Pain Management Guideline

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by the

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HCANJ Best Practice Committee's

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Best Practice Guideline

Disclaimer: This Best Practice Guideline is presented as a model only by way of illustration. It has not been reviewed by counsel. Before applying a particular form to a specific use by your organization, it should be reviewed by counsel knowledgeable concerning applicable federal and state health care laws and rules and regulations. This Best Practice Guideline should not be used or relied upon in any way without consultation with and supervision by qualified physicians and other healthcare professionals who have full knowledge of each particular resident's case history and medical condition.

This Best Practice Guidelines is offered to nursing facilities, assisted living facilities, residential health care facilities, adult day health services providers and other professionals for informational and educational purposes only.

The Health Care Association of New Jersey (HCANJ), its executers, administrators, successors, and members hereby disclaim any and all liability for damage of whatever kind resulting from the use, negligent or otherwise, of all Best Practice Guidelines herein.

This Best Practice Guideline was developed by the HCANJ Best Practice Committee ("Committee"), a group of volunteer professionals actively working in or on behalf of health care facilities in New Jersey, including skilled nursing facilities, sub-acute care and assisted living providers.

The Committee's development process included a review of government regulations, literature review, expert opinions, and consensus. The Committee strives to develop guidelines that are consistent with these principles:

- Relative simplicity
- Ease of implementation
- Evidence-based criteria
- Inclusion of suggested, appropriate forms
- Application to various long term care settings
- Consistent with statutory and regulatory requirements
- Utilization of MDS (RAI) terminology, definitions and data collection

Appropriate staff (Management, Medical Director, Physicians, Nurse-Managers, Pharmacists, Pharmacy Consultants, Interdisciplinary Care Team) at each facility/program should develop specific policies, procedures and protocols to best assure the efficient, implementation of the Best Practice Guideline's principles.

The Best Practice Guidelines usually assume that recovery/rehabilitation is the treatment or care plan goal. Sometimes, other goals may be appropriate. For example, for patients/residents receiving palliative care, promotion of comfort (pain control) and dignity may take precedence over other guideline objectives. Guidelines may need modification to best address each facility, patient/resident and family's expectations and preferences.

Recognizing the importance of implementation of appropriate guidelines, the Committee plans to offer education and training. The HCANJ Best Practice Guidelines will be made available at www.hcanj.org.

MISSION STATEMENT

The mission of a Pain Management Program is to promote the health, safety and welfare of residents in nursing facilities, assisted living, residential health care facilities and adult day health services, by establishing guidelines to meet the state's requirements for the assessment, monitoring and management of pain.

DEFINITIONS

- *Pain* means an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.
    A. Pain Classification
        - *Somatic Pain*: Result of activation of nociceptors (sensory receptors) sensitive to noxious stimuli in cutaneous or deep tissues. Experienced locally and described as constant, aching and gnawing. The most common type in cancer patients.
        - *Visceral Pain*: Mediated by nociceptors. Described as deep, aching and colicky. Is poorly localized and often is referred to cutaneous sites, which may be tender. In cancer patients, results from stretching of viscera by tumor growth.
    B. Chronic Pain Classification
        - *Nociceptive pain*: Visceral or somatic. Usually derived from stimulation of pain receptors. May arise from tissue inflammation, mechanical deformation, ongoing injury, or destruction. Responds well to common analgesic medications and non-drug strategies.
        - *Neuropathic Pain*: Involves the peripheral or central nervous system. Does not respond as predictably as nociceptive pain to conventional analgesics. May respond to adjuvant analgesic drugs.
        - *Mixed or undetermined pathophysiology*: Mixed or unknown mechanisms. Treatment is unpredictable; try various approaches.
        - *Psychologically based pain syndromes*: Traditional analgesia is not indicated.

- *Pain Management* means the assessment of pain and, if appropriate, treatment in order to assure the needs of residents of health care facilities who experience problems with pain are met. Treatment of pain may include the use of medications or application of other modalities and medical devices, such as, but not limited to, heat or cold, massages, transcutaneous electrical nerve stimulation (TENS), acupuncture, and neurolytic techniques such as radiofrequency coagulation and cryotherapy.
- *Pain Rating Scale* means a tool that is age cognitive and culturally specific to the patient/resident population to which it is applied and which results in an assessment and measurement of the intensity of pain.
- *Pain Treatment plan* means a plan, based on information gathered during a patient/resident pain assessment, that identifies the patient's/resident's needs and specifies appropriate interventions to alleviate pain to the extent feasible and medically appropriate.

OBJECTIVES

- To reduce the incidence and severity of pain and, in some cases, help minimize further health problems and enhance quality of life.
- To provide professional staff with standards of practice that will assist them in the effective assessment, monitoring and management of the resident's pain.
- To educate the resident, family and staff.

- To limit liability to health care providers.

PROGRAM OUTLINE

I. PAIN SCREEN
   A. A Pain Screen, including a Pain Rating Scale, shall be conducted upon admission.

II. PAIN RATING SCALE
   A. One of the 4 following Pain Rating Scales (or other evidence based rating scales as they become available) shall be used as appropriate for the individual resident:
      1. Wong-Baker Scale
      2. Numerical Scale
      3. FLACC Scale
      4. PAINAD

   B. A Pain Rating Scale shall be completed and documented, at a minimum, in the following circumstances:
      1. as part of the Pain Screening upon admission
      2. upon re-admission
      3. upon day of planned discharge (send a copy with the resident)
      4. when warranted by changes in the resident's condition or treatment plan
      5. self reported pain and/or evidence of behavioral cues indicative of the presence of pain is requires a "short assessment" every shift in a skilled nursing facility
      6. to identify and monitor the level of pain and/or the effectiveness of treatment modalities until the patient/resident achieves consistent pain relief or pain control as identified

   C. If the patient/resident is cognitively impaired or non-verbal, the facility shall utilize pain rating scales for the cognitively impaired and non-verbal resident. (see suggested tools in Appendix) Additionally, the facility shall ask for information from the resident's family, caregiver or other representative, if available and known to the facility.

III. PAIN ASSESSMENT
   A. A complete Pain Assessment shall be done if the Pain Rating Scale score is above 0 in the circumstances listed in II-B, no. 1-5 indicated on The Wong Baker Faces or FLACC scales, a 1 or 2 as indicated by the PAINAD included with the Pain Management Tools.
   B. A Pain Assessment shall be conducted whenever a new onset of pain occurs
   C. In skilled nursing facilities, a complete Pain Assessment shall be completed at admission, if pain is identified, an assessment must be completed on every shift. (MDS 3.0; Section J,) Complete the appropriate Pain Assessment at the time of the quarterly MDS if pain has been recorded. .
   D. In assisted living communities, the evaluations/assessments are completed at a frequency required by state regulations and shall include a pain rating scale appropriate to the resident. If greater than 0 on the Wong Baker, or a FLACC of 1 or greater or a 1 or 2 on the PAINAD a Pain Assessment shall be completed. In addition, it is recommended that a pain screen be completed during the monthly wellness check followed by an assessment if pain is indicated.
   E. In residential health care and adult day health services, a Pain Assessment shall be completed upon admission, when pain is reported or suspected, and every six months and annually thereafter.

IV. TOOLS
   A. Pain Screen

B. Pain Rating Scale

C. Pain Assessment

V. PAIN MANAGEMENT PLAN DEVELOPMENT AND IMPLEMENTATION

Non- Pharmaceutical Interventions

A. Information collected from the Pain Assessment is to be used to formulate and implement an individualized person centered Pain Management plan of care based on the resident's ability to function comfortably. If it is not possible to achieve the optimal Pain Management plan for the patient/resident, the patient/resident shall be referred for Pain Management to an expert pain consultant.

B. Rehabilitation Treatment Modalities (Physical Therapy-PT /Occupational Therapy-OT):

1. PT Intervention: Therapeutic Exercise
   - Passive range of motion, active assistive range of motion, active range of motion, progressive resistive exercise, balance training, gait training, postural correction and reeducation, ergonomics.
2. PT Intervention: Manual Therapy
   - Mobilization and manipulation of the joints, craniosacral therapy, myofascial release, massage.
3. PT Intervention: Modalities
   - Electrical stimulation, transcutaneous electrical nerve stimulation, iontophoresis, ultrasound, diathermy, infrared, hydrotherapy (warm), fluid therapy, cold laser, hot packs, paraffin wax therapy, ice packs.
4. OT Intervention for Pain Reduction:
   - Activity of daily living, adaptive devices to simplify tasks, energy conservation techniques, therapeutic exercises, wheelchair measurement, wheelchair positioning devices, bed positioning devices, cushions for appropriate pressure relief, splinting for stretching tight joints/muscles, reduce pain and prevent pressure sore.
5. Both PT and OT upon discharge from the therapy program should provide:
   - Illustrated home exercise program, in-service to the caregiver.
6. Guided Internet-Based Psycho-Education Intervention Using Cognitive Behavioral Therapy:
   1. Assess the resident, especially those with cognitive impairment, for unmet needs which could be interpreted as pain such as hunger, lonliness, depression, need to be toileted, to speak to a loved one, sleeplessness, anxiety and meet the need.
   2. Assure the patient/resident is comfortable; reposition, if appropriate to patient's/resident's level of function engage in an activity such as walking.

For patients/residents who suffer from Chronic Pain there is a new system of non-pharmacological interventions know as, "Guided Internet-Based Psycho-Education Intervention Using Cognitive Behavioral Therapy (CBT) and Self-Management (SM) for Individuals With Chronic Pain."

This study was conducted to determine strategies for improved access to evidence based non-pharmacological interventions for the management of chronic pain. The premise is to

provide, online education, guidance and interventions which are non-pharmacologic in nature for persons trying to manage chronic pain with little or no access to formal psychological services. The following information was extracted from the entire project as an informational resource for nurses and the patients/residents for whom they provide care: "The most effective treatments for chronic pain involve an interdisciplinary approach (Jeffery, Butler, Stark, & Kane, 2011; Scascighini, Toma, Dober-Spielmann, & Sprott, 2008; Turk, Wilson, & Cahana, 2011). Pharmacologic treatment is most commonly utilized, but other treatments are less consistently accessed. In particular, psychological interventions for chronic pain management are not readily available at a primary care level due to funding, time constraints, and lack of adequately trained staff (Jeffery et al., 2011)."

"Study Conclusion: In examining the status of accessibility to chronic pain care, a need was identified: individuals should have an opportunity to continue to move forward in treatment even if they do not have access to in-person, psycho-education, CBT, and SM therapies. Internet delivery of evidence-based therapies may benefit individuals with chronic pain. Considering factors such as demographics, environment, supports and symptoms, and building on previous research, an intervention was constructed for delivery via the Internet. Pilot testing of the intervention, with a view to usability and exploratory outcomes, was completed to inform content revision and structure of larger-scale research

- Suggested Evidence-based Intervention Components
  - Cognitive Behavioral Therapy (CBT)
  - Self-Management (SM)
  - Education

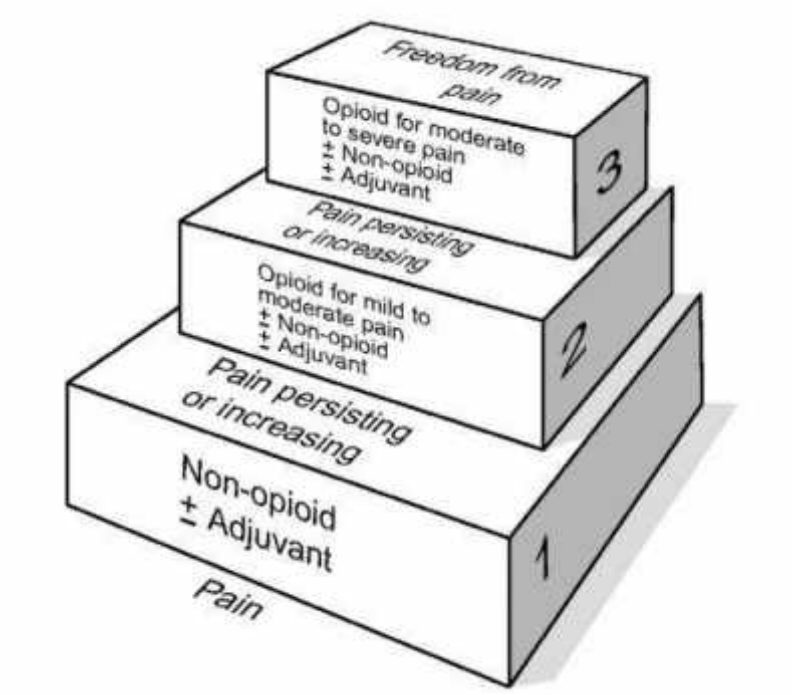
D. **Pharmacological Intervention**:

As a result of a nationwide effort to reduce unnecessary Opioid use and reduce incidents of patient abuse, clinicians are encouraged to carefully assess their patient's/resident's pain through assessment, limit the number of prescribed narcotic analgesics and limit further prescribing by evaluating the patient's/resident's pain relief and increased functional ability.

The trend to lower usage has had a tremendous impact on opiod use as indicated in the annual reports from QuintilesIMS. By 2016, acetaminophen/hydrocodone, which had been the leading medication prescribed for pain, had dropped from first most prescribed pain medication to the fourth most prescribed drug in the nation, with the volume of prescriptions down 7.2% from 2015 and 34% from 2012.
In order to facilitate this continuing trend it is recommended that the following WHO decision ladder and in depth patient/resident assessment be utilized before requesting or prescribing opioid compounds.

World Health Organization (WHO) Ladder

The WHO Ladder was first published over twenty years ago (1986) in a handbook called *Cancer Pain Relief*. Since then, the Ladder has guided clinicians all over the world in treating cancer as well as non-cancer pain.
Figure 1. The WHO Ladder (adapted).



The WHO Ladder is part of an overall pain treatment method that centers on five key principles:

- "By Mouth": use the oral route whenever possible, even for opioids
- "By the Clock": For persistent pain, provide medication at regular intervals (around the clock) rather than PRN (as needed)
- "By the Ladder": (Figure 1)
  - *Step 1:*
    - For mild to moderate pain, start with a nonopioid (e.g., acetaminophen, ibuprofen) and increase the dose, if necessary to the maximum recommended dose.
    - Use an adjuvant such as an anti-depressant or anticonvulsant, if indicated
    - If the patient presents with moderate or severe pain skip Step 1.
  - *Step 2:*
    - If or when non-opioids do not adequately relieve pain, add an opioid intended for moderate pain such as hydrocodone (combined with acetaminophen).
    - Add or continue adjuvants, if appropriate
  - *Step 3:*
    - If or when the non-opioid for mild to moderate pain no longer adequately relieves the pain, switch to an opioid that is not combined with another agent such as acetaminophen, and one that is effective for moderate to severe pain (e.g. morphine, oxycodone, hydromorphone).
    - Add or continue adjuvants, if appropriate "For the Individual": individualize the Pain Management Program according to the patient's goals to incorporate Person Centered criteria to meet the patient's pain needs.

1. Non-opioid analgesics, such as acetaminophen, aspirin, and nonsteroidal anti-inflammatory drugs (NSAIDs), cyclooxygenase-2 (cox-2) inhibitors and tramadol.
    - Considered but *not* recommended: Indomethacin, Prioxicam, Tolmetin, Meclofenamate.
2. Opioid analgesics include but not limited to: (oxycodone; morphine, transdermal fentanyl; hydromorphone; methadone; combination opioid preparations, such as codeine, hydrocodone, Oxycodone. Considered but *not* recommended: Propoxyphene, Meperidine, Pentazocine, Butorphanol

Table 1. Types of Opioids and Their Derivatives and Availability by Prescription

Opiates[5]	Semi-Synthetic[6, 7]	Synthetic[8, 9]
Opium	Buprenorphine*	Butorphanol*
Codeine*	Dihydrocodeine*	Fentanyl*
Morphine*	Heroin	Meperidine*
Papaverine	Hydrocodone*	Methadone*
Thebaine	Hydromorphone*	Pentazocine*
	Oxycodone*	Propoxyphene
	Oxymorphone*	Tapentadol*
		Tramadol*

* Available in prescription form.

- Before starting opioid therapy for chronic pain, it is recommended, based on person-centered care, a clinician work to establish pain management goals that utilize non-pharmacological methods that will increase the patient/resident's daily functional abilities at a comfortable level. What is a comfortable level? The level of pain that is tolerated by the established to enable a degree of independence in activities of daily living. With continuing assessment, evaluation and as the increase independence there is a continued reduction in the necessity for narcotic analgesics.

- Clinicians should establish treatment goals with all patients/residents and understand at what level on the selected Pain Scale the patient/resident feels they are comfortable and able to function. Every person's tolerance to pain is subjective. If a patient says they have pain, they do have pain. If they say they have pain at an 8 they do. A five on the pain scale may be uncomfortable for some else.

- At what level is the pain manageable for THIS resident. Once that is established, person centered goals can be set including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient/resident safety .

- When possible, abuse-deterent opioids should be utilized to minimize the risk and provide an additional barrier to opioid abuse

- Patients/Residents Aged $\geq$ 65 years- Inadequate pain management among persons aged ≥65 years has been documented (204). Pain management for older patients/residents can be challenging given increased risks of both non-opioid pharmacologic therapies (see Recommendation 1) and opioid therapy in this population. Per Dr. Manan Patel (April 25,2017) there are:

- Age related changes effecting Pain Management:
  - Decrease in pain receptors at the skin
  - Impaired Conduction velocities
  - Loss of neurons at dorsal horns.
  - Decrease in EEG amplitude and increase in latency to painful stimuli have been reported
  - Changes in painful thermal stimuli implies frontal and lateral wider recruitment of neurons and slower cognitive
  - medications
  - Ethical/cultural/religious beliefs placing admission of pain as a sign of weakness
  - Family and staff concerns about accidental overdoses

- Complications of dementia :
  - The intensity of painful conditions and the administration of analgesic medication seem to be inversely related as dementia progresses
  - Patients/Residents may have difficulty expressing the pain or inability due to neuropathologic changes which often result in misinterpreted signals processing

- Barriers to effective Pain Management:
  - Many elders can be more reluctant than young people to report painful stimuli
  - Physician, family and staff concerns about addiction to pain
  - As dementia worsens patients/residents may show more facial expressiveness. This may or may not be related to pain and should be investigated before seeking a pharmaceutical solution. Staff and families must rely on patient/resident facial expressions (as illustrated in the Advanced Dementia Pain Scale in the appendix)and body language as pain indicators for the non-verbal person.
  - Abrupt changes in behavior and function might be the best indicators of pain.

3. Reduced renal function and medication clearance even in the absence of renal disease, in patients/residents aged ≥65 years might have increased susceptibility to accumulation of opioids and a smaller therapeutic window between safe dosages and dosages associated with respiratory depression and overdose (contextual evidence review). Some older adults suffer from cognitive impairment, which can increase risk for medication errors and make opioid-related confusion more dangerous. In addition, older adults are more likely than younger adults to experience co-morbid medical conditions and more likely to receive multiple medications, some of which might interact with opioids (such as benzodiazepines). Clinicians should use additional caution and increased monitoring to minimize risks of opioids prescribed for patients/residents aged ≥65 years. Experts suggested that clinicians educate older adults receiving opioids to avoid risky medication-related behaviors such as obtaining controlled medications from multiple prescribers and saving unused medications. For residents' transitioning back into the community whose pain level requires the continued use of an opioid, clinicians need to provide education related to medication management, side effects, risk of falls, and all other risks associated with Opiod use. Clinicians should educate representatives/care givers for those with memory impairment and cognitive decline on safe administration, side effects and risk

associated with controlled medications. Clinicians should also implement interventions to mitigate common risks of opioid therapy among older adults, such as exercise or bowel regimens to prevent constipation, risk assessment for falls, and patient/resident monitoring for cognitive impairment

3. Other classes of drugs (corticosteroids, anticonvulsants, clonazepam, carbamazepine, anti-arrhythmics, topical local anesthetics, topical counter-irritants)

4. Monitor for safety and side effects of medications.
   - Utilize The Four A's of pain treatment outcomes (Passik and Weinreb, 1998) which are:
     Analgesia (pain control),
     Activities of daily living (patient/resident functioning and quality of life),
     Adverse events (medication side effects) and
     Aberrant drug-related behavior (addiction related outcomes).

5. Principles of Pharmacological treatment of chronic pain:
   - Administer medication routinely, *not* PRN (as needed). PRN analgesic may be administered for breakthrough pain or when resident/staff identifies circumstances when pain may be anticipated, On-going communication is recommended with the healthcare provider for optimal pain management. prior to wound treatment or skilled therapy.
   - Use the least invasive route of administration first. The oral route is preferred.
   - Using the WHO Pain Ladder begin with a low dose. Titrate carefully until comfort is achieved.
   - Reassess and adjust does frequently to optimize pain relief while monitoring and managing side effects.
   - Maximize therapeutic effect while minimizing medication side effects.

6. General Pain Management Principles:
   - A sk about pain regularly
   - B elieve the patient's/resident's & family's reports of pain and what relieves it
   - C hoose appropriate pain control options
   - D eliver interventions in a timely, logical and coordinated fashion
   - E mpower patients/residents and their families
   -

D. Alternative Interventions:
   1. Acupuncture, reflexology, aroma therapy, music therapy, dance therapy, yoga, hypnosis, relaxation and imagery, distraction and reframing, psychotherapy, peer support group, spiritual, chiropractic, magnet therapy, bio-feedback, meditation, relaxation techniques, Cognitive Behavior Therapy, Self-Management, education.

E. Pain Assessment findings shall be documented in the resident's medical record. This shall include, but not be limited to, the date, pain rating, pain rating tool, treatment plan, and patient/resident response.

F. In order to meet or exceed state and or federal quality initiatives and requirements ((Quality Assurance (QA) and Performance Improvement (PI)) and maintain control over pain management medications and patient/resident outcomes it is further suggested that a Pain

Management monthly summary be created and logged as part of your facility quality program. The summary should review the medications administered, the numbers of opioids ordered and administered (Information readily available from your pharmacy provider) and the effectiveness of the overall month's administration. This allows for better medical and nursing management of that particular resident's ability to function and at what level they are able to function comfortably. Also, at this assessment of pain management meeting what non-pharmacological interventions have been of benefit or what may be reviewed further with the patient/resident, representative if applicable, the care giver staff and the healthcare provider. PRN medications (as needed) utilization is also reviewed. An increase in PRN narcotic analgesic is an indicator the patient/resident's pain is not effectively being managed and the Pain Management plan should be revisited and revised. It should also be determined whether to discontinue ANY medication especially if not administered in 30 days. The data collected from these monthly meetings may be utilized as part of the Nursing Department's quality assurance program.

VI. EDUCATION AND TRAINING

A. The policy for each facility shall include the criteria found in subchapter 6, General Licensure Procedures and Enforcement of Licensure Rules, NJAC *8:43E 6.5 (a) 1-4 , (b):*

"*(a)* Each facility shall develop, revise as necessary and implement a written plan for the purpose of training and educating staff on pain management. The plan shall include mandatory educational programs that address at least the following:

1. Orientation of new staff to the facility's policies and procedures on pain assessment and management;
2. Training of staff in pain assessment tools; behaviors potentially indicating pain; personal, cultural, spiritual, and/or ethnic beliefs that may impact a patient's/resident's perception of pain; age related changes in perception to pain, new equipment and new technologies to assess and monitor a patient's/resident's pain status;
3. Incorporation of pain assessment, monitoring and management, non-pharmaceutical and pharmaceutical, into the initial orientation and ongoing education of all appropriate staff; and
4. rights.

(b) Implementation of the plan shall include records of attendance for each program."

B. /Family Education:

- Explain causes of the pain, assessment methods, treatment options and goals, use of analgesics and non- pharmaceutical self-help techniques.
- Regularly reinforce educational content.
- Provide specific education before special treatments and/or procedures.

VII. CONTINUOUS QUALITY IMPROVEMENT

The policy for each facility shall include the criteria found in subchapter 6, General Licensure Procedures and Enforcement of Licensure Rules, *NJAC 8:43E 6.6*:

"The facility's continuous quality improvement program shall include a systematic review and evaluation of pain assessment, management and documentation practices. The facility shall develop a plan by which to collect and analyze data in order to evaluate outcomes or performance. Data analysis shall focus on recommendations for implementing corrective actions and improving performance."

VIII. POLICY

A. Each facility shall develop a policy to define the system for assessing and monitoring patient/resident pain.

B. The policy for each facility shall include the criteria found in subchapter 6, General

Licensure Procedures and Enforcement of Licensure Rules, NJAC *8:43E 6.4(f) 1-7*:

"*(f)* The facility shall establish written policies and procedures governing the management of pain that are reviewed at least every year and revised more frequently as needed. They shall include at least the following:

1. A written procedure for systematically conducting periodic assessment of a patient's/resident's pain, as specified in *(b)* *above. At a minimum the procedure must specify pain assessment upon admission, upon discharge, and when warranted by changes in a patient's/resident's condition and self reporting of pain;
2. Written criteria for the assessment of pain, including, but not limited to: pain intensity or severity, pain character, pain frequency or pattern, or both; pain location, pain duration, precipitating factors, responses to treatment and the personal, cultural, spiritual, and/or ethnic beliefs that may impact an individual's perception of pain;
3. A written procedure for the monitoring of a patient's/resident's pain;
4. A written procedure to insure the consistency of pain rating scales across departments within the health care facility;
5. Requirements for documentation of a patient's/resident's pain status in the medical record;
6. A procedure for educating patients/residents and, if applicable, their families about pain management when identified as part of their treatment; and
7. A written procedure for systematically coordinating and updating the pain treatment plan of a patient/resident in response to documented pain status."

It should be noted and remembered:

PAIN IS INEVITABLE
SUFFERING IS OPTIONAL

It is the responsibility of the professional care team to develop an effective person-centered Pain Management Program which appropriately assesses patients/residents, analyzes the results of the assessment and devises a person centered plan to manage pain while allowing the person to remain as independent and functional as possible. The program is the manner in which professional care team members can provide a consistent approach to assessment and provide feedback on the effectiveness of the program in relation to the patient/resident outcomes and quality of life.

HCANJ
Health Care Association of New Jersey

BEST PRACTICE PROGRAM

PAIN MANAGEMENT TOOLS

- Pain Screen Form
- Pain Rating Scale Form
- Pain Assessment Form
- Pain Management: Rating/*Medication* Administration Record
- Pain Management: Rating/*Treatment* Administration Record
- Data Collection For Analysis, Outcome Evaluation and Performance Improvement Forms:
  - Pain Screen Form
  - Pain Assessment Form
  - Pain Treatment Form

PAIN SCREEN

Date_____/_____/_____

Resident Name_____ Age_____ Room_____

Diagnosis_____

Physician_____ Nurse_____

Objective: This interview will help to identify the level of pain education and history of the resident to provide optimal resident comfort in the process of easing, controlling and/or diminishing pain. The following documentation may be mutually established with the help of the resident, family members and staff. If the resident is *non*verbal, ask a family member or significant other if they can answer any of the questions. If not, note "not able to obtain from resident or significant other."

Who Answered the following questions:

†Resident Family Member (name)_____ Relationship to Resident:_____

RESIDENT INTERVIEW:

1. Do you have pain now? †Yes †No †If yes, PAIN SCORE of _____ using: †Wong-Baker †Numerical †FLACC
2. Do you ever have pain? †Yes †No †If Yes, how often and where: _____
3. Within the last two weeks, have you taken any medications or treatments to control pain? †Yes †No †If yes, list details:
4. Are you able to report your pain to the nurse? †Yes †No †If No, why not: _____
5. Do you feel that it is normal to have pain? †Yes †No †If No, why not: _____
6. Do you feel that all pain should be treated? †Yes †No †If No, why not: _____
7. Do you have any cultural or religious beliefs that would influence the management of pain? †Yes †No
   †If Yes, please explain: _____
8. How intense does your pain need to be to be treated? †Rate on a Scale of 1—10____ Or, explain: _____
9. How have you treated your pain in the past? (Explain) (medications, other modalities): _____
10. Have you ever used alcohol to relieve your pain? †Yes †No
11. What drugs, legal or illegal, have you used in the past to relieve your pain? †None List drugs: _____

INTERVIEWER OBSERVATIONS: 1. If the resident is not able to describe pain, please check below if there are any current *non*verbal signs of pain: †Moaning/Yelling †Rocking †Restless Movements †Combative †Grimacing †Guarding †Rubbing Area †*No Signs of pain* †Other: ____

2. EDUCATION: †Resident educated to report pain to the nurse †Family/significant other educated to report signs of resident's pain to the nurse †Family/significant other not available at admission to discuss/educate re: pain management
3. OTHER OBSERVATIONS: _____

Resident Name_____ Age_____ Room_____ DATE_____

PAIN RATING SCALE

GENERAL INSTRUCTIONS: Choose <u>only one</u> appropriate scale based upon the resident's ability to respond. Identify the scale used and the score for that scale on the bottom of this form. *Any score above 0 requires a Pain Assessment.*

WONG-BAKER SCALE:

Initial Instructions: Explain to the resident that each face is for a person who feels happy because he or she has no pain (hurt) or sad because he or she has some or a lot of pain. **FACE 0** is happy because he or she doesn't hurt at all. **FACE 2** hurts just a little bit **FACE 4** hurts a little more. **FACE 6** hurts even more. **FACE 8** hurts a whole lot. **FACE 10** hurts as much as you can imagine, although you don't have to be crying to feel this bad. Ask the resident to choose the face that best describes how he or she is feeling.

NO HURT	LITTLE BIT	HURTS LITTLE MORE	HURTS EVEN MORE	HURTS WHOLE LOT	HURTS WORST
0	2	4	6	8	10

NUMERIC SCALE: Choose a number from 0 to 10 that best describes the level of pain.

NO PAIN	MILD PAIN, ANNOYING Pain is present but does not limit activity.	NAGGING PAIN, UNCOMFORTABLE, TROUBLESOME Can do most activities with rest periods.	MISERABLE, DISTRESSING Unable to do some activities because of pain.	INTENSE, DREADFUL, HORRIBLE Unable to do most activities because of pain.	WORST PAIN POSSIBLE, UNBEARABLE Unable to do any activities because of pain.

0 1 2 3 4 5 6 7 8 9 10

FLACC SCALE:

Initial Instructions: The FLACC is a behavior pain assessment scale for use with nonverbal residents who are unable to provide reports of pain. Rate the resident in each of the five measurement categories, add the scores together, and document the total pain score.

FACE	0 No particular expression of smile.	1 Occasional grimace or frown, withdrawn, disinterested.	2 Frequent to constant frown, clenched jaw, quivering chin.
LEGS	0	1	2

PAIN ASSESSMENT

Date_____/_____/_____

Resident Name_____ Age_____ Room_____

Diagnosis_____

Initial Instructions: (1) Complete SECTION I. If the resident has pain now or has had pain recently, follow the instructions to assess each site of pain. Use another Pain Assessment Form if there are more than 2 sites of pain. (2) Complete SECTION II.

Who Answered the following questions?: (If the resident is nonverbal, ask a family member if they can answer any of the questions. If not, note "not able to obtain from resident or significant other.")

SECTION I—INDICATE THE BEST RESPONSE FOR RESIDENT ASSESSMENT:

1. COMMUNICATION: Is resident alert & oriented? ☐Yes ☐No | Can resident verbalize pain? ☐Yes ☐No
2. PAIN SITE PHYSICAL LOCATION: *Instructions:* Circle the anatomical location on the anatomy charts in SECTION II. *Number the sites of pain from 1-2* and answer the questions for that site. More than 2 sites of pain, use an additional form.

Chest Pain_____ Headache Pain_____

Back Pain: *Upper* Back____ *Lower* Back____ *Middle* Back____

Abdominal Pain: *Upper* Ab____ *Lower* Ab____ *Middle* Ab____

Leg Pain: *Right* Leg____ *Left* Leg____ *Both*____

Elbow Pain: *Right* Elbow___ *Left* Elbow____ *Both*____

Hip Pain: *Right* Hip____ *Left* Hip____ *Both*___

Arm Pain: *Right* Arm____ *Left* Arm____ *Both*___

Knee Pain: *Right* Knee____ *Left* Knee____ *Both*___

Shoulder Pain: *Right* Sh.____ *Left* Sh.____ *Both*___

____Incision Pain (specify):_____

____Wound Pain (specify):_____

____Joint Pain (specify):_____

____Other (specify):_____

PAIN SITE #1 ASSESSMENT:

1. PAIN CHARACTERISTICS: ☐Dull Pain ☐Sharp/Stabbing Pain ☐Pressure ☐Throbbing and Radiating Pain ☐Burning ☐Itching ☐Other (specify)_____
   ☐Pain *upon movement* (specify):_____
   ☐Pain *upon touch* (specify):_____
   ☐Other (specify):_____
2. PAIN FREQUENCY AND TIME: ☐Pain is daily ☐Pain is less than daily ☐All Times ☐Intermittent / no pattern
   Time of day_____ Pain Duration_____
3. NON-VERBAL OBSERVATIONS: ☐Anger ☐Agitation, Fidgeting and Restless ☐Complaining ☐Sighing and/or breathing heavily ☐Crying, Moaning and/or Yelling ☐Depressed, Sad and Worried Look ☐Wincing and Wrinkled Brow ☐Frightened, Guarding and Withdrawn Look ☐Muscle Rigidity, Resistive, Tense Fingers/Fist ☐Other (specify)_____
4. PAIN INTENSITY: Score from Pain Rating Scale: ☐Wong-Baker ☐Numerical ☐FLACC Scale Score:_____
5. INSPECTION OF PAIN SITE: (specify findings of swelling, redness, heat, etc.)_____

PAIN SITE #1 ORIGIN AND DIAGNOSIS:

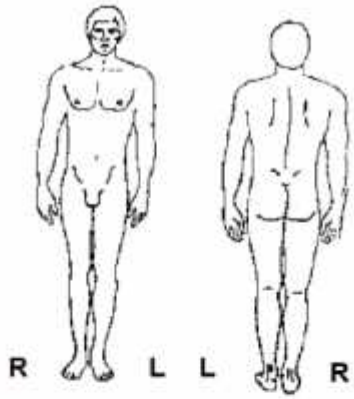
PAIN SITE #2 ASSESSMENT:

1. PAIN CHARACTERISTICS: ☐Dull Pain ☐Sharp/Stabbing Pain ☐Pressure ☐Throbbing and Radiating Pain ☐Burning ☐Itching ☐Other (specify)_____
   ☐Pain *upon movement* (specify):_____
   ☐Pain *upon touch* (specify):_____
   ☐Other (specify):_____
2. PAIN FREQUENCY AND TIME: ☐Pain is daily ☐Pain is less than daily ☐All Times ☐Intermittent / no pattern
   Time of day_____ Pain Duration_____
3. NON-VERBAL OBSERVATIONS: ☐Anger ☐Agitation, Fidgeting and Restless ☐Complaining ☐Sighing and/or breathing heavily ☐Crying, Moaning and/or Yelling ☐Depressed, Sad and Worried Look ☐Wincing and Wrinkled Brow ☐Frightened, Guarding and Withdrawn Look ☐Muscle Rigidity, Resistive, Tense Fingers/Fist ☐Other (specify)_____
4. PAIN INTENSITY: Score from Pain Rating Scale: ☐Wong-Baker ☐Numerical ☐FLACC Scale Score:_____
5. INSPECTION OF PAIN SITE: (specify findings of swelling, redness, heat, etc.)_____

PAIN SITE #2 ORIGIN AND DIAGNOSIS:

SECTION II—

INDICATE LOCATION OF PAIN:



PAIN SITE #1 - PAIN MANAGEMENT HISTORY AND RESIDENT GOALS:

1. What causes or increases the pain?_____
2. What medications and other methods have been used to relieve the pain?_____
3. How well have these medications and methods worked?
4. What is the resident's goal for pain management? ☐Decrease pain ☐Improved mobility ☐Improved sleep ☐Other: (explain)_____

PAIN SITE #2 - PAIN MANAGEMENT HISTORY AND RESIDENT GOALS:

1. What causes or increases the pain?_____
2. What medications and other methods have been used to relieve the pain?_____
3. How well have these medications and methods worked?_____
4. What is the resident's goal for pain management? ☐Decrease pain ☐Improved mobility ☐Improved sleep ☐Other: (explain)_____

OBSERVATIONS AND/OR COMMENTS:

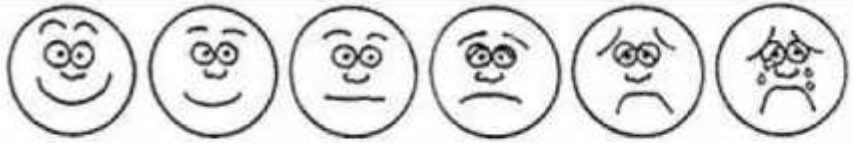
1. **Accompanying symptoms associated with pain:** (Example: Nausea, Headache)_____
2. **Appetite:** ☐No change ☐Loss of appetite ☐Difficult to sit and eat ☐Other: (explain)_____
3. **Sleeping:** ☐No change ☐Difficult to sleep at night ☐Other: (explain)_____
4. **Physical Activity:** ☐No change ☐Difficult to sit-up/get-up/walk ☐Non-participation in favorite activity ☐Other: (explain)_____
5. **Relationship to others:** ☐No change ☐Decrease in social action ☐Totally withdrawn from friends, family, etc. ☐Other: (explain)_____
6. **Concentration:** ☐No change ☐Loss of concentration ☐Other:_____
7. **Emotions** (complacent, agitated or aggressive behavior, etc.) ☐No change ☐Emotional change (Explain):_____
8. **Personal Hygiene:** ☐No change ☐Unable to wash, dress or perform personal care ☐Other:_____

Note: Information is to be used to formulate the Resident's Pain Treatment Plan. (Care Plan)

RN Signature_____

Resident Name: Month Year

Pain Scale:	Observation Codes:		Sedation:
0=No Pain 2=Mild Pain 4=Moderate Pain 6=Severe Pain 10=Worst Possible Pain	A. Anxious B. Agitated, Restless C. Whimpers/Moans D. Depressed Brow Line E. Clenched, tight Muscles	F. Crying G. Grimacing H. Relaxed I. Withdrawn J. Vital Sign Changes	1=Awake, Alert 2= Slightly Drowsy 3=Frequently Drowsy 4=Lethargic S=Sleep



Date	Time	Location of Pain/Aggravating factor	Scale By Client	Scale By Nurse	Observe	Medication Dose/Route	Results by Client	Result by Nurse	Time	Sedation	Initials

Pain Assessment IN Advanced Dementia – PAINAD-SCORE

sn	0	1	2	
Breathing Independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation	Noisy labored breathing. Long period of hyperventilation. Cheyne-stokes respirations	
Facial expression	Smiling or inexpressive	Sad, frightened, frown	Facial grimacing	
Body language	Relaxed	Tense. Distressed pacing. Fidgeting	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out	
Consolability	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure	
			**TOTAL "0" No Pain and "10" Severe Pain	

Instructions: Observe the older person both at rest and during activity/with movement. For each of the items included in the PAINAD, select the score (0, 1, or 2) that reflects the current state of the person's behavior. Add the score for each item to achieve a total score. Monitor changes in the total score over time and in response to treatment to determine changes in pain. Higher scores suggest greater pain severity.

Note: Behavior observation scores should be considered in conjunction with knowledge of existing painful conditions and report from an individual knowledgeable of the person and their pain behaviors.

Remember that some individuals may not demonstrate obvious pain behaviors or cues.

Pain Assessment in Advanced Dementia (PAINAD) Scale

Items*	0	1	2	Score
Breathing independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respirations.	
Negative vocalization	None	Occasional moan or groan. Low-level speech with a negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.	
Facial expression	Smiling or inexpressive	Sad. Frightened. Frown.	Facial grimacing.	
Body language	Relaxed	Tense. Distressed pacing. Fidgeting.	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.	
Consolability	No need to console	Distracted or reassured by voice or touch.	Unable to console, distract or reassure.	
			Total**	

*Five-item observational tool (see the description of each item below).

**Total scores range from 0 to 10 (based on a scale of 0 to 2 for five items), with a higher score indicating more severe pain (0="no pain" to 10="severe pain").

Breathing

1. Normal breathing is characterized by effortless, quiet, rhythmic (smooth) respirations.
2. Occasional labored breathing is characterized by episodic bursts of harsh, difficult or wearing respirations.
3. Short period of hyperventilation is characterized by intervals of rapid, deep breaths lasting a short period of time.
4. Noisy labored breathing is characterized by negative sounding respirations on inspiration or expiration. They may be loud, gurgling, or wheezing. They appear strenuous or wearing.
5. Long period of hyperventilation is characterized by an excessive rate and depth of respirations lasting a considerable time.
6. 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 is characterized by speech or vocalization that has a neutral or pleasant quality.
2. Occasional moan or groan 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 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 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 is characterized by mournful or murmuring sounds, wails or laments much louder than usual volume. Loud groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
6. Crying is characterized by an utterance of emotion accompanied by tears. There may be sobbing or quiet weeping.

Facial expression

1. 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 is characterized by an unhappy, lonesome, sorrowful, or dejected look. There may be tears in the eyes.
3. Frightened is characterized by a look of fear, alarm or heightened anxiety. Eyes appear wide open.
4. 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 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 is characterized by a calm, restful, mellow appearance. The person seems to be taking it easy.
2. Tense is characterized by a strained, apprehensive or worried appearance. The jaw may be clenched (exclude any contractures).
3. Distressed pacing is characterized by activity that seems unsettled. There may be a fearful, worried, or disturbed element present. The rate may be faster or slower.
4. 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 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 is characterized by tightly closed hands. They may be opened and closed repeatedly or held tightly shut.
7. 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 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 is characterized by hitting, kicking, grabbing, punching, biting, or other form of personal assault.

Consolability

1. No need to console is characterized by a sense of well being. The person appears content.
2. 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 is characterized by the inability to sooth the person or stop a behavior with words or actions. No amount of comforting, verbal or physical, will alleviate the behavior.

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PAIN MANAGEMENT: RATING/**MEDICATION** ADMINISTRATION RECORD

Month:________________ Year:_____

Instructions: Complete this form as you would complete a Medication Administration Record (MAR) document specifying the pain site, pain rating, & post treatment pain rating. (see other side for Pain Scale)

Pain Rating Scale used: **W** ONG-BAKER SCALE **N**UMERICAL SCALE **F**LACC SCALE

Medication	Date:	Date:	Date:	Date:	Date:	Date:	Date:
	Scale___ Level___ Pain Site___ Time___ am pm Initial___ **RESULTS:** Scale___ Level___ Time___ am pm Initial___	Scale___ Level___ Pain Site___ Time___ am pm Initial___ **RESULTS:** Scale___ Level___ Time___ am pm Initial___	Scale___ Level___ Pain Site___ Time___ am pm Initial___ **RESULTS:** Scale___ Level___ Time___ am pm Initial___	Scale___ Level___ Pain Site___ Time___ am pm Initial___ **RESULTS:** Scale___ Level___ Time___ am pm Initial___	Scale___ Level___ Pain Site___ Time___ am pm Initial___ **RESULTS:** Scale___ Level___ Time___ am pm Initial___	Scale___ Level___ Pain Site___ Time___ am pm Initial___ **RESULTS:** Scale___ Level___ Time___ am pm Initial___	Scale___ Level___ Pain Site___ Time___ am pm Initial___ **RESULTS:** Scale___ Level___ Time___ am pm Initial___
Medication	Date:	Date:	Date:	Date:	Date:	Date:	Date:
	Scale___ Level___ Pain Site___ Time___ am pm Initial___ **RESULTS:** Scale___ Level___ Time___ am pm Initial___	Scale___ Level___ Pain Site___ Time___ am pm Initial___ **RESULTS:** Scale___ Level___ Time___ am pm Initial___	Scale___ Level___ Pain Site___ Time___ am pm Initial___ **RESULTS:** Scale___ Level___ Time___ am pm Initial___	Scale___ Level___ Pain Site___ Time___ am pm Initial___ **RESULTS:** Scale___ Level___ Time___ am pm Initial___	Scale___ Level___ Pain Site___ Time___ am pm Initial___ **RESULTS:** Scale___ Level___ Time___ am pm Initial___	Scale___ Level___ Pain Site___ Time___ am pm Initial___ **RESULTS:** Scale___ Level___ Time___ am pm Initial___	Scale___ Level___ Pain Site___ Time___ am pm Initial___ **RESULTS:** Scale___ Level___ Time___ am pm Initial___
Medication	Date:	Date:	Date:	Date:	Date:	Date:	Date:
	Scale___ Level___ Pain Site___ Time___ am pm Initial___ **RESULTS:** Scale___ Level___ Time___ am pm Initial___	Scale___ Level___ Pain Site___ Time___ am pm Initial___ **RESULTS:** Scale___ Level___ Time___ am pm Initial___	Scale___ Level___ Pain Site___ Time___ am pm Initial___ **RESULTS:** Scale___ Level___ Time___ am pm Initial___	Scale___ Level___ Pain Site___ Time___ am pm Initial___ **RESULTS:** Scale___ Level___ Time___ am pm Initial___	Scale___ Level___ Pain Site___ Time___ am pm Initial___ **RESULTS:** Scale___ Level___ Time___ am pm Initial___	Scale___ Level___ Pain Site___ Time___ am pm Initial___ **RESULTS:** Scale___ Level___ Time___ am pm Initial___	Scale___ Level___ Pain Site___ Time___ am pm Initial___ **RESULTS:** Scale___ Level___ Time___ am pm Initial___

Resident Name:______________________ Room #________ Doctor:______________________

Diagnosis:____

General Instructions:

1. Choose only one appropriate scale based upon the resident's ability to respond.
2. Identify the scale used and the score for that scale on the other side of this form by using the following key:

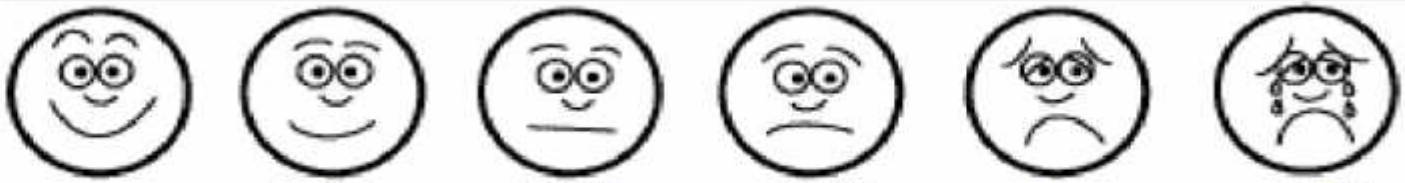
W ONG-BAKER SCALE

N UMERICAL SCALE

F LACC SCALE

WONG-BAKER SCALE:

Initial Instructions: Explain to the resident that each face is for a person who feels happy because he or she has no pain (hurt) or sad because he or she has some or a lot of pain. **FACE 0** is happy because he or she doesn't hurt at all. **FACE 2** hurts just a little bit. **FACE 4** hurts a little more. **FACE 6** hurts even more. **FACE 8** hurts a whole lot. **FACE 10** hurts as much as you can imagine, although you don't have to be crying to feel this bad. Ask the resident to choose the face that best describes how he or she is feeling.



0	2	4	6	8	10
NO HURT	HURTS LITTLE BIT	HURTS LITTLE MORE	HURTS EVEN MORE	HURTS WHOLE LOT	HURT WORS

NUMERIC SCALE: Choose a number from 0 to 10 that best describes the level of pain.

0	1	2	3	4	5	6	7	8	9	10
NO PAIN	MILD PAIN, ANNOYING Pain is present but does not limit activity.		NAGGING PAIN, UNCOMFORTABLE, TROUBLESOME Can do most activities with rest periods.		MISERABLE, DISTRESSING Unable to do some activities ecause of pain.		INTENSE, DREADFUL, HORRIBLE Unable to do most activities because of pain.		WORST PAIN POSSIBLE, UNBEARABLE Unable to do any activities because	

FLACC SCALE:

Initial Instructions: The FLACC is a behavior pain assessment scale for use with nonverbal residents who are unable to provide reports of pain. Rate the resident in each of the five measurement categories, add the scores together, and document the total pain score.

FACE	0 No particular expression of smile.	1 Occasional grimace or frown, withdrawn, disinterested.	2 Frequent to constant frown, clenched jaw, quivering chin.
LEGS	0 Normal Position or relaxed.	1 Uneasy, restless, tense.	2 Kicking, or legs drawn up.
ACTIVITY	0 Lying quietly, normal position, moves easily.	1 Squirming, shifting back and forth, tense.	2 Arched, rigid, or jerking.
CRY	0 No crying (awake or asleep).	1 Moans or whimpers, occasional complaint	2 Crying steadily, screams or sobs, frequent complaints.
CONSOLABILITY	0 Content, relaxed.	1 Reassured by occasional touching, hugging, or "talking to." Distractible.	2 Difficult to console or comfort.

DATA COLLECTION FOR ANALYSIS, OUTCOME EVALUATION AND PERFORMANCE IMPROVEMENT FORM

Pain Management Program: Pain Screen

Pain Screen Standard: A Pain Screen, including a Pain Rating Scale is documented for each new admission.

- Sample:

  Dates:
  From _____ to _____. Sample based upon a _____% of _____ number of residents.

- Audit Findings:

  ⌒ All sampled new admissions had properly documented Pain Screen and Rating Scale (when applicable).

  ⌒ ____% of sampled new admissions who had properly completed Pain Screen and Rating Scale.

  Comments: _____

  _____

- Preliminary Analysis: Based upon sample data, compliance with the facility's pain management/pain screen policy and procedure has been:

  ⌒ fully achieved, no referral.

  ⌒ partially achieved, referred to CQI Committee for analysis.

  ⌒ not achieved, immediately referred to Administrator for analysis and action plan.

  Comments: _____

  _____

- CQI Committee Analysis Findings: _____

  _____

  _____

  _____

- Action Plan to improve outcome/performance: _____

  _____

  _____

  _____

  _____

DATA COLLECTION FOR ANALYSIS, OUTCOME EVALUATION AND PERFORMANCE IMPROVEMENT FORM

Pain Management Program: Pain Assessment

Pain Assessment Standard: A Pain Assessment is documented if the Pain Rating Scale score is above upon admission, re-admission, planned discharge, when warranted by changes in condition, treatment, and self-reporting or evidence indicative of pain; in nursing facilities at the time of the quarterly MDS if has been recorded; in assisted living facilities, semi-annually, and at least annually in residential health facilities and adult day health centers.

- Sample:

  Dates:
  From _____ to _____. Sample based upon a _____% of _____ number of residents.

- Audit Findings:

  ^ All sampled resident records validate Pain Assessments properly documented.

  ^ ____% of sampled residents who had properly documented a Pain Assessment.

  Comments: _____

  _____

- Preliminary Analysis: Based upon sample data, compliance with the facility's pain management/pain sessment policy and procedure has been:

  ^ fully achieved, no referral.

  ^ partially achieved, referred to CQI Committee for analysis.

  ^ not achieved, immediately referred to Administrator for analysis and action plan.

  Comments: _____

  _____

- CQI Committee Analysis Findings: _____

  _____

  _____

- Action Plan to improve outcome/performance: _____

  _____

  _____

  _____

DATA COLLECTION FOR ANALYSIS, OUTCOME EVALUATION AND PERFORMANCE IMPROVEMENT FORM

Pain Management Program: Pain Treatment

Pain Treatment Standard: A Pain Treatment is documented and effectiveness of treatment is recorded us the Pain Rating Scale. Treatment plans are adjusted in response to resident outcomes.

- Sample:

  Dates:
  From _____ to _____. Sample based upon a _____% of _____ number of residents.

- Audit Findings:

  ^ All sampled resident records validate that the effectiveness of Pain Treatment measures are properly documented.

  ^ ____% of sampled residents whose records included a properly documented a Pain Treatment record.

  Comments: _____

  _____

- Preliminary Analysis: Based upon sample data, compliance with the facility's pain management/pain treatment policy and procedure has been:

  ^ fully achieved, no referral.

  ^ partially achieved, referred to CQI Committee for analysis.

  ^ not achieved, immediately referred to Administrator for analysis and action plan.

  Comments: _____

  _____

- CQI Committee Analysis Findings: _____

  _____

  _____

  _____

- Action Plan to improve outcome/performance: _____

  _____

  _____

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Research and Document Review initiated prior to submission of reviewed and updated version in November 2016 and emended version May 2017 to support the documentation contained in this Best Practice on Pain Management.

The committee conducted a thorough online and in person search and review of :

- Skilled Nursing Facility Regulations as promulgated and published by the Center for Medicare and Medicaid Services at CMS.gov and other websites
- The State Operations Manual
- 42 CFR and all of it's components
- MDS 3.0 RAI Manual v1.14 and MDS forms, effective October 1, 2016.
- Assisted Living Regulations in New Jersey N.J.A.C. Chapters 8:36 and 8:39
- Multiple internet searches for opioid use, reduction, warnings
- AMDA – The Society for Post-Acute and Long-Term Care Medicine PAINAD Assessment
- Attended multiple webinars and seminars including but not limited to:
  - "Assessment and Evidence-based Treatments for Opioid Use Disorder", 11/29/2016, presenters:
    - Deborah Dowell, MD, MPH, Senior Medical Advisor, CDC
    - Joseph O. Merrill, MD, MPH, Associate Professor Department of Medicine University of Washington Harborview Medical Center
    - Mark Sullivan, MD PhD, Professor Psychiatry and Behavioral Sciences, Anesthesiology and Pain Medicine, Bioethics and Humanities University Of Washington
  - "Management of Pain in the Elderly Patient" 4/25/2017 presenter
    - Manan Patel, MD, Mobile Pain Solutions

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