



POLARIS PULSE®

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CMS Issues DRAFT Revision to Surveyor Guidance at F Tag 309 - Pain

Following the template first used for the Revisions to F 314 – Pressure Ulcers, the draft guidance for Assessment and Management of Pain includes educational components, resources and an Investigative Protocol. The Centers for Medicare and Medicaid Services (CMS) timeline for final revisions and implementation of the guidance is early 2007. The below summarizes a selection of the key points included in the draft guidance.

INTENT

The intent of the requirement is to ensure residents with pain are helped to achieve or maintain the highest practicable level of well-being and functioning through:

- Screening to determine if the resident has or is experiencing pain;
- Comprehensively assessing the pain;
- Identifying circumstances when pain can be anticipated; and
- Developing and implementing a plan, using pharmacologic and/or non-pharmacologic interventions to manage the pain and/or try to prevent the pain consistent with the resident's goals.

ASSESSMENT

Screening

Screening for pain at admission helps identify the resident who is experiencing pain or for whom pain may be anticipated. In addition to the admission screening, it is expected that residents will be screened for pain periodically, when there is a change in condition, and anytime pain is suspected.

Recognizing the presence of pain and identifying those situations where pain may be anticipated involves the participation of multiple health care

professionals, direct care staff, therapists and ancillary staff who have contact with the resident (e.g., housekeeping or dietary).

Assessment

At a minimum, an initial pain assessment should include:

- A thorough pain history, including:
 - A detailed description or symptom analysis
 - The effectiveness of past efforts to relieve pain
 - Satisfaction with current pain management
- A physical examination including the pain site, the nervous system, and physical, psychological and cognitive functioning;
- Consideration of co-morbidities and/or diagnoses, especially those which may typically be associated with pain;
- Diagnostic tests, as indicated;
- Additional information such as the degree to which pain is interfering with the individual's mental, physical, psychosocial and spiritual well-being; or history of substance abuse.

MANAGEMENT

Pain management should follow appropriate clinical protocols and guidelines.

Interventions and treatments (both pharmacological and non-pharmacological) should be:

- Preceded by an assessment;
- Developed with respect for whether the pain is episodic or continuous;
- Provided or administered to meet the resident's needs;
- Monitored appropriately for effectiveness and/or adverse consequences; and modified as necessary.

Care planning and Implementation

The care plan should indicate how and when more structured, periodic monitoring with standardized

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tools is to occur. More consistent pain management may be achieved if the plan identifies the specific strategies to use for different levels of pain or pain related symptoms, who is to implement the care or supply the services (e.g., certified hospice), and what symptoms, behaviors, or consequences might indicate that it is necessary to use additional or alternate approaches.

Non-Pharmacological Interventions or Complementary Therapies

Non-pharmacologic interventions frequently are effective for managing pain when used either independently or in conjunction with pharmacologic agents. Non-pharmacologic approaches may include:

- Altering the environment for comfort (such as room temperature, body alignment and repositioning, tightening and smoothing linens, supportive mattress and positioning devices);
- Cognitive interventions (e.g., relaxation techniques, reminiscing, diversions, activities, music therapy, coping techniques and education about pain);
- Physical modalities (such as ice packs or cold to reduce swelling and lessen sensation, mild heat to decrease joint stiffness and increase blood flow to an area, massage, and baths); and Transcutaneous Electrical Nerve Stimulation (TENS), acupuncture/acupressure, chiropractic, or rehabilitation therapy.

If non-pharmacological interventions were not used at all over time, the resident's medical record should include the reasons why they were not pertinent.

Pharmacological Interventions

It is important that pharmacologic interventions for pain management follow a rational approach. General guidelines for choosing appropriate categories of medications in various situations are widely available. For example, the World Health Organization (WHO) pain ladder provides stepwise guidance on the types of medications appropriate for various levels of pain.

Important advice on the use of medication is to "start low, go slow", which means start with a low dose and titrate carefully especially in frail, older individuals. All pharmacologic interventions should be combined with non-pharmacologic interventions.

Monitoring

Periodic use of a standardized pain assessment tool facilitates an objective determination of the success of pain management interventions; the need for altering the current treatment regimen; and the potential for

reducing or eliminating the pain medication(s).

Staff Training Regarding Pain Management

It is important the facility provide orientation and ongoing staff education about pain. Training may include, but is not limited to:

- Using standardized scales to promote objective evaluation and effective management of pain;
- Recognizing and assessing pain, reporting and documenting findings, and monitoring interventions;
- Overcoming misconceptions and increasing understanding of the distinctions between addiction, physical dependence, and tolerance; and
- Identifying appropriate treatment modalities including the use of and when and how to use non-pharmacological interventions.

It is also important that staff understand and implement facility's policies, procedures and protocols regarding pain management.

INVESTIGATIVE PROTOCOL

Criteria for Compliance

The facility is in compliance with F309, Quality of Care, for assessment and management of pain if staff have:

- Screened residents on admission and periodically for the presence of pain;
- Recognized and evaluated residents who are experiencing pain to determine causes and characteristics the pain, as well as factors influencing the pain;
- Developed a care plan to address the pain;
- Provided care and services to control the pain to the greatest extent possible or to the level defined by the resident, in accordance with current standards of practice, or explained adequately in the medical record why they could not or should not do so;
- Recognized and provided pain control measures for situations such as treatments or activities known to potentially cause or exacerbate pain;
- Monitored the effects of interventions and modified the approaches as indicated;
- Contacted the health care practitioner with pertinent information to advise him/her when a resident was having pain that was not adequately managed or was having a potential adverse consequence related to the treatment; and
- Revised the approaches as appropriate, or verified their continued relevance.

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DEFICIENCY CATEGORIZATION EXAMPLES

Severity Level 4

Immediate Jeopardy to resident health or safety

Resident experienced recurring, episodic excruciating pain or incapacitating distress related to specific situations where pain could be anticipated (e.g., because pain has already been identified during dressing changes or therapies), and the facility failed to attempt pain management strategies to try to minimize the pain

Severity Level 3

Actual Harm that is not Immediate Jeopardy

The resident experienced daily moderate to severe pain or distress for the first month after admission that compromised the resident's function (physical and/or psychosocial) and/or ability to reach his/her highest practicable well-being as a result of the facility's failure to screen for pain or have a system that facilitates recognition of residents with pain. For example, the pain was severe enough that the resident experienced insomnia; anorexia with resultant weight loss; reduced ability to move and perform ADLs; a decline in mood; or inhibited social engagement and participation in activities

Severity Level 2

No Actual Harm with potential for more than minimal harm that is Not Immediate Jeopardy

The resident had persistent mild pain resulting from a failure to implement policies and procedures to recognize and evaluate a resident for pain, or to develop or evaluate the effectiveness of treatments and interventions for mild pain or symptom control.

Severity Level 1

No actual harm with potential for minimal harm

Severity Level 1 does not apply for this regulatory requirement.

SOLUTION CENTER Q&A

"Where No Question Goes Unanswered"

Q: If a resident goes to the hospital and is in the Emergency Room at midnight, but returns to the SNF in less than 24 hours, is the MDS cycle restarted with a Return Assessment?

A: No, the MDS schedule is not restarted in this instance. Since the day preceding the midnight on which the resident was absent from the facility is not a Medicare covered day, the Medicare schedule is adjusted and the assessment "clock" is adjusted by skipping that day in calculating when the next Medicare assessment is due.

TELECONFERENCE TRAININGS

Polaris Group is pleased to present the following *CEU approved* teleconference trainings

Live Teleconference Trainings

| <u>Topic</u> | <u>Date</u> |
|---|-------------|
| Sections I, J, O, and W | 7/18 |
| Med. Director and QAA Protocol | 7/19 |
| Urinary Incontinence | 7/20 |
| Part B Cap and Billing | 7/25 |
| How to have a successful FI Review or Appeals | 7/25 |
| QA Audits: What To Do When | 7/26 |
| Pain Management | 7/27 |
| Managing New Adm. & Acute Episodes | 7/27 |
| Medicare Basics | 8/1 |
| F-Tag Review | 8/2 |
| MDS, RAPS, Care Plan Fundamentals | 8/3 |
| SNF Denial Letters | 8/8 |
| Survey Process, Prep and Management | 8/9 |
| Master ADL Coding | 8/10 |
| No Payment Bills | 8/15 |
| Activities Protocol and Psychosocial Grid | 8/16 |
| Sections K, P, and T | 8/17 |
| Feedback on Performance | 8/22 |
| Public Quality Measures | 8/23 |

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