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Accreditation News

Fall 2022

Volume 14, Issue 3

Pain Management Issues Remain

By Joann Saporito, RN, MBA

Pain assessment and management has long been within the requirements of accrediting organizations such as The Joint Commission (TJC) and Healthcare Facilities Accreditation Program (HFAP). For years, facilities have been asked to comply with Standards surrounding not only pain assessment, but the management of pain throughout hospitalization. This includes assessing and intervening when someone complains of pain, performing re-assessments after intervention as per facility policy, providing patient/resident/family education, and updating the care plan. Yet issues around pain management still remain a common finding during surveys. In this article, we hope to share areas where facilities are most likely to experience findings related to pain management: the appropriate pain assessment tools, assessing and re-assessing pain as per hospital policies, following providers' orders, the provision of education and keeping the care plan current, and inclusion of pain management in Quality/Performance Improvement activities.

In addition to the requirement that policies are current, they should provide methods to evaluate pain for all patient/resident populations. The most common pain rating scale used is the numeric scale, a scale whereby patients/residents can rate their pain from 0 (no pain) to 10 (the most severe pain). Also commonly used is the Wong-Baker scale, which includes a series of facial expressions with a pain description for that face. For example, a smiling face would be "no pain" and a crying face would be "hurts the worst." But what about those who are non-verbal? One cannot assume that a non-verbal or sedated patient/resident is not feeling pain simply because they cannot verbalize this or point to a picture to indicate the level of pain they are experiencing. The patient/resident may be pediatric or perhaps someone with cognitive impairment.

The facility's policies should address how to evaluate pain and the effectiveness of pain management interventions, in these populations as well. There are a number of pain rating scales appropriate for these populations. For example, the "FLACC" scale evaluates Faces, Legs, Activity, Crying, and Consolability with a point value assigned to each area. A score of "0" means no pain, whereby a score of 7-10 means severe discomfort or pain. There is also the "CRIES" pain scale, which is intended for use more with infants aged 6 months or younger, which evaluates and places a score on the categories of Crying, Requirements for oxygen, Increase in vital signs, Expression, and Sleeplessness.

The facility should ensure that their policies not only address an appropriate way to timely assess pain in all of the patient/resident populations served, but also provide for assessments and re-assessments on admission and throughout the patient/resident stay in the facility. For example, some facilities may have it in policy that an initial pain assessment will be completed within the first twenty-four (24) hours. Though there is not a regulation that states how quickly such an assessment must be completed, surveyors may find this to be too long for a patient/resident to not have their pain evaluated and managed and can cite a facility under Joint Commission's Leadership or Provision of Care, Treatment and Services and Patient Rights and Responsibilities Chapters. In the HFAP manual, a facility might be cited under many chapters including the Patient Rights & Use of Restraint, Nursing Services, Discharge Planning, Physical Rehabilitation Services, Surgical Services,

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Outpatient Services, Swing Beds, and PPS Excluded & Distinct Part Unit chapters. The Centers for Medicare & Medicaid Services (CMS) has requirements around pain assessment, re-assessment, and management in virtually every healthcare setting from home health to outpatient clinics to short-term, acute care hospitals.

An initial pain assessment really should be completed on admission, preferably with the first set of vital signs. Also, once an intervention has been provided to a patient/resident, whether non-pharmacological or medicinal, a re-assessment of the effectiveness of the intervention should be performed and documented within the timeframe defined in hospital policy. It is still commonly cited that pain medication has been provided but there is no documentation afterwards of its effect (or lack thereof) on reducing pain. Re-assessments are important to not only confirm the intervention has reduced the pain level, but if not then a call to the provider might be warranted.

Another possible citation for facilities exists around following the providers' orders. Let us examine a common scenario. A physician might order Tylenol for a pain scale of 1-4, Vicodin for a pain scale of 5-7, and Morphine for a pain scale of 8 -10. These become the documented provider's orders for which medication is to be used based on the patient/resident complaint. During a chart audit, a night shift nurse is noted to have given Morphine for a patient complaint of pain rated at "6" on the pain scale but they documented the patient did not like the Vicodin so Morphine was given. Upon interview, the nurse states she did not want to call the physician in the middle of the night for a new order. But is this considered acceptable? Absolutely not! In this case, the nurse clearly went outside of the provider's orders and could even be perceived as practicing medicine without a license. Facility staff should give pain medication if needed but not more frequently than ordered or outside of the ordered parameters. If the orders as written are not sufficient to manage the patient's/resident's pain, it is the duty of the staff to notify the provider and obtain modifications to or additional orders.

Education around pain management should be provided to the patient/resident and to their family members. This education is expected to be documented and should start with an assessment of the patient's/resident's learning needs and language preferences. Education should then detail the patient's rights in relation to pain such as the staff believing the patient's reported pain level, their responsibilities in relation to their pain such as asking for pain relief upon onset and informing staff if the intervention is not alleviating the pain, some potential barriers to pain management such as avoiding pain medication due to fear of addiction, and expected effect and potential side effects of the medication being administered.

Additionally, the care plan should reflect pain management. It is a requirement that the care plan be maintained current, so it is important for staff to remember to update the care plan to reflect pain management if pain develops after admission. For example, if a patient/resident has had a procedure performed, has experienced an injury after admission, or their disease has progressed. But the requirements do not stop at the patient/resident. The Joint Commission also requires in the Human Resources Chapter that facilities orient staff to their specific job duties around managing pain and that the facility provides educational resources and programs to improve pain assessment, pain management, and the safe use of opioids. Non-pharmacological modalities must also be available as well as the ability to refer, when necessary, those with more complex pain management problems.

The Joint Commission's Leadership and Performance Improvement Chapters require pain management to be identified as an organizational priority and included in Performance Improvement activities. Facilities can demonstrate this commitment by including data surrounding pain management in its Quality Assurance/Performance Improvement (QAPI) program. Examples of data that can be collected, analyzed, and discussed might be pain assessments and re-assessments completed as per hospital policy, whether or not patients/residents were screened for prior opiate use before prescribing Fentanyl, if the appropriate pain medication is being administered based on provider orders and patient/resident level of pain, whether or not education has been provided to the patient/resident/family and that this education is documented, and if education has been provided about the patient's specific pain reducing medication such as intended effect and possible side effects.

Further, the Medical Staff Chapter requires that the medical staff is actively involved in pain assessment, pain management, and safe opioid prescribing as evidenced by medical staff members participating in establishment of protocols and quality metrics, as well as reviewing performance improvement data. The engagement of your medical staff can be documented within meeting minutes.

In summary, effective pain management is within the patient's/resident's rights, and facilities should properly assess a patient's/resident's level of pain including its nature, location and intensity. The facility should provide interventions (both non-pharmacologic and medicinal) when indicated and evaluate their ability to control pain. Notify the provider if pain is not managed. Effective pain management education should be provided to patients/residents and their family, as well as to facility staff. Hospital policies should be current, contain appropriate pain assessment tools for all patient populations served, and support safe, effective pain management. Pain management needs should be considered in the discharge planning process as well. It is the responsibility of each organization to determine who is qualified and responsible to educate the patient and family at discharge regarding the pain management plan, side effects of treatment, impact on activities of daily living, and safe use, storage, and disposal of opioids when prescribed. Finally, facilities should incorporate pain management in the organization's performance improvement processes.

GFCI Electrical Outlets

By Steven Hirsch, MPA, FACHE

Ground Fault Circuit Interrupter (GFCI) electrical receptacles are required in a number of locations in healthcare facilities, based on requirements published in the Health Care Facilities Code, NFPA 99-2012 Edition and the National Electrical Code (NEC), NFPA 70-2011 Edition. Generally, a ground fault circuit interrupter (GFCI) is required within 6 feet of a water source.

NFPA 70 states in Section 210.8 "Ground-Fault Circuit-Interrupter Protection for Personnel. Ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel.

(1) Bathrooms
(2) Kitchens
(3) Rooftops
(4) Outdoors
(5) Sinks
(6) Indoor wet locations
(7) Locker rooms with associated showering facilities
(8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used

Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required."

Requirements in NFPA 99 are not specific as to locations at which GFCI receptacles must be provided.

We have observed during regulatory surveys (CMS Certification and Accreditation Surveys) that many organizations are being cited for either lack of GFCI receptacles in areas identified by either of the above NFPA Codes, or for lack of documented testing.

Based on the NFPA Codes, GFCI electrical receptacles must be installed within 6 feet of a sink. GFCI electrical receptacles are frequently observed missing in laboratory settings at work benches that often are adjacent to sinks. These are locations that do need to be addressed, and GFCI receptacles installed.

GFCI receptacles are required in patient bathrooms. They must also be provided in Unit Nourishment Stations where water and ice dispensing machines are located, as well as coffee makers. Don't forget that drinking fountains must be supported with GFCI receptacles as well.

Additionally, GCFI receptacles need to be provided in rehabilitation service settings, such as by hydrotherapy equipment and at locations around therapeutic pools.

We have had several clients cited for not having GFCI receptacles at vending machines. These may be incorporated into the power cord of the vending machine if the machine was fabricated after 2005. If the machine is older, a GFCI wall receptacle must be provided. For reference, NFPA 70-2011 Edition states in Section 422.51 Cord-and-Plug-Connected Vending Machines. "Cord-and-plug-connected vending machines manufactured or remanufactured on or after January 1, 2005, shall include a ground-fault circuit interrupter as an integral part of the attachment plug or be located within 300 mm (12 in.) of the attachment plug. Older vending machines manufactured or remanufactured prior to January 1, 2005, shall be connected to a GFCI-protected outlet."

Now that GFCI receptacles are provided in locations as required, how do you track and test them? An inventory of GCFI receptacles installed in the facility should be created, identifying the location of each device and its manufacturer. Based on manufacturer's instructions for use, the organization is expected to conduct testing and document such, to assure that the device functions as intended.

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GFCI Electrical Outlets

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The tasks for testing as defined by the manufacturer should be listed on the work order used to conduct the required testing, or in policy defining the testing protocol. For each installed device, a test result should be recorded. If the device fails, there should be documentation of replacement and retesting to close the loop. While some organizations will replace the failed device on discovery of the failure and document that the GFCI "passed" its test, this is not an acceptable practice. There must be maintained an accurate record of required testing activities and follow-up or corrective action.

For further information about "GFCI Electrical Outlets"
or for questions regarding Environment of Care / Life Safety
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