F-tag 309 for Pain: Understanding New CMS Guidelines for Quality Care
Objectives

- Understand the new F-tag for Pain 309
- Identify ways to meet criteria for quality of care as it relates to pain
  - Screening & assessing for pain
  - Treating pain appropriately
  - Monitoring and preventing further pain episodes
  - Developing a care plan
“Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.”
F-tag elements
What is F-tag 309?

- F-tag 309 focus is overall quality of care – much of the F-tag has not changed
- Requires that NHs provide for the highest practicable level of function & well being
  - Comprehensive resident assessment
  - Care plans must address mental, physical, & psychosocial needs
- Requires that residents obtain optimal improvement or do not deteriorate
  - Within resident’s right to refuse
  - Within limits of recognized pathophysiology & normal aging
Pain management has specifically developed guidelines within this F-tag

- New definitions of terms
- Defined care processes for pain management
- Defined steps in pain recognition, assessment, management, interventions, care plans
- New investigative protocol for surveyors specific to pain
New Definition of Terms

- Addiction, tolerance, physical dependence
- Adverse consequence, adverse drug reaction
- Adjuvant analgesics
- Non-pharmacological interventions
- Complimentary and Alternative Medicine (CAM)
- 4 types of pain – acute, breakthrough, incident, persistent or chronic
- Standards of practice
Facilities & staff must be committed to effective pain management

Pain can be acute, chronic, or incident

Staff must evaluate resident reports of pain and/or nonverbal signs of pain

Residents with cognitive impairment must also have their pain recognized & managed

Facilities must break down myths about pain in older adults

Facilities must address staff, resident & family misperceptions about effective pain management
What is the Approach

- Screening for pain & treat if needed
- Perform comprehensive pain assessment
- Communicate with health care provider, resident, family, IDT
- Develop comprehensive care plan including pharmacological & non-pharmacological interventions as appropriate
- Implement the plan
- Monitor & revise plan as needed
Care Process Assessment

- All residents must have comprehensive pain assessment upon admission.

- Residents who trigger for pain (through MDS/RAI) or have a diagnosis of chronic pain or exhibit frequent pain must have more frequent comprehensive pain assessment.

- MDS must be completed as one “part” of the comprehensive assessment.

- Facilities must document a more detailed assessment that identifies problems and needs, monitors condition, records treatment and response to treatment.
Care Process

Pain Assessment Standards

- History of pain & its treatment
- Characteristics of pain
- Impact of pain on quality of life
- Factors that precipitate pain
- Strategies or factors that reduce pain
- Associated symptoms (for example, anxiety, decrease in function)
- Physical examination
- Current medical condition & medications
- Resident goals for pain management
All staff are responsible for recognizing pain upon admission and throughout the stay.

Recognition efforts must go beyond asking the question “are you in pain”.

- Verbalizations that may be nonsensical
- Non-verbal indicators
- Aberrant behaviors
- Functional decline
- Loss of appetite
- Difficulty sleeping

Observations should be at rest & with movement.
Pain Descriptors

- Acute pain vs. chronic pain
- Pain pattern – constant, intermittent
- Character – for example, stabbing, burning, dull, aching, etc.
- Location of pain
Pain Impacts

- Physiological changes – heart rate, resp. rate, BP, diaphoresis, flushing in acute pain
- Loss of appetite
- Insomnia
- Decreased mobility
- Social isolation
- Enjoyment of activities
Pain Related Diagnoses

- Admission diagnoses helps nurses to anticipate resident pain & types of pain
- Nociceptive pain
  - Somatic pain – arthritis, fractures
  - Visceral pain – abdominal pain, cancer
- Neuropathic pain – neuralgias, diabetic neuropathy
Bone and muscle pain is:

- Relatively well localized & worse on movement
- Tender to pressure over the area
- Often accompanied by a dull aching pain
- Sometimes referred, if it is bone pain, but not along a nerve path; e.g. hip to knee
Visceral Pain

- Often poorly localized, deep & aching
- Usually constant
- Often referred
  - Diaphragmatic irritation may be referred to right shoulder
  - Pelvic visceral pain is often referred to the sacral or perineal area
Neuropathic Pain

- A burning, deeply aching quality often accompanied by sudden, sharp lancing pains
- Often a nerve path radiation
- Numbness or tingling over the area of skin
- Skin sensitivity over the area
- Severe pain from even slight pressure from clothing or light touch
MEDICAL CONDITIONS THAT CAN BE PAINFUL

- Pressure ulcers
- Diabetes with neuropathic pain
- Amputations
- Post-CVA syndrome
- Venous ulcers
- Oral health conditions
- Infections
- Multiple sclerosis
- Immobility
- Arthritis
- Osteoporosis
- Fibromyalgia
- Gout
- Post-herpetic neuralgia
Care Process Management of Pain

- Based on assessment - facility, attending prescriber, staff collaborate to manage pain
- Develop appropriate interventions to prevent or manage pain
- Interventions may be integrated into care plan or included as a specific pain management need or goal
- IDT & resident develop pertinent, realistic & measurable goals for treatment
- Pain management approaches must follow clinical standards of practice
Care Process
Pharmacological Interventions

• IDT is responsible for developing individualized pain management regimen
• A systematic approach for meds & doses is important
• Addressing underlying cause of pain
• Administration timing – PRN vs. routinely
• Combining short & long acting drugs
• All medications including opioids or other potent analgesics must be dosed according to standards
• Clinical record should reflect ongoing communication with prescriber
Care Process
Non-Pharmacological Interventions

- Modifying environment for comfort
- Physical modalities – cold/heat, positioning
- Exercises to reduce stiffness, prevent contractures
- Cognitive/behavioral interventions
- Complementary & Alternative Medicine
  - includes acupuncture, herbal supplements
Care Process

Monitoring, Reassessment, Care Plan Revision

- Monitoring response over time helps to determine effectiveness of treatments
- Adverse consequences to medications can be anticipated & reduced
- Identification of target signs of pain
- Inadequate control of pain requires a revision of intervention
- Resolution of pain should be documented and treatment tapered or discontinued
In Summary

- Facilities & staffs responsible for ensuring residents obtain their highest practicable level
- Residents must be involved in their pain management & their individual needs & goals should be basis of care plan
- Care must be individualized based on a comprehensive assessment & MUST meet clinical standards of quality
- Staff must monitor continuously & revise when necessary in a timely manner
- Staff must communicate resident status or change of condition with health care practitioners, resident, & family
- Staff must document accurately
QUESTIONS?

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