Assessment & Prevention of Pain
Policy and Procedure

1.0 Objective

To maintain each resident's right to have pain prevented or controlled adequately.

2.0 Policies

2.1 All residents will have an admission assessment screen to determine need for pain control.

2.1.1 The entire interdisciplinary team will determine care plan needs based on an assessment.
2.1.2 The RN Care Manager (RCM) will be responsible for ensuring the assessment and care plan have been completed.
2.1.3 Pain monitoring will be initiated on admission for a minimum of 4 days.
2.1.4 A Comprehensive Assessment will be performed by day 5.

2.2 Assessment to determine the effectiveness of care plan interventions will be conducted quarterly (at a minimum) when it is reported by facility staff, the resident or significant others that interventions are ineffective and with each change of condition.

2.3 These policies are part of orientation and staff will be inserviced annually.

2.4 Residents with acute pain will be assessed (through interviews) at least twice per shift so pain medications can be administered and documented.

2.5 Complaints of pain and need for medication above resident goal will be considered a “STAT” (immediate) intervention for administration of pain medication.

2.5.1 Frequent use of prn pain medication (more than 5 times monthly) on Long-Term residents will require assessment to determine if a routine medication or change in a routine medication should be considered and ordered.

3.0 Procedures

3.1 The guidelines for documentation of assessment of pain are as follows:

3.1.1 Description of pain to include intensity, usual time of occurrence and exact location.
3.1.2 Related diagnosis, conditions or other factors related to or possibility causing pain.
3.1.3 Interview of the resident and/or family member.
3.1.4 Past and current methods to treat and their effectiveness.
3.1.5 The over-all effect that pain has on the resident's psychosocial, Activity, ADL and nutritional status.
3.1.6 Health referrals needed and future plans
3.1.7 Resident goal for Management
3.1.8 The assessment will determine how frequently the resident’s pain will be monitored – if acute pain at least every shift; if chronic at least quarterly once appropriate pain management has been identified; and with each condition change.

3.2 Documentation in the clinical record will occur on admission as part of the MDS and CAA’s and quarterly (at a minimum) thereafter.

3.2.1 The entire team will address a resident’s pain status.

3.3 Ineffectiveness of pain management based on resident, staff or family reports will be treated as a change of status and will include the following:

3.3.1 Documentation of the 24 hour report to alert the RCM.
3.3.2 Implementation of alert charting.
3.3.3 Social Service (SS) referral.
3.3.4 Assessment by the RCM and SS to determine further needs or new interventions.

3.4 Non-Pharmacological alternatives for pain control will reviewed and attempted per resident preferences and assessment.

3.5 A Quality Assurance and Performance Improvement (QAPI) measure will be examined by the QAPI committee quarterly.

3.5.1 Residents will be chosen randomly from the Casper report and reviewed to ensure compliance with policies and procedures.
Pain Assessment Instructions

Pain Screening: Complete this section as part of the admissions process

Overall Objectives

- To determine whether pain is present not or had been present in the last 5 days
- To determine necessary monitoring

Pain related diagnoses (check all that apply)

Review the list of pain-related diagnoses against the information provided by the sending or referral source (e.g. hospital transfer form, etc.). Check all that apply and add information as necessary.

Note any pain-related diagnoses, and ask the resident the next two questions using those diagnoses as a guide. For example, "I see that you have arthritis. Tell me if that causes you any discomfort or affects your ability to do what you want to do."

1. Do you have any pain or hurting anywhere now?
   - Whether yes or no, go on to question 2.

2. Have you had any pain or hurting in the last 5 days?
   - If “yes,” to either, initiate a pain monitoring schedule
   - If “no,” to both questions, and there are no pain-related diagnoses checked pain monitoring may not be necessary. Use your clinical judgment to determine if it is necessary to initiate a pain monitoring schedule.

Sign and date the form.

Comprehensive Pain Assessment: Complete this section with the Admission assessment and as an option with each assessment based on resident needs and changes

Overall Objectives

- To evaluate the effectiveness of a resident’s pain management plan since their admission or last assessment
- To complete a complete a comprehensive assessment of critical pain factors
- To determine a person-centered pain management goal

Section I. Staff assessment of pain monitoring data

Begin by reviewing all pain monitoring data (MAR, PRN sheet, staff observations, resident self-report, etc.) available for this resident and document your findings here. Use the data to inform your clinical judgment about the effectiveness of the current pain management plan for this resident.

Section II. Pain assessment interview

The pain assessment interview begins by repeating the initial screening questions, as the resident’s pain issues may have changed since admission. You must attempt these questions with the resident and/or the resident’s representative.
1. Do you have any pain or hurting anywhere now?
   - Whether yes or no, go on to question 2.
2. Have you had any pain or hurting in the last 5 days?
   - If "yes," go to question 3.
   - If "no," go to Section III, Staff observations for pain, and complete the section.
     - If none of these signs is observed, go to Section IV, Resident and staff goal(s) for pain management. Add other comments, sign and date the form, and update the care plan with any new information as needed.
     - If one or more signs are observed, note this, then go to Section IV, Resident and staff goal(s) for pain management. Add other comments, sign and date the form, continue monitoring and treating pain as needed; update care plan.
3. When you have pain, where is it?
   - Check all that apply.
4. Tell me what the pain feels like.
   - Check all that apply. If none of the words provided describes the pain, ask resident and document the resident’s actual words in “Other.” Indicate whether the pain radiates or is localized by circling “R” or “L.”
5. How would you rate the intensity of your pain during the last 5 days?
   - Based on the resident’s preferred pain scale, indicate the resident’s rating for the pain he or she is experiencing now or during past 5 days.
6. How much of the time have you experienced pain or hurting since your admission or the last time we talked about pain?
   - Ask the resident to think back over the time interval and tell you how much of that time he or she was in pain.
7. When you have pain, when is it worst?
   - Ask the resident whether he or she notices that pain is worse during different parts of the day and document the time.
8. How does your pain affect your everyday life?
   - Check all that apply. Ask whether pain has other effects that were not mentioned and document them after “Other.”
9. What medications have relieved your pain in the past?
   - Ask the resident what prescription and over-the-counter drugs have been helpful in managing their pain. Note whether these are the same or different from the medications they are currently using.
10. What nondrug approaches make your pain better?
    - Ask the resident what nondrug approaches have relieved their pain. Check all that apply. Ask whether any other approaches make their pain better and document them after “Other.”
11. What makes your pain worse?
    - Ask the resident what makes their pain worse. Check all that apply. Ask whether other factors make their pain worse and document them after “Other.”
12. Since your admission, how well has your pain been managed?
    - Determine whether pain treatment is aligned with goal, timely, and effective.
13. What is your goal for pain control in terms of function?
    - Check all that apply. Give examples if necessary: “Sleep for 4–5 hours at a stretch”; “Be able to visit with family and friends.”

What is your goal for controlling the intensity of your pain?
- Based on the same pain scale used for question 4, ask what the resident’s goal is for managing the intensity of his or her pain.
III. Staff observations for pain
   Complete this section for all residents. Use the categories to inform your clinical judgment about whether or not pain is present for residents who are nonresponsive or who deny pain. Consider utilizing a non-verbal assessment tool such as the PainAD tool.

IV. Resident and staff goal(s) for pain management
   Complete this section. Update the care plan.

V. Pain assessment interview attempted but not completed
   If the resident is rarely or never understood or is nonresponsive, and if a family member or other representative is not available, check the applicable box, then go to Section VI.

VI. Pain management goal for nonverbal resident
   Check the appropriate box for who determined the pain management goal. Complete this section, then sign and date the form. Update the care plan.

VII. Education
   Complete pain education provided; document date provided and by whom.

Jointly developed by Acumenra Health and Haffenreffer & Associates, with support from the Oregon Pain Management Commission.

This material was prepared by Acumenra Health, Oregon’s Medicare Quality Improvement Organization, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.
Pain—Admission Screening and Comprehensive Assessment

Resident Name: ____________________________ DOB: __________________
Date: ____________________ Time: ________________ □ New admission □ Re-admission □ Other________

Pain Screening (you must attempt the interview questions with the resident and/or their representative)

1. Do you have pain or hurting anywhere now? □ Yes □ No 2. Have you had any pain or hurting in the last 5 days? □ Yes □ No

Pain-related diagnoses (check all that apply)

□ AIDS □ CVA/post stroke □ Lower back disorder □ Other musculoskeletal □ Amputation □ Dental problems □ Neuropathy □ Unspecified □ Arthritis □ Fracture □ Osteoporosis/osteopenia □ Other (describe): □ Cancer □ Gout □ Postoperative □ Compression fractures □ Headache □ Pressure ulcers/skin lesions □ Contractures □ Joint replacement/pinning □ Shingles

Signature ____________________________ Date ____________

Comprehensive Pain Assessment

I. Staff assessment of pain monitoring data collected since admission or last MDS

Review the MAR, PRN sheet, resident’s self-report of pain location, quality, and intensity, resident’s self-report of pain relief obtained through drug and nondrug interventions.

II. Pain assessment interview (you must attempt the interview questions with the resident and/or representative)

1. Do you have pain or hurting anywhere now? □ Yes □ No
2. Have you had any pain or hurting in the last 5 days? □ Yes □ No
3. When you have pain, where is it? (check all that apply)

□ Back pain □ Hip pain □ Neck pain
□ Bone pain □ Incisional pain □ Stomach pain
□ Chest pain with usual activities □ Joint pain (not hip) □ Unspecified
□ Headache □ Muscle pain □ Other (describe): ________________________________

4. Tell me what the pain feels like. (check all that apply; circle R for radiating or L for localized)

□ Aching R L □ Numbing R L □ Stabbing R L □ Other (describe):
□ Burning R L □ Pressure R L □ Throbbing R L □ R L
□ Crushing R L □ Prickling R L □ Tingling R L □ L
□ Dull R L □ Sharp R L □ Tender R L
□ Gnawing R L □ Sore R L □ Uncomfortable R L

5. How would you rate the intensity of your pain now or during the last 5 days? (indicate which scale was used)

□ Numeric scale 1–10: ______ □ Numeric scale 1–5: ______ □ Faces scale: ________ □ Verbal descriptor: ______

6. How much of the time have you experienced pain or hurting in the last 5 days? (check one)

□ Almost constantly □ Daily or several times a day □ Less than daily □ Rarely □ Unable to answer

7. When you have pain, when is it the worst? (check all that apply)

□ Early morning □ Mid-morning □ Afternoon □ Late evening □ Night

8. How does your pain affect your everyday life? (check all that apply)

□ Sleep □ Therapy or activities of choice □ Interaction with other people □ Other: ____________________________
□ Appetite □ Concentration □ Ability to bathe, groom, dress self □ Nausea □ Emotions

OVER →
Comprehensive Pain Assessment (continued)

9. What medications have relieved your pain in the past? ______________________________________________________________________

10. What nondrug approaches make your pain better?

☐ Warm packs ☐ Cold packs ☐ Repositioning ☐ Rest
☐ Breathing and relaxation ☐ Exercise ☐ Other (describe): ____________________________
☐ Distraction ☐ Massage

11. What makes your pain worse? (check all that apply)

☐ Physical activity/exercises ☐ Bathing ☐ Feeling anxious
☐ Dressing changes ☐ Rising from a chair, bed ☐ Other (describe): ______________________
☐ Turning/Repositioning ☐ Feeling fatigued

12. Since admission or the last MDS, how well has your pain been managed? (check one)

☐ Very poorly ☐ Poorly ☐ Moderately ☐ Well ☐ Very well

Add additional comments from the resident here: _______________________________________________________________________

13. What level of pain relief would you be satisfied with, in terms of function and intensity of pain? (indicate which scale was used)

☐ Sleep comfortably ☐ Rest comfortably ☐ Move comfortably ☐ Stay alert ☐ Perform activities
☐ Total pain control ☐ Other: __________________________

☐ Numeric scale 1–10: _______ ☐ Numeric scale 1–5: _______ ☐ Faces scale: _______ ☐ Verbal descriptor: _______

III. Staff observations for pain (check all that apply)

☐ Nonverbal sounds (crying, whining, gasping, moaning, groaning)
☐ Vocal complaints of pain ("that hurts," "ouch," "stop")
☐ Facial expressions (grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw)
☐ Protective body movements or postures (bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement) or behaviors (yelling, resisting care, etc.)
☐ None of these signs observed

IV. Resident and staff goal(s) for pain management & recommendations:

Examples: Walk comfortably to dining room for evening meal; participate in 30 minutes of PT twice daily, pain 3–4 on a 10-point scale

☐ Continue with current plan ☐ Update current plan of care

V. Pain assessment interview attempted but not completed (check all that apply)

☐ Staff are never or rarely able to understand resident’s speech ☐ Resident is nonresponsive
☐ Resident does not have a representative available at this time

VI. Pain management goal for nonverbal resident ☐ Determined by staff ☐ Determined by resident’s representative

VII. Pain Education – the following has been discussed with Resident and/or family: Completed on_______________ by ______________

General Overview of pain & pain management: ☐ Fear of addiction; ☐ Concerns about side effects; ☐ Fear of injections;
☐ Desire to be stoic; ☐ Desire to be a “good patient.” ☐ Medications; ☐ Non-med interventions; ☐ Side effects of interventions;
☐ Effectiveness of interventions; ☐ Other (state): __________________________

Further Comments: ______________________________________________________________________

☐ Continue with current plan ☐ Update current plan of care ☐ Other (state): __________________________

Completed by __________________________ Date __________________________

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Pain Assessment Narrative

General Instructions

This assessment should be performed on all residents complaining of pain and on residents with behaviors in order to rule out pain.

If the resident and/or family are unable to be interviewed use the PainAd tool in addition to any narrative notes based on your observations and interview of staff.

Conduct this assessment quarterly

Goals

To determine if the resident is having pain, the cause(s) and the best treatments both pharmacological and non-pharmacological.

Guidelines

1. Characteristics of pain:
   - What makes it better / worse,
   - Describe the frequency (words used to describe),
   - Intensity (1-10 or mild, moderate, severe, excruciating),
   - Type (intermittent, varies over time),
   - General location pain occurs,
   - Examine location

2. Diseases and diagnosis that could cause pain.

3. Does the resident have any non-verbal indicators of pain.

4. Any effects on daily function such as sleep, activities, activities of daily living, mood, appetite.

5. What are the resident’s goals for pain relief? (This can then become a service plan goal).

6. Other considerations:
   - Increase use of prn medications
   - Medications do not seem effective
   - Behaviors

7. Plan: Treatment changes, Update care / service plan.
Pain Assessment Narrative

CAA 19 Pain triggers as resident is currently experiencing acute pain in left back and leg due to recent fall – see nursing progress notes 8/16/12. Fracture of leg has been ruled out, but does have a possible new fracture of lumbar spine – see X-rays 8/17/12 and physician progress notes for same date. He describes pain as stabbing and radiates down left leg. Having some difficulty walking greater than 20 feet and he has been limiting his activity attendance – loved walking outdoors and attending exercise classes. Physician has ordered therapy referrals – awaiting evaluation results. He is now on routine pain medications and prn meds – see MAR for look back period. He is also using ice which he says is helpful. His current goals for pain management are to participate in therapy and attend his favorite activities – feels he can handle a pain level of 3 to 4. If not controlled at that level he requires more medications and does not like feeling lethargic. Routine pain medication is currently effective at maintaining goals, however with therapy he may require prn medication prior to treatment. He fears chronic pain related to recent injury. Will proceed to care plan to address pain issues, ensure staff monitoring of pain, and to monitor results from therapy. Will reevaluate after therapy treatment has completed or with changes.
Pain Assessment Updates

Interview
Do you have pain or hurting anywhere now?   ___Yes   ___No
Have you had any pain or hurting in the last five days?   ___Yes   ___No
How well has your pain been managed? ___Very poorly ___Poorly ___Moderately ___Well ___Very well
Other interview results ____________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Review of pain monitoring and prn use (as applicable) __________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Assessment and Plan _______________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Signature __________________________________________ Date ____________

Interview
Do you have pain or hurting anywhere now?   ___Yes   ___No
Have you had any pain or hurting in the last five days?   ___Yes   ___No
How well has your pain been managed? ___Very poorly ___Poorly ___Moderately ___Well ___Very well
Other interview results ____________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Review of pain monitoring and prn use (as applicable) __________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Assessment and Plan _______________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Signature __________________________________________ Date ____________

Resident Name __________________________________________ Room ____________
Interview
Do you have pain or hurting anywhere now? ___Yes ___No
Have you had any pain or hurting in the last five days? ___Yes ___No
How well has your pain been managed? ___Very poorly ___Poorly ___Moderately ___Well ___Very well

Other interview results


Review of pain monitoring and prn use (as applicable)


Assessment and Plan


Signature_____________________________ Date________________


Interview
Do you have pain or hurting anywhere now? ___Yes ___No
Have you had any pain or hurting in the last five days? ___Yes ___No
How well has your pain been managed? ___Very poorly ___Poorly ___Moderately ___Well ___Very well

Other interview results


Review of pain monitoring and prn use (as applicable)


Assessment and Plan


Signature_____________________________ Date________________


Resident Name_________________________________________ Room__________
Pain Assessment IN Advanced Dementia
PAINAD

Item definitions

Breathing

1. **Normal breathing.** DESCRIPTION: Normal breathing is characterized by effortless, quiet, rhythmic (smooth) respirations.

2. **Occasional labored breathing.** DESCRIPTION: Occasional labored breathing is characterized by episodic bursts of harsh, difficult or wearing respirations.

3. **Short period of hyperventilation.** DESCRIPTION: Short period of hyperventilation is characterized by intervals of rapid, deep breaths lasting a short period of time.

4. **Noisy labored breathing.** DESCRIPTION: Noisy labored breathing is characterized by negative sounding respirations on inspiration or expiration. They may be loud, gurgling, wheezing. They appear strenuous or wearing.

5. **Long period of hyperventilation.** DESCRIPTION: Long period of hyperventilation is characterized by an excessive rate and depth of respirations lasting a considerable time.

6. **Cheyne-Stokes respirations.** DESCRIPTION: Cheyne-Stokes respirations are characterized by rhythmic waxing and waning of breathing from very deep to shallow respirations with periods of apnea (cessation of breathing).

Negative Vocalization

1. **None.** DESCRIPTION: None is characterized by speech or vocalization that has a neutral or pleasant quality.

2. **Occasional moan or groan.** DESCRIPTION: Occasional moaning is characterized by mournful or murmuring sounds, wails or laments. Groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.

3. **Low level speech with a negative or disapproving quality.** DESCRIPTION: Low level speech with a negative or disapproving quality is characterized by muttering, mumbling, whining, grumbling, or swearing in a low volume with a complaining, sarcastic or caustic tone.

4. **Repeated troubled calling out.** DESCRIPTION: Repeated troubled calling out is characterized by phrases or words being used over and over in a tone that suggests anxiety, uneasiness, or distress.

5. **Loud moaning or groaning.** DESCRIPTION: Loud moaning is characterized by mournful or murmuring sounds, wails or laments in much louder than usual volume. Loud groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.

6. **Crying.** DESCRIPTION: Crying is characterized by an utterance of emotion accompanied by tears. There may be sobbing or quiet weeping.

**Facial Expression**

1. **Smiling or inexpressive.** DESCRIPTION: Smiling is characterized by upturned corners of the mouth, brightening of the eyes and a look of pleasure or contentment. Inexpressive refers to a neutral, at ease, relaxed, or blank look.

2. **Sad.** DESCRIPTION: Sad is characterized by an unhappy, lonesome, sorrowful, or dejected look. There may be tears in the eyes.

3. **Frightened.** DESCRIPTION: Frightened is characterized by a look of fear, alarm or heightened anxiety. Eyes appear wide open.

4. **Frown.** DESCRIPTION: Frown is characterized by a downward turn of the corners of the mouth. Increased facial wrinkling in the forehead and around the mouth may appear.

5. **Facial grimacing.** DESCRIPTION: Facial grimacing is characterized by a distorted, distressed look. The brow is more wrinkled as is the area around the mouth. Eyes may be squeezed shut.

**Body Language**

1. **Relaxed.** DESCRIPTION: Relaxed is characterized by a calm, restful, mellow appearance. The person seems to be taking it easy.

2. **Tense.** DESCRIPTION: Tense is characterized by a strained, apprehensive or worried appearance. The jaw may be clenched. (exclude any contractures)

3. **Distressed pacing.** DESCRIPTION: Distressed pacing is characterized by activity that seems unsettled. There may be a fearful, worried, or disturbed element present. The rate may by faster or slower.

4. **Fidgeting.** DESCRIPTION: Fidgeting is characterized by restless movement. Squirming about or wiggling in the chair may occur. The person might be hitching a chair across the room. Repetitive touching, tugging or rubbing body parts can also be observed.

5. **Rigid.** DESCRIPTION: Rigid is characterized by stiffening of the body. The arms and/or legs are tight and inflexible. The trunk may appear straight and unyielding. (exclude any contractures)

6. **Fists clenched.** DESCRIPTION: Fists clenched is characterized by tightly closed hands. They may be opened and closed repeatedly or held tightly shut.

7. **Knees pulled up.** DESCRIPTION: Knees pulled up is characterized by flexing the legs and drawing the knees up toward the chest. An overall troubled appearance. (exclude any contractures)

8. **Pulling or pushing away.** DESCRIPTION: Pulling or pushing away is characterized by resistiveness upon approach or to care. The person is trying to escape by yanking or wrenching him or herself free or shoving you away.

9. **Striking out.** DESCRIPTION: Striking out is characterized by hitting, kicking, grabbing, punching, biting, or other form of personal assault.

**Consolability**

1. **No need to console.** DESCRIPTION: No need to console is characterized by a sense of well being. The person appears content.

2. **Distracted or reassured by voice or touch.** DESCRIPTION: Distracted or reassured by voice or touch is characterized by a disruption in the behavior when the person is spoken to or touched. The behavior stops during the period of interaction with no indication that the person is at all distressed.

3. **Unable to console, distract or reassure.** DESCRIPTION: Unable to console, distract or reassure is characterized by the inability to soothe the person or stop a behavior with words or actions. No amount of comforting, verbal or physical, will alleviate the behavior.

Pain Assessment in Advanced Dementia (PAINAD)

**Instructions:** Put the appropriate score for each category in the “Total” column; then add the scores.

Use the scoring key to interpret the total score in terms of MDS Section J0600B.

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<th>2</th>
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<td>Occasional labored breathing, short</td>
<td>Noisy labored breathing, long periods</td>
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<td></td>
<td></td>
<td>periods of hyperventilation</td>
<td>of hyperventilation, Cheyne-Stokes</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>respiration</td>
<td></td>
</tr>
<tr>
<td>Negative vocalization</td>
<td>None</td>
<td>Occasional moan or groan, low-level</td>
<td>Repeated troubled calling out, loud</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>speech with negative, disapproving</td>
<td>moaning or groaning, crying</td>
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<td>quality</td>
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<tr>
<td>Facial expression</td>
<td>Smiling or</td>
<td>Sad, frightened, frowning</td>
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<td>Body language</td>
<td>Relaxed</td>
<td>Tense, distressed, pacing, fidgeting</td>
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<td>Consolability</td>
<td>No need to console</td>
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<td>Moderate Pain</td>
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<td>Severe pain</td>
<td>7–8</td>
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<td>9-10</td>
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<td>pain monitor for all new admissions every 4 hours while awake for 5 days using number or verbal scale</td>
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<td>0-no pain</td>
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<td>8-10 very severe/horrible</td>
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<td>document response to pain medications per pink pain sheets and stools in med books</td>
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</tr>
<tr>
<td>ask resident and if unable to respond use clinical signs to assess pain</td>
<td></td>
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<tr>
<td>(facial expressions, crying, restlessness, moaning, refuse care)</td>
<td></td>
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<tr>
<td>use PAINAD</td>
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<tr>
<td>once pain stable pain monitor every shift unless otherwise determined by RCM</td>
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</tr>
</tbody>
</table>

RESIDENT NAME ___________________________ DATE ________________ ROOM _______________
Quality Scorecard
Pain Management Program

Standards

1. Prescreening is performed prior to admission (2 points)

2. Pain screening is performed within 8 hours of admission & readmission (2 points)

3. Pain screen questions – Do you have pain? Have you had pain in past 5 days? (2 points)

4. Pain monitoring for 7-14 days based on answers to pain screen questions (2 points)

5. Pain monitoring is more than once per shift (2 points)

6. Pain is comprehensively assessed by midnight of the 14th day (2 points)

7. Comprehensive assessment includes the following: (14 points = 1 per item)
   a. Pain related diagnoses
   b. Trending of pain monitor
   c. Resident and/or family interview
   d. Intensity of pain
   e. Location of pain
   f. Quality of pain
   g. Frequency and duration of pain
   h. History
   i. What makes it better and what makes it worse
   j. Effects of pain on ADL’s, sleep, mobility, mood, activity
   k. Resident goal for pain management
   l. Staff observations
   m. Methods for identifying pain in non-verbal or impaired resident
   n. Pain scale that is consistently used

8. The comprehensive assessment is conducted a minimum of quarterly & with resident changes (2 points)

9. A person-centered care plan is developed with person-centered goals (2 points)

10. Training programs and information available for staff, residents family members (6 points = 3 per item)
    a. Staff is able to articulate pain management principles and facility program

11. Pain treatments are delivered as STAT when a resident has pain (2 points)

12. Non-pharmacological interventions are considered and/or attempted (2 points)

(Possible 40 points) Score Total
1 - 10 = poor; 11 - 15 = below average; 15 - 20 = average; 21 - 30 = above average; 31 - 40 = excellent

Quality Improvement Plan

Analysis

___________________________________________________________

___________________________________________________________

___________________________________________________________

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___________________________________________________________

Plan

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Reviewer ___________________________ Date __________________
Pain Management Chart Audit

Reviewer: ___________________________ Date(s) Reviewed: ____________ / ____________, 20______

Directions: Put a “check” in a box if intervention done, an “x” if not done or documentation not clear, and leave blank if intervention not applicable.

<table>
<thead>
<tr>
<th>Care Practices</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Was the resident screened for pain using an appropriate screening tool*</td>
<td></td>
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<tr>
<td>a. Within 24 hrs of admission or move-in?</td>
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<tr>
<td>b. Within 24 hours of readmission?</td>
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<tr>
<td>c. With any change in condition or increase in pain symptoms?</td>
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<tr>
<td>d. At each MDS assessment?</td>
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<tr>
<td>2. If pain was present at screening, was there a pain assessment that documented</td>
<td></td>
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</tr>
<tr>
<td>a. Intensity of pain?</td>
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<tr>
<td>b. Location of pain?</td>
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<tr>
<td>c. Quality of the pain?</td>
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<tr>
<td>d. Frequency and duration of pain?</td>
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<tr>
<td>e. Hx of what makes pain better?</td>
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<tr>
<td>f. Hx of what makes pain worse?</td>
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<tr>
<td>g. Effects of pain on ADLs, sleep, mobility, and mood?</td>
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<tr>
<td>h. What was important TO the resident in managing his/her pain?</td>
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<tr>
<td>3. If pain medication was indicated, was the resident’s medication appropriate for cause, type, and intensity based on clinically accepted guidelines (e.g., WHO three-step analgesia ladder)?</td>
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</tr>
<tr>
<td>a. Were orders for pain medication received within 24 hours of identifying pain?</td>
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<tr>
<td>4. If pain was present, does the plan of care include</td>
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</tr>
<tr>
<td>a. A measurable pain management goal defined by the resident/family member or care team?</td>
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<tr>
<td>b. Routine pain medication?</td>
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<tr>
<td>c. PRN pain medication for breakthrough pain?</td>
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<tr>
<td>d. Routine non-drug pain treatment (e.g., heat or cold, massage, distraction)?</td>
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<tr>
<td>e. A schedule for monitoring the effects of pain management interventions at appropriate intervals?</td>
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<tr>
<td>f. Interventions for handling expected side effects (e.g., constipation)?</td>
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<tr>
<td>5. If pain management goal was not met, did the care team</td>
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<tr>
<td>a. Increase the frequency or dose of currently ordered pain medications?</td>
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<tr>
<td>b. Add complimentary therapy to current pain treatments?</td>
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<tr>
<td>c. Use WHO 3-step analgesia ladder to select new class of medication?</td>
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<tr>
<td>d. Conduct a comprehensive pain re-assessment?</td>
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<tr>
<td>e. Communicate with the resident’s health care provider?</td>
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<tr>
<td>6. If pain was present, did the resident have a diagnosis for its underlying cause?</td>
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</tbody>
</table>

*This material was prepared by Acumenira Health, Oregon’s Medicare Quality Improvement Organization, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

850W-OR-NH-07-02
1/26/07
Use

- Use this protocol to determine whether the facility has provided, and the resident has received care, and services to address and manage the resident’s pain in order to support his or her highest practicable level of physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.
- Use this protocol for a resident who has pain symptoms or who has the potential for pain symptoms related to conditions or treatments. This includes a resident:
  - Who states he/she has pain or discomfort,
  - Who displays possible indicators of pain that cannot be readily attributed to another cause;
  - Who has a disease or condition or who receives treatments that cause or can reasonably be anticipated to cause pain;
  - Whose assessment indicates that he/she experiences pain;
  - Who receives or has orders for treatment for pain; and/or
  - Who has elected a hospice benefit for pain management.

NOTE: If dental concerns were identified in Stage 1, the Dental care area must be initiated and completed.

Procedure

- Briefly review the care plan and orders to identify any current pain management interventions and to focus observations.
- Corroborate observations by interview and record review.

NOTE: Determine who is involved in the pain management process (for example, the staff and practitioner, and/or another entity such as a licensed/certified hospice).
## Pain Recognition and Management Critical Element Pathway

**Observations**

<table>
<thead>
<tr>
<th>Observations</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observe to determine:</td>
<td></td>
</tr>
<tr>
<td>☐ If the resident exhibits signs or symptoms of pain, verbalizes the presence of pain, or requests interventions for pain, or whether the pain appears to affect the resident’s function or ability to participate in routine care or activities;</td>
<td></td>
</tr>
<tr>
<td>☐ If there is evidence of pain, whether staff have assessed the situation, identified, and implemented interventions to try to prevent or address the pain, and have evaluated the status of the resident’s pain after interventions;</td>
<td></td>
</tr>
<tr>
<td>☐ If care and services are being provided that reasonably could be anticipated to cause pain, whether staff have identified and addressed these issues, to the extent possible;</td>
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<tr>
<td>☐ Staff response, if there is a report from the resident, family, or staff that the resident is experiencing pain;</td>
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<tr>
<td>☐ If there are pain management interventions for the resident, whether the staff implements them. Follow up on:</td>
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<tr>
<td>▪ Deviations from the care plan;</td>
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<tr>
<td>▪ Whether pain management interventions have a documented rationale and if it is consistent with current standards of practice;</td>
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<tr>
<td>▪ Potential adverse consequence(s) associated with treatment for pain (e.g., medications); and</td>
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</tr>
<tr>
<td>▪ How staff responded if the interventions implemented did not reduce the pain consistent with the goals for pain management.</td>
<td></td>
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</tbody>
</table>
### Pain Recognition and Management Critical Element Pathway

#### Interviews

<table>
<thead>
<tr>
<th>Resident/Representative Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview the resident or representative to the degree possible to identify:</td>
</tr>
<tr>
<td>- The resident's/representative's involvement in the development of the care plan, defining the approaches and goals, and if the interventions reflect choices and preferences, and how they are involved in developing and revising pain management strategies; revisions to the care plan if the interventions do not work.</td>
</tr>
<tr>
<td>- If the resident is presently or periodically experiencing pain, determine:</td>
</tr>
<tr>
<td>- Characteristics of the pain, including the intensity, type (e.g., burning, stabbing, tingling, aching), patterns of pain (e.g., constant or intermittent), location, radiation of pain, and frequency, timing and duration of pain;</td>
</tr>
<tr>
<td>- Factors that may precipitate or alleviate the pain;</td>
</tr>
<tr>
<td>- How the resident typically has expressed pain and responded to various interventions in the past;</td>
</tr>
<tr>
<td>- Who the resident and/or representative has told about the pain/discomfort, and how the staff responded;</td>
</tr>
<tr>
<td>- What treatment options (pharmacological and/or non-pharmacological) were discussed and attempted;</td>
</tr>
<tr>
<td>- How effective the interventions have been; and</td>
</tr>
<tr>
<td>- If interventions have been refused, whether there was a discussion of the potential impact on the resident, and whether alternatives or other approaches were offered.</td>
</tr>
</tbody>
</table>

| Notes: |
### Pain Recognition and Management Critical Element Pathway

#### Staff Interviews

**Nurse Aide(s) Interview**

Interview staff who provide direct care on various shifts to determine:

- [ ] If they are aware of a resident’s pain complaints or of signs and symptoms that could indicate the presence of pain;
- [ ] To whom they report the resident’s complaints and signs or symptoms; and
- [ ] If they are aware of and implement interventions for pain/discomfort management for the resident consistent with the resident’s plan of care (for example, allowing a period of time for a pain medication to take effect before bathing and/or dressing).

<table>
<thead>
<tr>
<th>Notes:</th>
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</table>
Pain Recognition and Management Critical Element Pathway

### Assessment

Review information such as orders, medication administration records, multidisciplinary progress notes, the RAI/MDS, and any specific assessments regarding pain that may have been completed. Determine whether the information accurately and comprehensively reflects the resident’s condition, such as:

- Identifies the pain indicators and the characteristics, causes, and contributing factors related to pain;
- Identifies a history of pain and related interventions, including the effectiveness and any adverse consequences of such interventions;
- Identifies the impact of pain on the resident’s function and quality of life; and
- Identifies the resident’s response to interventions, including efficacy and adverse consequences and any modification of interventions as indicated.

Determine whether there was a "significant change" in the resident's condition and whether the facility conducted a significant change comprehensive assessment within 14 days. A "significant change" is a decline or improvement in a resident's status that:

1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not "self-limiting"
2. Impacts more than one area of the resident's health status; and
3. Requires interdisciplinary review and/or revision of the care plan.

If there was a "significant change" in the resident's condition and the facility did not conduct a significant change comprehensive assessment within 14 days, initiate **F274, Resident Assessment When Required**. If a comprehensive assessment was not conducted, also cite F272.

| Notes: |  |
Pain Recognition and Management Critical Element Pathway

Assessment

1. Did the facility comprehensively assess the resident’s physical, mental, and psychosocial needs to identify characteristics and/or to determine underlying causes (to the extent possible) of the resident’s pain and the impact of the pain upon the resident’s function, mood, and cognition?  
   ☐ Yes  ☐ No  F272

☐ NA, condition/risk identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS

NOTE: Although Federal requirements dictate the completion of RAI assessments according to certain time frames, standards of good clinical practice dictate that the assessment process is more fluid and should be ongoing.

The comprehensive assessment is not required to be completed until 14 days after admission. For newly admitted residents, before the 14-day assessment is complete, the lack of sufficient assessment and care planning to meet the resident’s needs should be addressed under F281, Professional Standards of Quality.
**Pain Recognition and Management Critical Element Pathway**

**Care Planning**

*If the comprehensive assessment was not completed (CE#I = No), mark CE#2 “NA, the comprehensive assessment was not completed”.*

Review the care plan to determine whether pain management interventions include, as appropriate:

- [ ] Measurable pain management goals, reflecting resident needs and preferences;
- [ ] Pertinent non-pharmacological and/or pharmacological interventions;
- [ ] Time frames and approaches for monitoring the status of the resident’s pain, including the effectiveness of the interventions; and
- [ ] Identification of clinically significant medication-related adverse consequences, such as falling, constipation, anorexia, or drowsiness, and a plan to try to minimize those adverse consequences.

**NOTE:** If the care plan refers to a specific facility pain management protocol, determine whether interventions are consistent with that protocol. If a resident’s care plan deviates from the protocol, determine through staff interview or record review the reason for the deviation.

- [ ] If the resident has elected a hospice benefit, all providers must coordinate their care of the resident. This care includes aspects of pain management, such as:
  - Choice of palliative interventions;
  - Responsibility for assessing pain and providing interventions; and
  - Responsibility for monitoring symptoms and adverse consequences of interventions and for modifying interventions as needed.

**Notes:**
2. Did the facility develop a plan of care with measurable goals and interventions to prevent (to the extent possible) or manage the resident's pain in accordance with the assessment, the resident's/patient's input, and current standards of practice?  

☐ Yes  ☐ No  F279

NA, the comprehensive assessment was not completed within 7 days after the comprehensive assessment (the assessment completed with the C.A.S.S. tool) or sufficient care planning to meet the needs of a newly admitted resident should be addressed under F281, Professional Standards of Quality.
Pain Recognition and Management Critical Element Pathway

<table>
<thead>
<tr>
<th>Care Plan Implementation by Qualified Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observe care and interview staff over several shifts and determine whether:</td>
</tr>
<tr>
<td>☐ Care is being provided by qualified staff, and/or</td>
</tr>
<tr>
<td>☐ The care plan is adequately and/or correctly implemented.</td>
</tr>
<tr>
<td>3. Did the facility provide or arrange services to be provided by qualified persons in accordance with the resident’s written plan of care?</td>
</tr>
<tr>
<td>☐ NA, no provision in the written plan of care for the concern being evaluated</td>
</tr>
</tbody>
</table>

*NOTE: If there is a failure to provide necessary care and services, the related care issue should also be cited when there is actual or potential outcome.*

| Notes: |
Pain Recognition and Management Critical Element Pathway

<table>
<thead>
<tr>
<th>Care Plan Revision</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the comprehensive assessment was not completed (CE#1 = No), OR, if the care plan was not developed (CE#2 = No), mark CE#4 “NA, the comprehensive assessment was not completed OR the care plan was not developed”</td>
<td></td>
</tr>
<tr>
<td>Determine whether the pain has been reassessed and the care plan has been revised as necessary (with input from the resident or representative, to the extent possible). For example:</td>
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<tr>
<td>▪ The current interventions are not effective,</td>
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<tr>
<td>▪ The pain has resolved, or</td>
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<tr>
<td>▪ The resident has experienced a change of condition or status.</td>
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<tr>
<td>4. Did the facility reassess the pain and review and revise the plan of care (with input from the resident or representative, to the extent possible), if necessary, to meet the needs of the resident?</td>
<td>□ Yes □ No F280</td>
</tr>
<tr>
<td>□ NA, the comprehensive assessment was not completed OR the care plan was not developed</td>
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</table>
### Pain Recognition and Management Critical Element Pathway

**INTERVIEWS TO CONDUCT ONLY IF PROBLEMS HAVE BEEN IDENTIFIED**

**Nurse Interview**

Interview a nurse who is knowledgeable about the needs and care of the resident to determine:

- [ ] How and when staff try to identify whether a resident is experiencing pain and/or circumstances in which pain can be anticipated;
- [ ] How the resident is assessed for pain;
- [ ] How the interventions for pain management have been developed and the basis for selecting them;
- [ ] How staff monitor for the emergence or presence of adverse consequences of interventions;
- [ ] If the resident receives routine pain medication (including PRN and adjuvant medications), how, when, and by whom the results of the medications are evaluated (including the dose, frequency of PRN use, schedule of routine medications, and effectiveness);
- [ ] What is done if pain persists or recurs despite treatment, and the basis for decisions to maintain or modify approaches;
- [ ] How staff communicate with the prescriber about the resident’s pain status, current measures to manage pain, and the possible need to modify the current pain management interventions; and
- [ ] For a resident who is receiving care under a hospice benefit, how the hospice and the facility coordinate their approaches and communicate about the resident’s needs and monitor the outcomes (both effectiveness and adverse consequences).

**Notes:**
# Pain Recognition and Management Critical Element Pathway

## Interviews to Conduct Only if Problems Have Been Identified

### Interviews with Other Health Care Professionals

If the interventions or care provided do not appear to be consistent with current standards of practice and/or the resident’s pain appears to persist or recur, interview one or more health care professionals as necessary (e.g., attending physician, medical director, consultant pharmacist, director of nursing, or hospice nurse) who, by virtue of training and knowledge of the resident, should be able to provide information about the evaluation and management of the resident’s pain/symptoms. Depending on the issue, ask about:

- How chosen interventions were determined to be appropriate;
- How they guide and oversee the selection of pain management interventions;
- The rationale for not intervening, if pain was identified and no intervention was selected and implemented;
- Changes in pain characteristics that may warrant review or revision of interventions; or
- When and with whom the professional discussed the effectiveness, ineffectiveness, and possible adverse consequences of pain management interventions.

NOTE: If during the course of this review, the surveyor needs to contact the attending physician regarding questions related to the treatment regimen, it is recommended that the facility’s staff have the opportunity to provide the necessary information about the resident and the concerns to the physician for his/her review prior to responding to the surveyor’s inquiries. If the attending physician is unavailable, interview the medical director as appropriate.

### Notes:
**Pain Recognition and Management Critical Element Pathway**

### Provision of Care and Services

<table>
<thead>
<tr>
<th>Determine whether the facility:</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Recognized and evaluated the resident who experienced pain to determine (to the extent possible) causes and characteristics of the pain, as well as factors influencing the pain;</td>
<td></td>
</tr>
<tr>
<td>□ Developed and implemented interventions for pain management for a resident experiencing pain, consistent with the resident’s goals, risks, and current standards of practice; or has provided a clinically pertinent rationale why they did not do so;</td>
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</tr>
<tr>
<td>□ Recognized and provided measures to minimize or prevent pain for situations where pain could be anticipated;</td>
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<tr>
<td>□ Monitored the effects of interventions and modified the approaches as indicated; and</td>
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<tr>
<td>□ Communicated with the health care practitioner when a resident was having pain that was not adequately managed or was having a suspected or confirmed adverse consequence related to the treatment.</td>
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</table>

5. **Based on observation, interviews, and record review, did the facility provide care and services necessary to meet the needs of the resident in order to attain or maintain the highest practicable physical, mental and psychosocial well being including the identification, treatment, monitoring, and management of pain to the extent possible in accordance with the comprehensive assessment and plan of care?** □ Yes □ No F309
### Concerns with Independent but Associated Structure, Process, and/or Outcome Requirements

During the investigation of care and services provided to prevent or manage the resident’s pain, the surveyor may have identified concerns with related structure, process, and/or outcome requirements. If an additional concern has been identified, the surveyor should initiate the appropriate care area or F tag and investigate the identified concern. Do not cite any related or associated requirements before first conducting an investigation to determine compliance or non-compliance with the related or associated requirement. Some examples include, but are not limited to the following:

<table>
<thead>
<tr>
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<th>Notes:</th>
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<tbody>
<tr>
<td><strong>F155, Rights Regarding Treatment, Experimental Research and Advance Directives</strong> — For concerns regarding the resident’s right to refuse treatment, to participate in experimental research, and to formulate an advanced directive.</td>
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</tr>
<tr>
<td><strong>Choices (the Right to Refuse Treatment)</strong> — If a resident has refused treatment or services, determine whether the facility has assessed the reason for this resident’s refusal, clarified and educated the resident as to the consequences of refusal, offered alternative treatments, and continued to provide all other services.</td>
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<tr>
<td><strong>Notification of Change</strong> — Determine whether staff:</td>
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<tr>
<td>&quot; Notified the physician when pain persisted or recurred despite treatment, or when they suspected or identified adverse consequences related to treatments for pain; and</td>
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</tr>
<tr>
<td>&quot; Notified the resident’s representative (if known) of significant changes in the resident’s condition in relation to pain management and/or the plan of care.</td>
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<tr>
<td><strong>Choices (Self-Determination and Participation)</strong> — Determine whether the facility has provided the resident with relevant choices about aspects pain management.</td>
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<tr>
<td><strong>F246, Accommodation of Needs</strong> — Determine whether the facility has adapted the resident’s physical environment (room, bathroom, furniture) to accommodate the resident’s individual needs related to pain management.</td>
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</tbody>
</table>
**Pain Recognition and Management Critical Element Pathway**

**Concerns with Independent but Associated Structure, Process, and/or Outcome Requirements**

- __pain management._

  - **F278, Accuracy of Assessments** — Determine whether staff that are qualified to assess relevant care areas and are knowledgeable about the resident’s status, needs, strengths, and areas of decline conducted an accurate assessment.

  - **F281, Professional Standards of Quality** — Determine whether care was provided in accordance with accepted standards of quality for pain management.

  - **Unnecessary Medication Review** — Determine whether medications ordered to treat pain are being monitored for effectiveness and for adverse consequences, including whether any symptoms could be related to the medications.

  - **F385, Physician Supervision** — Determine whether pain management is being supervised by a physician, including participation in the comprehensive assessment process, development of a treatment regimen consistent with current standards of practice, monitoring, and response to notification of change in the resident’s medical status related to pain.

  - **F425, Pharmacy Services** — Determine whether the medications required to manage a resident’s pain were available and administered as indicated and ordered at admission and throughout the stay.

  - **F501, Medical Director** — Determine whether the medical director:
    - Helped the facility develop and implement policies and procedures related to preventing, identifying, and managing pain, consistent with current standards of practice; and
    - Interacts with the physician supervising the care of the resident if requested by the facility to intervene on behalf of the resident with pain or one who may have been experiencing adverse consequences related to interventions to treat pain.
**Pain Recognition and Management Critical Element Pathway**

**Concerns with Independent but Associated Structure, Process, and/or Outcome Requirements**

- **F514, Clinical Records** — Determine whether the clinical records:
  - Accurately and completely document the resident’s status, the care and services provided (e.g., to prevent, to the extent possible, or manage the resident’s pain) in accordance with current professional standards and practices and the resident’s goals; and
  - Provide a basis for determining and managing the resident's progress including response to treatment, change in condition, and changes in treatment.


23 World Health Organization (WHO) pain ladder: www.who.int/cancer/palliative/painladder/en


Investigative Protocol for Pain Management

Quality of Care Related to the Recognition and Management of Pain

Objective

The objective of this protocol is to determine whether the facility has provided and the resident has received care and services to address and manage the resident’s pain in order to support his or her highest practicable level of physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Use

Use this protocol for a resident who has pain symptoms or who has the potential for pain symptoms related to conditions or treatments. This includes a resident:

- Who states he/she has pain or discomfort;
- Who displays possible indicators of pain that cannot be readily attributed to another cause;
- Who has a disease or condition or who receives treatments that cause or can reasonably be anticipated to cause pain;

- Whose assessment indicates that he/she experiences pain;

- Who receives or has orders for treatment for pain; and/or

- Who has elected a hospice benefit for pain management.

Procedures

Briefly review the care plan and orders to identify any current pain management interventions and to focus observations. Corroborate observations by interview and record review.

NOTE: Determine who is involved in the pain management process (for example, the staff and practitioner, and/or another entity such as a licensed/certified hospice).

1. Observation

Observe the resident during various activities, shifts, and interactions with staff. Use the observations to determine:

- If the resident exhibits signs or symptoms of pain, verbalizes the presence of pain, or requests interventions for pain, or whether the pain appears to affect the resident’s function or ability to participate in routine care or activities;

- If there is evidence of pain, whether staff have assessed the situation, identified, and implemented interventions to try to prevent or address the pain and have evaluated the status of the resident’s pain after interventions;

- If care and services are being provided that reasonably could be anticipated to cause pain, whether staff have identified and addressed these issues, to the extent possible;

- Staff response, if there is a report from the resident, family, or staff that the resident is experiencing pain;

- If there are pain management interventions for the resident, whether the staff implements them. Follow up on:
  - Deviations from the care plan;
  - Whether pain management interventions have a documented rationale and if it is consistent with current standards of practice; and
  - Potential adverse consequence(s) associated with treatment for pain (e.g.,
medications); and

- How staff responded, if the interventions implemented did not reduce the pain consistent with the goals for pain management.

2. Resident/Representative Interviews

Interview the resident, or representative to the degree possible in order to determine the resident's/representative's involvement in the development of the care plan, defining the approaches and goals, and if interventions reflect choices and preferences, and how they are involved in developing and revising pain management strategies; revisions to the care plan, if the interventions do not work. If the resident is presently or periodically experiencing pain, determine:

- Characteristics of the pain, including the intensity, type (e.g., burning, stabbing, tingling, aching), pattern of pain (e.g., constant or intermittent), location and radiation of pain and frequency, timing and duration of pain;

- Factors that may precipitate or alleviate the pain;

- How the resident typically has expressed pain and responded to various interventions in the past;

- Who the resident and/or representative has told about the pain/discomfort, and how the staff responded;

- What treatment options (e.g., pharmacological and/or non-pharmacological) were discussed;

- How effective the interventions have been; and

- If interventions have been refused, whether there was a discussion of the potential impact on the resident, and whether alternatives or other approaches were offered.

3. Nurse Aide(s) Interview. Interview staff who provide direct care on various shifts to determine:

- If they are aware of a resident’s pain complaints or of signs and symptoms that could indicate the presence of pain;

- To whom they report the resident’s complaints and signs, or symptoms; and

- If they are aware of, and implement, interventions for pain/discomfort management for the resident consistent with the resident’s plan of care, (for example, allowing a period of time for a pain medication to take effect before bathing and/or dressing).
4. Record review

Assessment. Review information such as orders, medication administration records, multidisciplinary progress notes, The RAI/MDS, and any specific assessments regarding pain that may have been completed. Determine if the information accurately and comprehensively reflects the resident’s condition, such as:

- Identifies the pain indicators and the characteristics, causes, and contributing factors related to pain;
- Identifies a history of pain and related interventions, including the effectiveness and any adverse consequences of such interventions;
- Identifies the impact of pain on the resident’s function and quality of life;
- Identifies the resident’s response to interventions including efficacy and adverse consequences, and any modification of interventions as indicated; and
- Identifies if the resident triggers the CAA for pain.

NOTE: Although Federal requirements dictate the completion of RAI assessments according to certain time frames, standards of good clinical practice dictate that the assessment process is more fluid and should be ongoing. (Federal Register, Vol. 62, No. 246, 12/23/97, Page 67193)

Care Plan. Review the care plan. Determine if pain management interventions include as appropriate:

- Measurable pain management goals, reflecting resident needs and preferences;
- Pertinent non-pharmacological and/or pharmacological interventions;
- Time frames and approaches for monitoring the status of the resident’s pain, including the effectiveness of the interventions; and
- Identification of clinically significant medication-related adverse consequences such as falling, constipation, anorexia, or drowsiness, and a plan to try to minimize those adverse consequences.

If the care plan refers to a specific facility pain management protocol, determine whether interventions are consistent with that protocol. If a resident’s care plan deviates from the protocol, determine through staff interview or record review the reason for the deviation.
If the resident has elected a hospice benefit, all providers must coordinate their care of the resident. This care includes aspects of pain management, such as choice of palliative interventions, responsibility for assessing pain and providing interventions, and responsibility for monitoring symptoms and adverse consequences of interventions and for modifying interventions as needed.

**NOTE:** If a resident is receiving services from a Medicare certified hospice and the hospice was advised of concerns by the facility and failed to address and/or resolve issues related to coordination of care or implementation of appropriate services, file a complaint with the State Agency responsible for oversight of this hospice, identifying the specific resident(s) involved and the concerns identified.

**Care Plan Revisions**

Determine whether the pain has been reassessed and the care plan has been revised as necessary (with input from the resident or representative, to the extent possible). For example, if the current interventions are not effective, if the pain has resolved, or the resident has experienced a change of condition or status.

5. **Interviews with health care practitioners and professionals:**

   **Nurse Interview.** Interview a nurse who is knowledgeable about the needs and care of the resident to determine:

   - How and when staff try to identify whether a resident is experiencing pain and/or circumstances in which pain can be anticipated;
   - How the resident is assessed for pain;
   - How the interventions for pain management have been developed and the basis for selecting them;
   - If the resident receives pain medication (including PRN and adjuvant medications), how, when, and by whom the results of medications are evaluated (including the dose, frequency of PRN use, schedule of routine medications, and effectiveness);
   - How staff monitor for the emergence or presence of adverse consequences of interventions;
   - What is done if pain persists or recurs despite treatment, and the basis for decisions to maintain or modify approaches;
   - How staff communicate with the prescriber/practitioner about the resident’s pain status, current measures to manage pain, and the possible need to modify the current pain management interventions; and
• For a resident who is receiving care under a hospice benefit, how the hospice and the facility coordinate their approaches and communicate about the resident’s needs and monitor the outcomes (both effectiveness and adverse consequences).

**Interviews with Other Health Care Professionals.** If the interventions or care provided do not appear to be consistent with current standards of practice and/or the resident’s pain appears to persist or recur, interview one or more health care professionals as necessary (e.g., attending physician, medical director, consultant pharmacist, director of nursing or hospice nurse) who, by virtue of training and knowledge of the resident, should be able to provide information about the evaluation and management of the resident’s pain/symptoms. Depending on the issue, ask about:

• How chosen interventions were determined to be appropriate;

• How they guide and oversee the selection of pain management interventions;

• The rationale for not intervening, if pain was identified and no intervention was selected and implemented;

• Changes in pain characteristics that may warrant review or revision of interventions; or

• When and with whom the professional discussed the effectiveness, ineffectiveness and possible adverse consequences of pain management interventions.

If during the course of this review, the surveyor needs to contact the attending physician regarding questions related to the treatment regimen, it is recommended that the facility’s staff have the opportunity to provide the necessary information about the resident and the concerns to the physician for his/her review prior to responding to the surveyor’s inquiries. If the attending physician is unavailable, interview the medical director as appropriate.

**DETERMINATION OF COMPLIANCE WITH F309 FOR PAIN MANAGEMENT**
(Task 6, Appendix P)

**Synopsis of Regulation (Tag F309)**

The resident must receive and the facility must provide the necessary care and services to attain or maintain his/her highest practicable level of physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

**Criteria for Compliance with F309 for a Resident with Pain or the Potential for Pain**

For a resident with pain or the potential for pain (such as pain related to treatments), the facility is in compliance with F309 Quality of Care as it relates to the recognition and management of pain, if each resident has received and the facility has provided the necessary care and services to attain
or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care i.e., the facility:

- Recognized and evaluated the resident who experienced pain to determine (to the extent possible) causes and characteristics of the pain, as well as factors influencing the pain;

- Developed and implemented interventions for pain management for a resident experiencing pain, consistent with the resident’s goals, risks, and current standards of practice; or has provided a clinically pertinent rationale why they did not do so;

- Recognized and provided measures to minimize or prevent pain for situations where pain could be anticipated;

- Monitored the effects of interventions and modified the approaches as indicated; and

- Communicated with the health care practitioner when a resident was having pain that was not adequately managed or was having a suspected or confirmed adverse consequence related to the treatment.

If not, cite at F309.

**Noncompliance with F309 for a Resident with Pain or the Potential for Pain**

After completing the Investigative Protocol, analyze the data in order to determine whether or not noncompliance with the regulation exists. Noncompliance for F309, with regard to pain management, may include, for example, failure to:

- Recognize and evaluate the resident who is experiencing pain in enough detail to permit pertinent individualized pain management;

- Provide interventions for pain management in situations where pain can be anticipated;

- Develop interventions for a resident who is experiencing pain (either specific to an overall pain management goal or as part of another aspect of the care plan);

- Implement interventions to address pain to the greatest extent possible consistent with the resident’s goals and current standards of practice and have not provided a clinically pertinent rationale why this was not done;

- Monitor the effectiveness of intervention to manage pain; or

- Coordinate pain management as needed with an involved hospice to meet the resident’s needs.