psychosocial well-being needs of the residents. Among other things, the Nursing Home Reform Act requires that nursing homes use the Resident Assessment Instrument (RAI), which is a standardized and comprehensive assessment tool aimed at helping clinical staff identify residents’ strengths, weaknesses, preferences and needs in key areas of functioning. This assessment then becomes an important part of the resident’s medical record and should be updated frequently to reflect changes in the resident’s condition and needs over time. Nursing homes are required to complete the RAI within 14 days of admission to the facility.

The Minimum Data Set (MDS) is also a component of the resident assessment. Triggers from MDS help identify areas for additional assessment and review.

Some facilities may not have a completed RAI, if the resident has been at the facility for less than 14 days. They may have instead completed a 5-day assessment for Medicare beneficiaries. If this was completed and utilized Resident Assessment Protocols (RAPS), surveyors may utilize the 5-day assessment if an RAI has not yet been completed for the resident.

If the Pain Management Care Area is triggered for Stage 2 investigation, surveyors will review physician orders, multidisciplinary progress notes, and other information and tools addressing the assessment of pain to determine if the assessment information accurately and comprehensively reflects the status of the resident.

A thorough pain assessment includes obtaining a history of pain along with prior treatments, pain characteristics (including intensity, descriptors, pattern, location and radiation, frequency, timing and duration), impact of pain on the quality of life, factors that may precipitate or aggravate pain, strategies that may lessen pain, additional symptoms associated with pain, current medical condition and medications and the resident’s goals for pain management. In addition, it is important to conduct a physical
exam with every pain assessment to establish any underlying causes for the pain and to allow appropriate treatment.

Developing and implementing a standardized pain assessment form will help the clinician to perform and document a thorough assessment. Residents should be thoroughly assessed for pain at admission, at readmission, at each MDS assessment and with each change in condition. Residents should also be reassessed for any persistent or worsening pain, which could indicate a change in condition. An appropriate pain scale should be used at each assessment to establish the level of pain for both the cognitive and the non-cognitive resident.

There are many pain scales available for the cognitive resident such as numerical pain scales, verbal pain scales, Wong-Baker faces scale, and analogue pain scales. There are also many observational pain scales available for the cognitively impaired who are unable to self report pain. An example of a validated pain scale for residents with dementia is called the Abbey Pain Scale. Consistency is important to evaluate the effectiveness of any interventions, so the same pain scale that is used during the initial assessment should be used to monitor the effectiveness of the interventions implemented to reduce pain. Another useful pain scale for non-cognitive or non-verbal residents is the FLACC, which often is used for young children.xxvii

Determine whether the assessment:

- Identifies the causal, risk and contributing factors of the pain
- Identified a previous history of pain, what was used to manage the pain and the response to analgesics such as pain relief, side effects, impact on functioning
- Identifies conditions that may cause pain and/or discomfort, such as arthritis, diabetic neuropathies, cancer, osteoporosis, fractures, shingles, peripheral vascular disease, skin ulcers, contractures, or paresthesia related to strokes
- Identifies potential non verbal expressions of pain/discomfort such as:
  - Changes in breathing (noisy, deep/shallow, labored, fast/slow)
  - Vocalizations (grunting, moans, yelling out, silent)
  - Mood/behavior (changes, more irritable, striking out, squirming, constant motion)
  - Eyes (wide open/narrow slits/shut, glazed, tearing, no focus)
  - Face (sad, crying, worried, scared, clenched teeth, grimacing)
  - Body (tense, rigid, rocking, curled up, thrashing)
- Identifies limitations on ADL functioning
- Identifies the location, type (description), severity and pattern of pain
- Utilizes a valid instrument for the evaluation of pain for both the cognitively impaired and cognitively intact resident
- Identifies and evaluates the appropriateness of the dose and dosing interval
- Identifies factors that effectively lessen the pain
- Addresses the risk/benefit of the type of pain medication and drug allergy status

**Care Planning**

As explained earlier, the Critical Element Pathway provides a structured process for the surveyor to investigate whether the facility is in compliance with associated regulatory requirements. Before starting the investigation, surveyors will briefly review the comprehensive assessment and interdisciplinary care plan, to identify facility interventions and to guide their observations. Care Plans must be completed 7 days after the comprehensive assessment.

Surveyors are instructed to review the Care Plan to ascertain if the resident's goals, interests and preferences are reflected in the Care Plan and if a lack of sufficient care planning is an issue. Surveyors will review Care Plans to determine if the resident or their representative participated in the plan and if it was revised, as needed, to reflect changes in the resident's interests, abilities or health, cognitive state or if some aspects of the original plan were not successful.

When developing the pain management plan, complementary therapies should be considered as an alternative to pharmacological interventions. Studies indicate that many non-pharmacological approaches are effective in relieving pain.

For example, in a study involving peripheral neuropathy, 77 percent of the study population experienced a significant decrease in their pain level after a series of acupuncture treatments. In a review of the literature, pain relief is among the list of benefits attributed to Reiki, an ancient energy healing art. Music therapy has been shown to alleviate pain in palliative care. Researchers at the Yale Prevention Research Center found that massage significantly decreased pain and stiffness from osteoarthritis. With possible side effects associated with pharmacological therapies, these complementary therapies are viable interventions to add to the pain management plan.
Federal Tags
The Centers for Medicare & Medicaid Services revised the guidance for long-term care at F309, Quality of Care, which went into effect on March 31, 2009. The major change to F309 is the addition of a pain management guidance and investigative protocol.

Another change is that the review of residents receiving hospice care and dialysis care was moved from Appendix P to F309. The section of F309 regarding review of residents with non-pressure related skin ulcer/wound remains unchanged.

Pain Indicators
✓ Groaning, crying, whimpering, screaming
✓ Grimacing, frowning, fright, jaw clenching
✓ Limping
✓ Increased vital signs: heart rate, respiration, blood pressure
✓ Resisting care, distressed pacing, irritability, distressed mood, decreased social activities
✓ Guarding a limb or other body part, rubbing a specific location of the body
✓ Difficulty eating or loss of appetite
✓ Difficulty sleeping or insomnia

The first rule about pain is to trust what the resident says. If a resident reports pain, the healthcare worker needs to believe him or her, even if it doesn’t look like they are in pain. Some residents use words other than “pain” to describe what they are feeling. They may use words such as pressure, achy, hot, throbbing, stabbing, itching, flickering, tugging or tiring to describe their pain. Recognizing these words as descriptions of pain is critical for healthcare workers to implement the appropriate interventions to relieve the pain.

Common misconceptions regarding pain prevent some healthcare workers, family members and residents from recognizing or acknowledging pain. Many people believe that pain is a normal part of aging, rather than part of a disease process or injury. Another misconception is that elderly and cognitively impaired people can tolerate more pain. Just like a younger person, an older person has an individualized tolerance level for pain.
A review of the literature shows that older people may have a higher or lower pain threshold depending on the circumstances. Another misconception regarding pain has some healthcare workers labeling “pain” as attention-seeking behavior. Many residents do not report pain because they do not want to trouble the staff. Still other residents may see pain as a sign of weakness and are reluctant to admit having pain. Healthcare workers should address these misconceptions with the resident and family members to encourage them to report pain. Recognizing and acknowledging pain is important. The onset of acute pain could indicate the resident’s condition is changing, or there is an infection, or even a life-threatening condition like a heart attack or a fecal impaction, which could lead to a bowel rupture.

Figure 3: Related Federal Tags

<table>
<thead>
<tr>
<th>Related Federal Tags</th>
<th>Surveyor Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>F157—Notification of Changes</td>
<td>Determine whether staff notified the physician of significant changes in the resident’s condition or failure of the treatment plan to prevent or manage pain; or the resident’s representative (if known) of significant changes in the resident’s condition in relation to the pain management plan of care.</td>
</tr>
<tr>
<td>F242—Self-determination and Participation</td>
<td>Determine whether the facility has provided the resident with choices about aspects of his or her life in relation to pain management and type and amount of analgesics.</td>
</tr>
<tr>
<td>F246—Accommodation of Needs</td>
<td>Determine whether the facility has adapted the resident’s physical environment (room, bathroom, furniture, temperature, lighting, sound levels) to accommodate the resident’s individual needs.</td>
</tr>
<tr>
<td>F250—Social Services</td>
<td>Determine whether the facility is providing medically-related social services, including: ▪ Meeting the needs of a resident who has pain, discomfort, or unrelenting pain; ▪ Maintaining contact with family; ▪ Providing or arranging for provision of needed counseling services; ▪ Supporting preferences, customary routines, concerns and choices; ▪ Assisting residents/families in decision-making; and ▪ Promoting actions by staff that maintain or enhance dignity.</td>
</tr>
<tr>
<td>F353—Sufficient Staff</td>
<td>Determine whether the facility had qualified staff in sufficient numbers to assure the resident was provided necessary care and services, based upon the</td>
</tr>
</tbody>
</table>
comprehensive assessment and care plan, to prevent or manage pain.

**F385 — Physician Supervision**
Determine whether the physician has assessed and developed a treatment regimen relevant to preventing or managing pain and responded appropriately to the notice of changes in condition.

**F501 — Medical Director**
Determine whether the medical director:
- Assisted the facility in the development and implementation of policies and procedures for prevention, identification and management of pain, and that these are based on current standards of practice; and
- Interacts with the physician supervising the care of the resident if requested by the facility to intervene on behalf of the resident with pain.

After completing interviews, observations and document reviews, surveyors will enter their findings into the DCT to determine compliance with respect to five specific federal tags: F272, F279, F280, F281 and F309.

1) Was a comprehensive pain assessment completed for the resident with or at risk of developing pain and/or discomfort?
   - No  Yes  F272

2) Did the plan of care identify measurable goals and interventions for pain control?
   - No  Yes  F279

3) Did the staff review the plan of care for pain/symptom reduction, evaluate, reassess, if necessary, and revise the plan of care to meet the needs of the resident?
   - No  Yes  F280
   
   Did the facility implement practices that meet professional standards of quality?
   - No  Yes  F281

4) Did the resident receive care and services including the identification, treatment, monitoring and relief—if possible—of pain?
   - No  Yes  F309

Surveyors may find that the facility is in compliance, even if Pain Management is triggered for Stage 2 investigation.

II IASP Classification of Chronic Pain, 1986.


IV Ipid, p. 9.


VIII Department of Health & Human Services, Centers for Medicare & Medicaid Services, Updated Brochure Describing the Quality Indicator Survey (QIS), Ref: S&C-08-21, May 16, 2008, p. 2.

IX Ipid, p.2.

X QIS Training Manual, p.10

XI QIS Training Manual, p. 81.

XII Resident Interview and Observation, Department of Health & Human Services, Centers for Medicare & Medicaid Services, FORM CMS-20050 (06/07), p.5.

XIII Ipid, p. 5.

XIV Updated Brochure Describing the QIS, p. 3.


XVIII Resident Interview and Observation, Department of Health & Human Services, Centers for Medicare & Medicaid Services, FORM CMS-20050 (06/07), p.5.

XIX Pain, QP255, QP129 and QP125, Quality of Care and Quality of Life Indicators (QCLI) Dictionary, CMS (03/10), p.6.


XXI Stage II Care Area Investigation Key, Department of Health and Human Services, Centers for Medicare & Medicaid, CMS Form--20076 (06/07), p. 2.

XXII Nursing Home Resident Assessment Quality of Care, Department of Health and Human Services, Office of Inspector General June Gibbs Brown, January 2001, OEI-02-99-00040, p. 3.

XXIII Stage II – Critical Element for Activities, p. 10.


XXVII O’Callaghan CC., Pain, music creativity and music therapy in palliative care. American Journal Hospital Palliative Care, 1996;13 (2):43-49.