# PROVING PAIN IN NURSING HOME CASES

Establishing that a nursing home resident suffered pain when it was not documented can be a challenge. But if you keep in mind some basic rules for handling these cases, you can prevail.

*By* || **Steven M. Levin and Cari F. Silverman**

More often than not, nursing home residents' charts do not document pain. The problem is compounded when a resident has cognitive deficits that hinder communication of pain. Plaintiff attorneys litigating nursing home pressure sore cases often must prove pain and suffering without the benefit of medical records. Because defendants often argue that "just because it was not documented, that doesn't mean it was not done," you might expect them to argue that absence of documented pain means that the home treated the resident for pain. But they usually argue the opposite: They claim that the lack of documentation means the resident did not experience pain.

You can prove pain and suffering without documentation by confronting and undermining defense arguments from day one. The first step in any case is identifying the rules that direct the conduct and care at issue.[1] In the nursing home context, the federal Omnibus Budget Reconciliation Act of 1987 (OBRA) establishes a comprehensive set of rules governing pain prevention and treatment,[2] and most states have statutory schemes that mandate full compliance with federal regulations. Therefore, pursuant to both federal and state law, nursing homes are required to comply with OBRA.

Although attorneys may argue over the meaning of the OBRA regulations, it is undisputed that failure to comply with them exposes the nursing home to financial penalties, withholding of federal and state monetary reimbursement, and closure by the government. Therefore, plaintiff attorneys should use these regulations as the basis for establishing the standard of care.

Nursing homes are required to assess, monitor, and treat pain associated with a patient's pressure sore.[3] These actions are a priority in maximizing a patient's quality of life and are integral components of pressure ulcer prevention and treatment. You should be aware of several steps nursing homes must take to meet the standard of care.

***Initial assessment.*** The nursing home is required to complete an accurate and thorough assessment of every resident on admission and readmission.[4] The purpose of this assessment is to identify the resident's risk factors and pain-causing conditions. The standard of care requires the nursing staff to identify the type and extent of pain present so that appropriate interventions may be provided. Nursing staff use various pain rating scales to assess and measure a resident's pain, and the scale used depends on the resident's cognitive status and needs. The failure to accurately assess a patient's potential for pain may expose the resident to unnecessary harm.

***Planning.*** Nursing homes use information collected from the pain assessment to formulate a resident-specific pain treatment plan. Federal and state regulations, the standard of care, and the facility's own policies and procedures require the nursing home to develop a comprehensive, individualized plan addressing the resident's potential for pain and problems associated with pain.[5]

The plan must state personal goals and list strategies to minimize pain and its consequences. Specifically, the nursing home must develop interventions designed to anticipate and aggressively treat a resident's pain before, during, and after painful wound treatments. The care plan must include interventions such as documentation of daily pain assessment findings, administration of medications before dressing changes or wound treatments, and documentation of resident responses to pain medication.

***Implementation.*** Staff providing direct care to the resident have an obligation under the standard of care to implement the interventions contained in the resident's care plan. If the staff are unable to follow the resident's care plan, the standard of care requires them to notify a supervisor and the attending physician.

***Reassessment.*** When the resident's condition changes, the nursing home must re-evaluate the patient for signs and symptoms of pain and implement additional interventions. For example, if a resident develops a pressure sore, the nursing home must identify the resident's potential for pain associated with the sore and the type and extent of the pain. Identifying pain and appropriately classifying the type of pain is pertinent to the re-evaluation process.

### Lack of Documentation

The nursing staff's failure to document pain is part of the problem; it is evidence the nursing home continuously failed to identify and treat your client's pain. The absence of basic pain evaluations in a resident's chart indicates systemic negligence. Plaintiff attorneys should use these blatant documentation failures to highlight the problem of untreated pain.

The first step in proving the defendant's negligence is establishing what documentation is required. Nursing

## ELECTRONIC MEDICAL RESEARCH PRIMER

Nursing home litigation demands a working knowledge of the medical issues underlying your client's injury. Taking the time to conduct your own preliminary medical research makes sense—and it's easier than you may think.

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Your client falls in a nursing home bathroom and X-rays confirm a broken hip; the defense claims it was a pathologic fracture. Another client, his brain already compromised by vascular dementia, dies from dehydration despite being rehydrated with saline. These are just two examples that may involve complex medical questions and the misconduct or negligence of nursing homes. To advocate for your client, you need special knowledge and resources.

Nursing home cases present complex corporate structures, corporate greed, and multiple liability theories. Each patient presents a unique medical history and clinical condition that must be considered when analyzing the case. When you are handling such complex medicolegal issues, the need for reliable and sophisticated information competes with the need to control expenses, maximize revenue, and enhance client recovery. Electronic research can help you balance these competing interests.

Attorneys commonly rely on electronic search engines such as Westlaw and LexisNexis to search and analyze state statutes, regulations, and legal precedents. Analyzing the medical elements of a nursing home case is no different. You can access numerous search engines and medical resources designed for health care consumers and practitioners.

Conducting your own electronic medical research will help you build your case and save time and money. It often costs at least $50,000 to bring a case to trial, and without medical training, it can be difficult to decide whether to pursue litigation. You must identify the medical issues early on, and electronic medical research can help you identify appropriate defendants, determine applicable standards of care, identify the necessary experts, and zero in on negligence issues.

Because many states require increasingly detailed expert testimony regarding causation, cases of nursing home negligence usually require expert medical support. Electronic medical research can help you understand complex physiological reactions and articulate them well. Performing your own electronic medical research may also be helpful in identifying and assessing a patient's future medical needs and damages.

Well-crafted electronic medical research can also help you manage your case. You can use what you learn to craft pointed requests, rather than taking a scattershot approach. If you are well prepared, you can engage in more productive conversations with your experts about the case's salient issues. Peer-reviewed authority and learned treatises will help you prepare your direct and cross-examinations.

The body of electronic medical resources and search engines is continuously growing. Lawyers can readily access numerous search engines designed for consumers and clinicians. The challenge is to access the germane sources quickly, cost-effectively, and reliably.

***Start easy.*** The first step is to perform generalized searches of potential medical issues using a basic search engine. For example, nearly everyone uses Google and its branches, including Google Scholar and Google News. Conducting a search on these sites for general terms (such as pressure ulcer, dehydration, or sepsis) may lead to surprisingly sophisticated results. The goal at this initial stage is to get an overview of the topic, identify potential key issues and terminology, gain initial familiarity with the issues, and identify additional questions and potential sources for further information.

***Narrow the issue.*** Now that you have gained an overview in the initial research phase, you can use consumer-oriented

homes must administer the pain scale on admission, readmission, quarterly, on discharge, and when there is a significant change in a resident's condition, such as the development of a pressure sore.[6] These assessments should be documented and in the resident's chart. The lack of documented pain assessments constitutes multiple violations of the standard of care and government regulations.

The nursing home is required to assess a patient's pressure sore weekly—at a minimum.[7] This mandatory weekly assessment includes documentation of pain intensity, frequency, duration, relieving/aggravating factors, and responses to treatment.[8] Additionally, most nursing homes have policies and procedures in place requiring daily wound status monitoring and notations about pain. The nursing home also must complete a pain evaluation before and after routine and only-as-needed pain medication. These assessments are not only infrequently documented but also rarely done. Again, the absence of this required documentation is not evidence that the resident did not experience pain, but rather evidence of the nursing home's negligence.

You can use literature to prove that the prevalence of pain in nursing home patients is significant, with many patients experiencing pain on a daily basis.[9] Elderly and cognitively impaired residents' pain often goes overlooked and undertreated.[10] A 1998 study found that 60 percent of residents in long-term care facilities with at least one painful diagnosis received no pain medication.[11] The study also found that cognitively impaired residents received significantly less pain medication than patients who did not have cognitive impairments.[12]

Use this literature to your advantage. A plaintiff attorney faced with the burden of proving pain and suffering

resources to develop and fine-tune your understanding of the topic. Before you consult an expert, you should perform narrower, more focused searches into the medical issues presented using guided keyword searching.

The goal at this stage is to explore the key medical issues and terminology, gain generalized understanding of those issues and how they apply to a specific case, and identify additional questions and potential sources for further information. Then you will be prepared to contact the appropriate expert consultants to identify and discuss the medical issues of the case.

Medline Plus is a consumer-oriented medical research tool with encyclopedic health information on hundreds of diseases and conditions. Websites such as WebMD.com, MedicineNet.com, and eMedicineHealth.com provide readable and authoritative medical information for consumers. All these resources are free and require no membership or registration. If you are presented with a clinical condition with which you have little or no knowledge, they are reliable places to deepen your understanding of the medical issues.

***Drill down.*** Next you can begin to access more sophisticated electronic resources. The goal at this stage is to gain a detailed understanding of the medical issues relevant to the case.

Medscape, part of the WebMD Health Professional Network, is free. It requires registration to access full content, but it provides original, professional medical content (organized by medical specialty) on hundreds of diseases and conditions. Medscape Reference (formerly eMedicine) is designed to be an authoritative, accessible point-of-care medical reference for physicians and health care professionals. The registration-based site provides current practice guidelines, as well as more than 6,000 evidence-based, peer-reviewed articles at no cost.

Another resource is UpToDate, an evidence-based, physician-authored clinical support resource designed for physicians to use to make point-of-care decisions. It requires an annual subscription, but it provides a comprehensive synthesis of the literature and the latest evidence, including specific recommendations for patient care. You can learn from this reference all the major aspects of a particular condition, including symptoms, available tests and diagnostic methodologies, and treatment options.

These resources provide detailed medical information about prevention and treatment recommendations, signs and symptoms, differential diagnoses, common complications, morbidity and mortality, sequelae, and life expectancy. This knowledge will allow you to discuss the salient medical issues with your expert consultants and witnesses and determine how those issues affect your prima facie case.

***Identify key treatises and articles.*** Almost everything is available online, including scientific articles and treatises. PubMed and HighWire, for example, provide abstracts and links to scholarly, scientific medical journals and articles. These search engines provide full-text versions of scholarly articles once they are available online. Through PubMed, for example, you can access MEDLINE, the National Library of Medicine's bibliographic database, which contains more than 19 million references to journal articles, newspapers, magazines, and newsletters. A growing number of references are available at no charge; links to the publisher's website are provided for articles that require a fee.

Physicians and other health care professionals can perform medical research for plaintiff lawyers, but this approach takes time and costs money. Performing your own electronic medical research, especially in nursing home litigation, lets you make informed and timely decisions about accepting a case, and it helps you develop a case strategy, work with experts, and craft knowledgeable questions for witnesses. Most important, it enables you to explain complex medical issues to juries clearly, concisely, and persuasively.

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without documentation must elicit the potential for pain through deposition testimony. Confirming the literature with testimony by the defendant's employees will provide invaluable proof of pain.

Specifically, ask the nurses the following questions:

- A majority of nursing home residents experience pain on a daily basis, correct?
- Isn't it true that it is difficult to assess pain in a noncommunicative resident?
- It is also difficult to assess pain in elderly patients with cognitive impairments, right?
- As a result, don't patients with cognitive or communication impairments have pain that often goes unrecognized and untreated?
- So the absence of documentation of pain does not mean that this resident did not experience pain as a result of his or her pressure sore, does it?

Most jurisdictions have case law that allows inferences about the degree of pain from the nature of the resident's condition and the medical treatment provided.[13] Use the deponents to establish basic principles of pressure sore pain. Pressure sores develop because of unrelieved pressure on bony prominences of the body. Have the nurse break down the etiology of wound development. Specifically, unrelieved pressure cuts off circulation to the tissue for a long enough period of time that the tissue dies. If the deponent is forthcoming, ask him or her to give an example in laymen's terms. The best one we have heard is that you're essentially strangling the tissue. Therefore, even a Stage I pressure sore can be painful.

Next, take it a step further and have the nurse testify to the different stages of wounds. Descriptive testimony detailing the etiology of a pressure sore's development will convince the jury of pain. For example, for a Stage IV wound, ask the nurse this series of questions:

- The resident had a Stage IV pressure sore, correct?
- To be classified as a Stage IV wound, there has to be exposed bone, tendon, or muscle, right?
- So my client's wound went down through her skin, through the layers of fat, through her muscles, through her tendons, all the way down to her bone, correct? (This becomes a particularly interesting line of

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# UNTREATED PAIN

questioning if the nursing home first identified the sore when it was Stage IV.)

- Does this mean you could see her bone when you assessed her wound?
- And she had a Stage IV pressure sore for eight months, correct?
- And she died with that Stage IV pressure sore, correct?

Once you have established the basic fundamentals of pressure sore development, shift gears to proving pain through the treatment required in healing a pressure sore. Don't just rely on vague medical descriptions to prove pain. Make the witness break down each wound treatment, specifically detailing the fundamentals of how each treatment works. For example:

- Debridement is a process in which the doctor orders removal of dead tissue, correct?
- There are five different types of debridement: surgical, sharp, mechanical, autolytic, and enzymatic debridement, correct?
- And is sharp debridement when the doctor uses a scalpel to surgically remove dead tissue?
- Specifically, the doctor uses a scalpel to scrape out all of the dead tissue in the wound, sometimes scraping down all the way to the patient's bone, correct?
- What is mechanical debridement?
- So with mechanical debridement, the nurse removes dead tissue and debris from the wound using mechanical force, correct?
- For example, a wet-to-dry dressing is a common form of mechanical dressing, right?
- With a wet-to-dry dressing, do you physically adhere gauze to the dead tissue?
- And when you remove the gauze, the dead tissue sticks to the gauze?
- This is similar to what happens when you rip off a band-aid, correct?
- And one of the potential complications with mechanical debridement is the possibility that healthy tissue may be removed, causing pain, correct?

If you sufficiently establish that with each of these five debridement methods, the resident is more likely than not experiencing pain, then you can show that each time your client underwent a debridement or a dressing change, he or she experienced pain. Because most dressing changes are daily, you will have undocumented pain every day.

Also, establish the painful byproducts of pressure sores. If your client required a Foley catheter to aid in wound healing, bring that out. If your client's wound was infected, discuss the likelihood that your client experienced pain as a result. In situations with multiple pressure sores, explain that your client could not be placed in a position that would offload pressure onto an existing wound.

Don't focus only on what is not documented; you can also prove pain by what is documented. Look first at the medication administration records (MAR). If the MARs show only-as-needed pain medication being administered, you have pain. If you have a nurse's note mentioning a pain complaint, look at the MAR for that shift and see if pain medication was ever given to address the complaint. If the resident complained and no medication was given, you have negligence.

## Family Member Testimony

Do not undervalue the importance of family member testimony in proving pain and suffering. Your clients often are the most compelling witnesses to show pain and suffering. Start at the initial client interview: Ask your clients questions designed to trigger their memories. Often they have witnessed pain and suffering but do not remember to tell you until after their depositions. Cognitively impaired residents' pain and discomfort often are exhibited nonverbally through behaviors such as crying out, restlessness, grimacing, clammy skin, and involuntary cries and groaning. Ask your clients whether their loved one exhibited these behaviors.

To the extent your clients testify

### MORE ON PROVING PAIN IN NURSING HOME CASES

**Visit the Web pages below for additional information.**

**AAJ SECTION**
Professional Negligence
**www.justice.org/sections**

**AAJ LITIGATION GROUP**
Nursing Home
**www.justice.org/litgroups**

**LITIGATION PACKET**
Nursing Home Litigation: Regulations, Discovery, and Damages
**www.justice.org/litigationpackets**

**AAJ EDUCATION PROGRAM**
2013 Annual Convention: Nursing Home Litigation Group Program
**www.PlaybackAAJ.com**

to pain and suffering, and the medical record is void of any such identification or treatments, you have established that the nursing home failed to identify, document, and treat the resident's pain. Therefore, the resident routinely experienced pain that went untreated.

With regard to suffering, ask your clients to describe what the wound looked and smelled like. You should also always ask the nurses this—you may be surprised with some of the answers you get. Finally, ask your clients to discuss dignity issues, such as incontinence and how long it took the nursing staff to provide incontinence care.

Don't wait until your experts testify at trial to establish pain and suffering. The pain and suffering testimony you elicit from the defendant's employees and your client will be invaluable at deposition and especially at trial. Confront the lack of documentation on day one by establishing that "if it was not documented, it was not done." Defendants may try to take that position to explain holes in the nursing staff's documentation and then fight against it when it comes to pain, but you can prevent them from getting away with it.




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**Notes**

1. This approach is based on Rick Friedman and Patrick Malone, *Rules of the Road: A Plaintiff Lawyer's Guide to Proving Liability* (2d ed., Trial Guides 2010).
2. 42 C.F.R. §483 (1987).
3. 42 C.F.R. §483.25(c).
4. 42 C.F.R. §483.20.
5. 42 C.F.R. §483.25 (interpretive guidelines).
6. *Id.*
7. 42 C.F.R. §483.25(c) (interpretive guidelines).
8. *Id.*
9. Kimberly S. Reynolds et al., *Disparities in Pain Management Between Cognitively Intact and Cognitively Impaired Nursing Home Residents*, 35 J. Pain & Symptom Mgt. 388 (2008).
10. Patricia M. Mezinskis et al., *Assessment of Pain in the Cognitively Impaired Older Adult in Long-Term Care,* 25 Geriatric Nursing 107 (2004).
11. Karen S. Feldt et al., *Treatment of Pain in Aggressive Cognitively Impaired Older Adults*, 24 J. Am. Geriatric Socy. 14 (1998).
12. *Id.*
13. *Capelouto v. Kaiser Found. Hosps.*, 7 Cal. 3d 889 (1972).