

Training Scenarios and Questions for Pain Management

Aging Services of Minnesota's Regulatory Affairs Committee asks that these scenarios be covered in the training on F309, particularly with respect to pain management.

1. Resident has significant dementia and is unable to communicate verbally. Facility assesses significant pain as a possible cause of the resident's aggressive behavior, but the family asks the physician to cancel the pain medications because of their fear of over-medicating the resident. Physician stops the pain medication. There are no appropriate or relevant non-pharmacological interventions. Aggressive behavior returns, potentially endangering other residents and staff.
2. Resident has significant dementia and is unable to communicate verbally. Resident also has several wound conditions and gangrene, which require dressing changes two or three times a day. Resident's reactions during dressing changes indicate obvious pain. Facility assesses the pain and obtains prescription from the physician for medication taken one hour before dressing change. Family asks the physician to stop the medication because they feel the resident is drugged up when they visit, and the family denies that the resident is in pain. Physician caves in to the family and cancels the medication.
3. Resident is post-operation in a transitional care unit that specializes in rehab. The whole point here is to rehab the resident rapidly, so that they can go home. There is considerable post-surgery pain, but the resident receives physical therapy several times a day. Pain medication is relatively minimal so that the medication does not mask or camouflage potential limits on physical therapies, which could otherwise cause significant injury to the resident. What guidance is there for surveyors and providers in this situation?
4. Resident is post-operative in transitional care unit and will return home in three or four weeks. Resident has been on a medication like Ambien for some years. Should the facility be required to try to change this long-standing medication practice when the resident is in the facility for another purpose?
5. Is there a good non-verbal pain assessment tool for dementia residents that has been thoroughly tested and validated?
6. Particularly under the QIS, there is more of a focus on questions directed to residents. Some residents will tell the surveyor or a family member that they have pain, but they never report the pain to the facility. How are the surveyors to determine whether the reports of pain are true? What guidelines are there for the surveyors to evaluate the residents' reports? Some residents with dementias present very well, but inaccurately. If the surveyors think they are true, what evidence can the facility use to "prove the negative" or prove the absence of pain?
7. Is there a requirement that a facility try non-pharmacological interventions before pharmacological ones? Or should the surveyors accept the facility's choice and concentrate on its effectiveness and the facility's follow-up? Is there a requirement that a facility try "alternative" methods under any circumstance?
8. Many facilities as a matter of normal practice do provide some non-pharmacological interventions that can prevent pain—e.g., positioning cushions—but they do not have them in the care plan or document them because it is their customary practice. Are the surveyors going to recognize these practices that are not in the individualized care plan?