TRACER METHODOLOGY 101

Tracing Pain Management in a Nursing Care Center

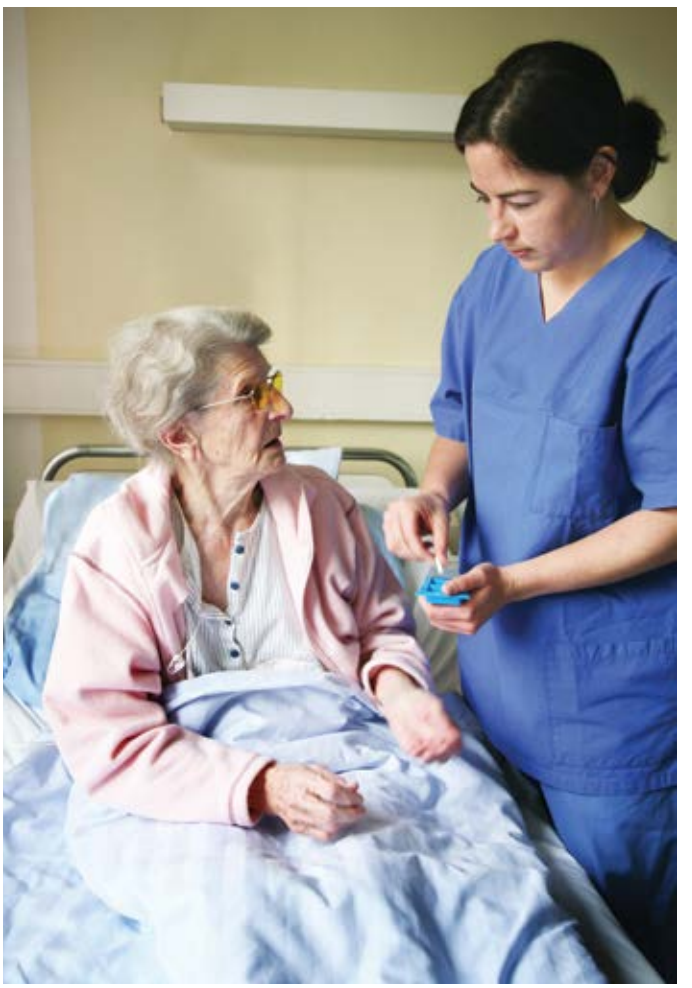
For the patient or resident of a nursing care center, pain is likely included in the complexity of health concerns that he or she may face. Unfortunately, pain may not be managed as effectively as it should be in some nursing care settings, with the effective assessment and management of pain representing a top compliance challenge in 2015. The Joint Commission's Provision of Care, Treatment, and Services (PC) Standard **PC.01.02.07** states, "The organization assesses and manages the patient's or resident's pain." During 2015, 20% of nursing care centers that underwent survey were found noncompliant with this standard (*see* the sidebar on page 5 for the complete standard).

Effective management of pain requires not only regular assessment and reassessment, but a clear process to document its management within the care plan and to communicate this clearly with the resident and family.

Organizations are generally quite effective at writing policies for pain management and at creating assessment forms for staff to complete, explains Elaine Buccellato, RN, MS, surveyor, Nursing Care Center (NCC) accreditation at The Joint Commission. "Where they can tend to struggle, however, is in consistently carrying out their own policies around pain management and in documenting their response," she adds.

Buccellato notes that in some centers, the problem is not about whether or not a resident is given medication or an intervention for his or her pain but that this is not consistently documented or reassessed in a timely manner. "For example, as a surveyor, I will probably raise a few questions if I am tracing a resident for whom their documentation shows an initial assessment of having no pain, but then later in the day their record indicates that they were given a pain medication or intervention," she explains. "I will want to know what changed or was left undocumented to explain this disconnect between assessment and care planning."

When considering the provision of pain management during an on-site accreditation survey, surveyors are interested in following a resident's experience with care and pain management across the range of his or her care experience, so from the time of admission through to ongoing care and reassessment. They will often select a patient based around his or her experience with breakthrough pain or based on the reason for the patient's admission. As in the tracer scenario beginning on page 6, a new resident may be admitted to a nursing care center to recover from surgery and can present with acute pain issues that will require managing and assessing not only from the point of admission but also in an ongoing and timely manner.



Patients suffering from disorders that affect cognition, such as dementia, may have trouble communicating their level of pain.

Varying Assessment Strategies

Buccellato stresses the importance of understanding the complexity of pain and how many residents experience it, particularly when approaching assessment and care planning. "We're very good at assessing and coping with types of acute pain that are clearly impossible to miss," she explains. But in cases of chronic pain or intermittent discomfort, she notes that some assessment procedures may inadvertently overlook or under-assess the pain management needs of residents. "While a resident may indicate that they have no pain at the time of assessment, this may not mean that they are not experiencing pain in a chronic manner which has caused them pain earlier in the day," Buccellato notes. "By asking more questions—such as how often they have felt pain over the course of a single day, when they last experienced pain, or how debilitating they have found pain in the past seven days—the assessment can perhaps provide more insight into the care planning process and ensure pain management better supports the resident's needs over time."

As pain assessment forms are a critical part of the medication and pain management process, Buccellato also emphasizes their importance in ensuring that the nature and scope of pain are being properly assessed and responded to at the right time. By designing forms to ask pain assessment questions in a more probing manner, as Buccellato suggests above, the center can also plan other suitable approaches to pain management beyond medication administration alone, particularly if these pain issues are chronic and not related to an acute issue that may predominate care at the time of admission (such as a resident with arthritis who has been admitted to the NCC

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Related Requirements

Standard PC.01.02.07
The organization assesses and manages the patient's or resident's pain.

Elements of Performance for PC.01.02.07

1. The organization conducts a comprehensive pain assessment of the patient or resident that is consistent with the patient's or resident's condition. (*See also* PC.01.02.01, EP 2; RI.01.01.01, EP 8)
2. The organization uses methods to assess pain that are consistent with the patient's or resident's age, condition, and cognitive ability.
3. The organization reassesses the patient's or resident's pain, based on its reassessment criteria.
4. The organization either treats the patient's or resident's pain or refers the patient or resident for treatment.
   Note 1: *Treatment strategies for pain may include pharmacologic and nonpharmacologic approaches. Strategies should reflect a person-centered approach and consider the patient's or resident's current presentation, the health care providers' clinical judgment, and the risks and benefits associated with the strategies, including potential risk of dependency, addiction, and abuse.*
   Note 2: *Treatment of pain includes interventions for breakthrough pain.*
6. **For organizations that elect The Joint Commission Post–Acute Care Certification option:** When assessing the patient for pain, the organization documents the following:
   - Location
   - Duration
   - Type (for example: sharp, dull, throbbing)
   - Intensity (pain scale)
   - Exacerbating factors
   - Alleviating factors
   - Previous treatments and response
   - Any barriers which may prevent effective treatment

   Note: *This element of performance applies only for those patients receiving rehabilitation or advanced care under the optional certification.*
7. **For organizations that elect The Joint Commission Post–Acute Care Certification option:** If the patient is unable to convey the presence of pain, the organization solicits input from the family in identifying and managing the patient's pain. This input is documented.
   Note: *This element of performance applies only for those patients receiving rehabilitation or advanced care under the optional certification.*
8. **For organizations that elect The Joint Commission Post–Acute Care Certification option:** The organization takes measures to prevent or reduce discomfort and pain before a treatment or procedure.
   Note 1: *Nonmedication (nonpharmacological) interventions for pain can be important adjuncts to pain treatment regimens.*
   Note 2: *This element of performance applies only for those patients receiving rehabilitation or advanced care under the optional certification.*
9. If the patient or resident is unable to convey the presence of pain, the organization uses a validated non-verbal/non-cognitive pain assessment tool.‡

‡ A useful tool for assessing pain for patients and residents with dementia is the "Pain Assessment in Advanced Dementia (PAINAD) Scale." It can be found on the American Medical Directors Association website at www.amda.com/publications/caring/may2004/painad.cfm.

to recover from knee surgery). "For example, one resident may disclose that their chronic pain can often present at particular times of the day and may actually be better managed by receiving repositioning support or a heat pack," Buccellato adds.

Effective Documentation

Effective documentation of pain assessment should not be overlooked and can have a significant impact on other areas of supporting the care of residents, including the suitability of the care plan and resident and family education. "Typically, nurses will provide resident education around pain based on the assessment undertaken," explains Buccellato. "If the resident has been assessed with pain, then the nurse will educate the resident and family about pain and its management, as it is on their care plan and integral to the care and assessment going forward." But, Buccellato warns, if the assessment is not clearly documented or assessed appropriately, this can result in poor care planning, lacking resident and family education, and inadequate pain management.

By planning for pain management in a consistent way and by critically evaluating how the process is both carried out and documented, organizations can better assess for pain and plan for care that supports its residents in an ongoing manner.

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>
> ***Elaine Buccellato, RN, MS***
> ***Surveyor for Nursing Care Center (NCC) accreditation at The Joint Commission***

The Scenario

This individual tracer took place in a nursing care center in northern Texas. The surveyor selected a male resident to trace who had been admitted to the NCC seven days previously from an area hospital after undergoing surgery to implant a left ventricular assist device (LVAD). The resident's documentation indicated that the 69-year-old's surgery

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was successful and resulted in no complications, though the patient did require a ventilator. Upon admission to the NCC, the resident was still being weaned from the ventilator and receiving intravenous pain medication. He was also receiving physical and occupational therapy to support his recovery.

Learning about the assessment of pain in the center. The surveyor met with nursing staff to learn about how they assess and plan for pain management in the center. She was also interested in how the physician orders pertaining to this resident were communicated from the hospital to the center. [1, 2] The nurse showed the surveyor the completed assessment form and explained their process for initial assessment. [3] The surveyor was then able to review the

Mock Tracer Tracking Worksheet

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Use this worksheet to record notes and areas of concern that you identify while conducting your organization's mock tracers. This information can be used to highlight a good practice or to determine issues that may require further follow-up.

Tracer Team Members: _____ Tracer Patient or Medical Record: _____

Staff Interviewed: _____

Unit or Department Where Tracer Was Conducted: _____

TRACER PROMPTS	Correct Processes Observed	Areas of Concern	Follow-Up Needed	Required Written Documentation		Notes
				Required?	Present?	
1. Can you explain your process for pain assessment in the center? How is this documented?						
2. How do you receive orders for an admission to the center? How is pain management factored into that documentation? How do you plan for the admission based on this information?						
3. How is your initial pain assessment conducted? How is this documented?						
4. How is pain management handled in the ongoing provision of care? In addition to medication management, what other pain management techniques are used or communicated to the resident and family?						
5. To the resident and family: How has your experience of care been in the NCC? Have you had your care needs met? Have there been any concerns? If so, how have you communicated these?						
6. *To the resident and family:* What information have you been given about pain assessment while in the center?						
7. Please tell me your process to document assessment and care planning in relation to ongoing pain management. How is this communicated to staff?						

documentation provided by the hospital and by the center on admission.

She noted that the staff had documented, through their initial assessment and care plan, the patient's need for ongoing pain management, including the provision of intravenous pain medication every six hours. [4] She also noted that physical and rehabilitation therapy had been planned to support his recovery. The resident had already had a few short assessments with physical and occupational therapy, which had been documented in his record.

Exploring effectiveness of pain management. The surveyor continued her review of the resident by receiving permission to visit with the resident and his wife and son, who were visiting at the time. The patient was conscious and responsive and had been so since admission to the center. [5, 6] While meeting with the resident and family, the surveyor asked them about their experience of care in the NCC. The resident's wife explained that they were generally pleased with care but that it had been more than two hours past the six-hour point at which he was meant to receive his latest dose of intravenous medications. In addition, the resident required repositioning at various times since admission, but it had taken a very long time. The family had informed one of the nursing assistants who had been in the room earlier, though they weren't sure why the delay had occurred. When the surveyor explored this with the nursing staff, she found in the resident's record that the medication administration was delayed and that staff had been unaware of requests passed along for repositioning. [7]

Moving forward. The surveyor discussed improving the pain assessment and management process with staff, including improving staff training on communication and documentation.

Sample Questions

The following represent some questions that could be asked during a tracer. Use them as a starting point to plan your own tracers.

1. Can you explain your process for pain assessment in the center? How is this documented?
2. How do you receive orders for an admission to the center? How is pain management factored into that documentation? How do you plan for the admission based on this information?
3. How is your initial pain assessment conducted? How is this documented?
4. How is pain management handled in the ongoing provision of care? In addition to medication management, what other pain management techniques are used or communicated to the resident and family?
5. *To the resident and family:* How has your experience of care been in the NCC? Have you had your care needs met? Have there been any concerns? If so, how have you communicated these?
6. *To the resident and family:* What information have you been given about pain assessment while in the center?
7. Please tell me your process to document assessment and care planning in relation to ongoing pain management. How is this communicated to staff? TS