Committing to Consistency in Pain Management in Your Facility

PARK VIEW POST ACUTE

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Who

As MDS Coordinator and Director of Rehab at Park View Post Acute, Claudia and Jennifer observed that there was ongoing discrepancy between pain levels reported by OT/PT/ST and nursing for the same patients. In addition, many patients were continually stating that they had 10/10 pain and that was being documented in the medical record but they were not demonstrating behaviors consistent with that high pain level

Requirement

From RAI Manual: Facility policy should provide standardized tools to use throughout the facility in assessing pain to ensure consistency in interpretation and documentation of the resident's pain.

Surveyors Interview Question: Is there a tool that is used to assess residents with pain? Is the same tool used for everyone? How is the resident assessed for pain? How and when do staff try to identify circumstances in which pain can be anticipated?

Challenge

- Nursing and therapy not utilizing the same pain tool resulting in conflicting reports of pain at Medicare Meeting, in clinical documentation, and MD reporting
- Inaccurate reporting negatively affecting optimal pain control via both pharmacological and non-pharmacological interventions
- Patient confusion regarding their levels of pain due to lack of education on how to report it

Methods

- Researched available pain tools and chose one that had a clear interpretation of pain
- Researched the federal and state regulation requirements regarding assessment of pain to insure that we were meeting the standards
- Shared plan with IDT Team and Medical Director for buy in
- Collaborated on development of an in-service training module for nurses and therapists that emphasized consistent training on the use of the tool with each patient
- Copied and laminated the pain assessment tool for each therapist, nurse and each skilled patient bed
- In collaboration with the Director of Nursing scheduled and completed in-service group training for all nursing clinical team and therapists
- Monitored implementation during Medicare Meeting team reports and MDS patient interviews

Pain Assessment Tool

Very Severe/ Horrible Pain	10	VERY SEVERE/ HORRIBLE PAIN 10- Unable pain. Worst pain that can be imagined. (Very few people ever experienced this level of pain.)
Moderate to Severe pain	9	MODERATE TO SEVERE PAIN 9 - Excruciating pain. Inability to converse. Uncontrolled crying out and/ or moaning.
	8	8 - Intense pain. Physical activity is severely limited. Conversing requires great effort
	7	7 - Very strong pain that significantly limits the ability to perform normal daily activities. Interferes with sleep
	6	6 - Strong pain that interferes with normal daily activities. It is difficult to concentrate.
	5	5 - Strong pain that can't be ignored for more than a few minutes. Normal daily activities can be managed.
Mild Pain	4	MILD PAIN 4 - Pain can be ignored for a period of time but is distracting.
	3	3 - Pain is noticeable. It is possible to get used to it and adapt.
	2	2 - Pain is minor.
	1	1 - Pain is barely noticeable.
No Pain	0	NO PAIN 0 - No pain

Conclusions

- Decrease in patient reports of 10/10 pain following education on the pain assessment tool
- Increased success in conversation with patients regarding their pain levels and their response to interventions
- Increased ability for clinical team to identify actual changes in pain levels
- Increased collaboration between nursing and therapy regarding pain management because they are all "speaking the same language"
- Increased physician satisfaction due to more consistent reporting by nursing and therapy
- Increased patient satisfaction due to better communication with staff and involvement in their own pain control