LIABILITY
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BY LINDA WILLIAMS, RN

# Pain *mis*management

Pain has been clinically defined as "whatever the experiencing person says it is, existing whenever the experiencing person says it does." Unfortunately, this definition is inadequate for understanding pain in long-term care residents, as many have cognitive deficits and/or are conscious of pain but are unable to express it. Moreover, residents often don't know how to get relief and staff members are unaware of the problem because they fail to adequately and routinely assess residents for pain. Therefore, both groups misunderstand the importance of managing pain.

Some recent findings from the Centers for Medicare & Medicaid Services suggest that pain experienced by nursing home residents is prevalent but is often not fully reported, recognized, assessed, or treated. Studies have shown that 45–80% of nursing home residents have substantial pain that is undertreated as a result of suboptimal compliance with guidelines for treating pain in geriatric populations. Among those with pain who are assessed, 41% of nursing home residents are in persistent, severe pain at the next assessment.

Poor pain management can trigger survey citations for abuse, violation of residents' rights (per the self-determination act), and substandard care. In addition, many states have proposed or enacted statutes that address pain management, which has spawned a new trend of lawsuits against healthcare providers that have inadequate pain management policies and services. Please review the following situation in which some caregivers unintentionally mismanaged a resident's chronic pain for several months. Plan to make changes as appropriate in your facility.

## The Situation

After suffering a stroke that left him with right-sided paralysis and difficulty speaking, a man sold his home and moved to an independent living facility in a continuing care retirement community (CCRC) near his daughter. He had chronic pain in his ribs from previous fractures and took three medications daily for muscle relaxation and nerve pain relief. As the years went by, he became more dependent on others for assistance with his daily living, so he reluctantly moved again—to the CCRC's skilled nursing facility.

The independent living facility did not keep charts or medical records, so upon admission to the nursing unit a note was faxed to the man's attending physician requesting a current copy of his admission and medication orders, a physician plan of care (PPOC), and an updated history and physical (H&P) to reflect his current status.

When the information was faxed back to the facility, the muscle relaxant and pain medications were listed on the H&P, which read "current with no real changes." The physician also wrote "see attached" on the man's PPOC in the current medications section. The attachment was a list of medication orders that were written according to diagnosis. Since chronic pain was not a diagnosis, the three medications were not listed. The nurse transcribed the orders as indicated on the PPOC and attached medication orders, omitting the three medications because she did not compare those documents with the H&P.

Later that day, the man's daughter gave the nurse a bag of his medications from the old apartment. The nurse said she would send the medications to the pharmacy for "repackaging," as was custom in these situations. When the pharmacist saw the three medications, he placed them in storage because he did not have any orders for them.

Although the man was alert, oriented, and able to direct his own care, his daughter acted as his Power of Attorney for Health Care Decisions because of his communication difficulties. His daughter could understand him, so she bridged the communication gap and signed all of the detailed, business-type forms within his healthcare records. A note in the man's chart alerted the staff that he had expressive aphasia and his daughter should be consulted for all decision making. The staff complied and consulted his daughter whenever needed, such as having her sign the disclosure list for health records many times and asking her to be present whenever the physician visited her father.

While at the nursing facility, the man occasionally became frustrated whenever staff members could not understand what he was trying to tell them. He also was in constant pain. Among the man's medication orders was hydrocodone, a narcotic analgesic to be given as needed (prn). Since that was his only pain reliever, he asked for it frequently, to the extent that the nursing staff asked that it be administered three times a day, as well as prn. The prn doses were used on an average of one out of every three days for the next four months.

At the end of the fourth month, the daughter felt that her father was having increased leg pain at night and asked that he receive a routine dose of pain medication at bedtime. This was ordered and as the daughter reviewed her father's list of medications, she discovered the three missing pain medications. The pharmacist was immediately

contacted, and he explained that he was holding the medications for the man until he received an order for disbursement. The man's attending physician promptly wrote the order and the three medications were dispensed and restarted.

As a result, the man's chronic pain began to subside, and a month later the daughter asked for the bedtime dose of hydrocodone to be discontinued. When the physician examined him, he noted that the man was "far more comfortable now that the medications have been restarted—may be able to reduce the scheduled narcotics." Within the next month the hydrocodone was discontinued altogether, and the man's appetite increased and his weight jumped from 121 pounds (upon admission) to 138 pounds. Overall, he appeared happier and more social than ever since being admitted.

When the man's daughter realized what all had happened to her father, she became angry and contacted the nursing facility with the intent to sue. She stated that her father had become combative and difficult to deal with when the medications had stopped. She reported that the physician told her they were lucky her father didn't die from withdrawal as a result of the abrupt discontinuation of the medications. She also alleged that her father had communicated to her that he was constantly in unbearable pain, with which the physician agreed. She further alleged that a care conference was held 14 days after admission, and she went through the list of medications with the staff, item by item, and everything was on the list.

The staff apologized for the mishap and reminded her that the pharmacist and physician also had made an error during the ordeal. A chart review revealed that the man had stabilized during the four-month period, as he was given the hydrocodone as directed and he attended the same amount of activities during and after that time. While no one questioned that his pain became more controlled after restarting the medications, nothing in the chart supported the allegations that he had any withdrawal symptoms or combative behaviors. None of the staff that attended his initial care plan conference could recall a conversation about the three medications. During those four months, the man's physician saw him twice, and neither the physician nor the daughter discussed increased or unbearable pain. The claim was settled for a nominal amount.

## Protecting Your Residents and Facility

The tragedy in this situation is that the man's pain could have been optimally controlled from the start of his admission to the nursing home had the following taken place:

- The physician had been more clear and consistent with his orders;
- The admitting nurse had read and compared all of the faxed information that she had requested; and
- The pharmacist had followed up with the nurses or daughter regarding the three medications, instead of storing them.

Here are some ways that staff can protect your residents and facility from a similar mishap:

1. Carefully review and update or adopt current pain management policies.
2. Educate residents, families, and employees about pain management and communication, and provide ongoing training using experts within the community.
3. Provide tools for use by all frontline caregivers, such as pocket-size cards with reminders of what staff should check when assessing for pain, emphasizing both verbal and nonverbal signs of pain.
4. Include clinicians with pain management expertise on interdisciplinary care teams and the quality assurance (QA) committee.
5. Assess every resident for pain upon admission, then quarterly, and with every physical or behavioral status change, and screen every shift until well controlled. Staff should use a variety of clinically standardized tools to assess pain in both verbal and nonverbal residents. The initial pain assessment should include the family or caregiver to help identify:

- The characteristics (e.g., location, intensity, etc.) of the pain, and precipitating and relieving factors.
- How the resident responds to pain and how it affects his or her quality of life. Try to determine what his or her beliefs, knowledge, or perception of pain management strategies are.
- The effectiveness of past and present pain-relieving strategies (e.g., over-the-counter or prescription medications, therapies, etc.).

6. Team with the resident and family members to provide pain management strategies and interventions that are individualized to meet the resident's needs.
7. Address pain management in resident care plans and interdisciplinary care plan reviews as indicated. The care plan for pain should include a pain control goal as defined by the resident, family, and caregivers. Don't forget to address the resident's nutrition and hydration status, since pain and pain medications can produce multiple side effects, such as loss of appetite, gastrointestinal distress, constipation, etc.
8. Monitor the resident to determine the response to the interventions, including effectiveness and emergence of adverse consequences. Record changes in the resident's pain routinely and keep the physician and family informed of the resident's status in a timely manner.
9. Conduct audits to ensure that the facility's pain management policies are being implemented effectively and the pain management needs of the residents are being appropriately addressed.
10. Report and discuss pain management at QA and morning management meetings.

Residents with chronic or acute pain can create many challenges for their loved ones and providers alike. By working as a team, much can be done to alleviate suffering by managing the pain effectively. ■

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