

A SYSTEMS APPROACH TO QUALITY IMPROVEMENT  
IN LONG-TERM CARE:

# PAIN MANAGEMENT

**MASSPRO**

*Making an Impact.*



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# A Systems Approach to Quality Improvement in Long-Term Care:

## Pain Management

### Table of Contents

Introduction

Tab 1 Organizational Commitment to Pain Management

Tab 2 Pain Management Policies

Tab 3 Educating Staff

Tab 4 Screening, Assessing and Monitoring Pain

Tab 5 Treatment and Clinical Tools for Pain Management

Tab 6 Care Planning for Pain

Tab 7 Educating Residents and Families

Tab 8 Identifying and Reporting Pain: A Facility-Wide Responsibility

Tab 9 Regulations and Resources Related to Pain

Tab 10 References

## Acknowledgements

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- The University of Wisconsin-Madison Institutionalizing Pain Management Project (References from Building an Institutional Commitment to Pain Management - The Wisconsin Resource Manual 2<sup>nd</sup> Edition, 2000)
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## Disclaimer

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Masspro stresses that medical knowledge and pharmacologic options for pain management are constantly changing. Information found in this workbook is intended as general information only. This workbook should be used as a guide for implementing processes and all medical/ pharmacologic references would need verification for current appropriateness.

This material was prepared by Masspro under contract with the Centers for Medicare & Medicaid Services (CMS). The contents presented do not necessarily reflect CMS policy.

## Terms

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**Masspro** – Massachusetts Peer Review Organization, Inc., the healthcare Quality Improvement Organization (QIO) for Massachusetts.

**QIO** – (Quality Improvement Organization) The name for the organizations across the United States working to improve quality of care in various healthcare settings.

**CMS** – Centers for Medicare & Medicaid Services, an agency of the U.S. Department of Health and Human Services

**NHQI** – (Nursing Home Quality Initiative) The CMS initiative on improving nursing home quality of care. Includes the public reporting of 10 quality measures and work done in partnership with QIOs across the country on improvement projects.

**MedQIC** – ([www.medqic.org](http://www.medqic.org)) CMS developed this comprehensive online resource of quality improvement information for Medicare's National Quality Improvement Priority Topics.

## A Systems Approach to Quality Improvement in Long-Term Care: Pain Management

### Introduction

The goal of this workbook is to give long-term care health providers throughout Massachusetts the information and resources they need to improve systems essential for managing pain for residents. The workbook should also assist long-term care facilities in advancing the quality of pain management services and clinical outcomes for residents receiving those services and provide information to assist facilities with JCAHO (Joint Commission on Accreditation of Healthcare Organizations) evaluations of pain care.

This workbook is based upon material developed for the Centers for Medicare & Medicaid Services (CMS) Nursing Home Quality Initiative (NHQI) and information obtained from multiple sources and guidelines related to pain management. Recommendations from the American Geriatrics Society (AGS), the American Medical Directors Association (AMDA), the American Pain Society (APS), the University of Wisconsin-Madison, Institutionalizing Pain Management Project, and others are referenced throughout this manual.

### Need

Pain is the most common reason individuals seek medical attention. According to the American Pain Society (APS), 50 million Americans are partially or totally disabled by pain, and 45% of all Americans seek care for persistent pain at some point in their lives. Pain is the most common reason individuals seek healthcare.

What is pain? The International Association for the Study of Pain gives this definition, “an unpleasant sensory and emotional experience, associated with actual or potential tissue damage or described in terms of such damage.” (Merskey and Bogduk 1994; APS 2003).

There are no biological markers of pain. Therefore, the most accurate evidence of pain and its intensity is based on the patient’s self report (Turk and Melzack; 1992, APS 2003). A simpler definition might be that pain is “whatever the person says it is, existing whenever he/she says it does” (McCaffery 1999; Teno et al.).

Pain may include a range of physiological, emotional and sensory symptoms, such as aching, throbbing, burning, numbness, squeezing, pressure, cramping, and tightness. These sensations may vary in severity, persistence, source, and management. In the long-term care setting, pain prevalence can be as high as 85% (Stein; et al. 1996). According to the AGS Panel on Chronic Pain in Older Persons (1998, 2002), chronic pain in the long-term care setting is generally under-recognized and under-treated.

Assessment and treatment of pain are basic rights for all residents. Working towards the goal of competent pain care for residents in nursing facilities starts with an administrative commitment to improve pain assessment and management and provide policies, procedures, and support for staff. Components of clinical practice include outlining the processes necessary for understanding and recognizing pain, routinely screening all residents for pain, assessing pain, planning care to manage pain, and ongoing monitoring of the pain plan. A cycle occurs that involves continuous analysis of the individual resident’s pain management needs and outcomes. Evaluating outcome measures can reflect overall success of the facility’s pain management program.

## Masspro's Nursing Home Quality Initiative

Masspro staff and project partners have been working since 2002 to improve pain assessment and management in long-term care facilities in Massachusetts through the NHQI. Efforts include:

### Information Campaign

Since the fall of 2002, Masspro staff and project partners have educated long-term care facilities (LTCF) about the CMS NHQI and the public reporting of 10 quality measures. Information and resource sharing will continue to be provided to providers and the public.

### Pain Workbook

Distribution of this pain workbook, "A Systems Approach to Quality Improvement in Long-Term Care: Pain Management" to Massachusetts LTCFs.

### Educational Workshops and Consultation

Masspro presents workshops on pain management and consultation for LTCFs throughout the state.

### Contributions to [www.medqic.org](http://www.medqic.org)

Masspro has contributed education materials and resources to the MedQIC website.

## How to Use This Resource Manual

This pain management workbook is designed to outline a process that leads to improvement in managing pain. Each tabbed section has an explanation of the material found within each tab. Tools that apply to the particular section are listed as well as actions, key points, and reminders that assist you in moving through the various tabs.

Though the tabs may be thought of as "steps," you may find your facility has worked on all or some of the areas or may be at the beginning stages of forming a pain management program. No matter where you determine

your facility's needs, improvement is continuous and can involve both new development of practices as well as revisions of current practices.

## Major Areas of Focus

- Tab 1 Organizational Commitment to Pain Management
- Tab 2 Pain Management Policies
- Tab 3 Educating Staff
- Tab 4 Screening, Assessing and Monitoring Pain
- Tab 5 Treatment and Clinical Tools for Pain Management
- Tab 6 Care Planning for Pain
- Tab 7 Educating Residents and Families
- Tab 8 Identifying and Reporting Pain: A Facility-Wide Responsibility
- Tab 9 Regulations and Resources Related to Pain Management
- Tab 10 References

### Note:

For ease of reading, we used the term "residents" throughout this workbook. All materials apply to long-term care residents and short-stay patients.

# Tab 1: Organizational Commitment to Pain Management

## Commitment of Organization

Many factors make pain assessment and management in the long-term care setting challenging. Organizational commitment, also referred to as institutional commitment, is essential to overcoming these barriers. The leadership of the organization must ensure that a commitment to resident comfort permeates all aspects of the facility's operation. The Agency for Healthcare Research and Quality (AHRQ), American Pain Society (APS), and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) emphasize the need for:

- Establishment of a formalized approach to pain management
- Agency standards for collaborative and interdisciplinary approaches
- Policies and procedures that guide appropriate practice
- Individualized pain control plans
- Routine screening, assessment, and frequent reassessment
- Both pharmacological and non-pharmacological strategies to alleviate pain

This system-wide interdisciplinary approach has become known as “institutionalizing pain management.” This process focuses on identifying and breaking down system barriers to effective pain management, while using several methods to incorporate the basic principles of pain management into patterns of daily practice.

### Actions:

- Commit your organization to improving pain assessment and management for all residents.
- Assess pain management practices and policies. Compare them to nationally published standards and guidelines.
- Identify improvement areas
  - Develop a plan for improvement
  - Pilot the plan in one area of the facility
  - Evaluate the plan and make necessary changes
  - Roll out the plan facility-wide
  - Evaluate improvement

### In This Section:

#### Recognition of Pain in LTC

Addresses building a facility-wide, “top leadership down” commitment to managing pain.

#### Pain Management: Essential Systems for Quality Care

This tool is designed to help you identify areas of focus for systems review. It provides key interventions for the area being reviewed and allows you to identify where actions are needed.

#### Flow Diagram: Organization Commitment to Pain Management

This diagram addresses logical steps and key elements that explain a system-wide approach to managing pain.

#### Checklist: Evaluate Key Steps for Organizational System

This checklist focuses on the initial process steps necessary in developing a pain management program. This checklist links to other checklists in following tabs.

#### Action Plan

Use this form to help plan your improvement steps.

#### Quality Improvement Monitoring of Pain Management Process

#### Quality Improvement Monitoring of Pain Management for Resident

### Key Point:

Identifying current practice and determining strengths and weaknesses is pivotal in planning improvement activities.

# Recognition of Pain in Long-Term Care

## Recognizing Pain

Pain is under-recognized for many of the same reasons that the early signs and symptoms of many other conditions, such as depression, congestive heart failure, and adverse effects of medications are under-recognized in the long-term care setting. The clinical practice guidelines for “Chronic Management in the Long-Term Care Setting” from the American Medical Directors Association (AMDA), identifies some of the following barriers regarding the recognition of chronic pain in the long-term care setting.

## Barriers

### System Barriers

Pain is often overlooked and is a low priority for many facilities. High turnover of direct caregivers, inadequately functioning care teams, insufficient commitment to pain management by leadership in long-term care facilities, and the highly regulated nature of the long-term care setting may result in a system that fails to give priority to the recognition, assessment, and treatment of pain. Other factors may include inappropriate nurse/resident ratios, physician reluctance to use opioids for non-malignant pain, the lack of staff knowledge or appropriate tools, and the fear of regulatory scrutiny.

### Co-Existing Illnesses, Multiple Diagnoses, and Multiple Medication Use Barriers

Illness such as depression, multiple diagnoses such as degenerative joint disease, diabetes, cancer (occurring at the same time), as well as multiple medication use, may reduce residents’ ability to interpret or report pain. The use of multiple medications may also modify response to pain, hindering staff ability to recognize that a resident is in pain.

### Cognitive and Communication Barriers

Cognitive impairment, delirium (common among the acutely ill elderly), and dementia which occurs in as many as 50% of the institutionalized elderly, pose serious barriers to pain assessment. Residents may be unable to report feeling pain or to respond to caregivers’ questions about pain due to cognitive or sensory impairments, or because of difficulties with language or speech. Direct care staff or supervisors may fail to recognize the behaviors or language (of cognitively impaired residents) that suggest the presence of pain.

### Cultural and Social Barriers

Racial, ethnic, and gender biases held by both residents and caregivers may hinder residents from reporting pain and may reduce caregivers’ sensitivity to the signs and symptoms of pain. Strongly held religious beliefs may prevent residents from acknowledging pain or accepting treatment for pain.

### Atypical Presentation

Elderly residents in general may not show the typical signs and symptoms of a condition or may not exhibit the expected signs and symptoms to the same degree as younger residents.

### Staff Training and Access to Appropriate Tools

Caregiving staff may need education regarding current recommendations for assessing pain in elders and/or using valid tools that are available to screen for pain.

## Recognition of Pain in Long-Term Care

### Misconceptions

In addition to the aforementioned issues regarding the under-recognition of pain, there are several specific reasons rooted in the nature of pain and societal attitudes toward it. Pain is subjective and lacks objective biological markers.

Some of the common misconceptions about chronic pain in the elderly include:

- Chronic pain is a sign of personal weakness.
- Chronic pain is a punishment for past actions.
- Chronic pain means death is near.
- Chronic pain always indicates the presence of a serious disease.
- Pain will lead to a loss of independence.
- The elderly, especially the cognitively impaired, have a higher tolerance for pain.
- The elderly and the cognitively impaired cannot accurately self-report pain.
- Residents in long-term care say they are in pain in order to get attention.
- Elderly residents are likely to become addicted to pain medication.

The most accurate and reliable evidence of the existence of pain and its intensity is the **residents' self-report**. Elderly people often describe **discomfort, hurting, or aching**, rather than use the specific word "pain."

Unrelieved chronic pain is not an inevitable consequence of aging. The presence of pain is always abnormal. Certain conditions that cause chronic pain are more common in the elderly, including: joint disease, osteoporosis, neuropathic pain from diabetes, shingles or other sources, peripheral vascular disease, immobility, and amputations.

### Chronic Pain in LTC

Most chronic pain in the long-term care setting is related to arthritis and musculoskeletal problems. Surveys have found that nearly one in four nursing facility residents had some form of arthritis (AGA; 1998). Older people with chronic pain may experience deconditioning, gait disturbances, falls, slow rehabilitation, multiple medication use, cognitive impairment, malnutrition, social withdrawal, and depression.

Weissman (2001) developed the eight-step process detailed in a report called, "Building an Institutional Commitment to Pain Management." This process can guide an organization through the process of developing a pain management program:

#### Steps to Making an Institutional Commitment

1. Develop an interdisciplinary workgroup
2. Analyze current pain management practices in your care setting
3. Articulate and implement a standard of practice for pain management
4. Establish accountability for pain management
5. Provide information about both pharmacologic and non-pharmacologic intervention to clinicians to facilitate order writing, interpretation, and implementation of orders
6. Promise individuals and families a quick response to their reports of pain
7. Provide education for all staff
8. Continually evaluate and work to improve the quality of pain management.

### Recognition of Pain in Long-Term Care

The AMDA Guidelines for “Chronic Pain Management in the Long-Term Care Setting” outline the following areas as critical in building an institutional commitment to pain management:

#### **Communication**

Communication mechanisms must be in place to ensure that information about a resident’s pain is routinely conveyed and acted on by the appropriate staff. The use of a common vocabulary to describe pain along with standard pain screening and assessment tools that are understood by everyone should be used routinely.

#### **Education**

Healthcare professionals at all levels need better education about pain management. Education about pain assessment and treatment is an essential element of orientation and training. Nursing assistants and other direct caregiving staff should receive training and mentoring in pain recognition.

A pain management program should include correcting misconceptions and myths about pain. The education should help staff identify and overcome their own cultural and gender biases. Staff should be trained in the proper use of pain assessment tools, and how to promote and coordinate pain management.

#### **Staffing**

There is some evidence that staffing patterns that allow for staff to remain with the same residents for extended time periods may improve pain detection.

## Pain Management: Essential Systems for Quality Care

The following information suggests areas to focus on while evaluating current facility interventions for pain management.

### Systems to Review      Key Interventions to Review For Improvement in Pain Management

#### *Organizational commitment to pain management*

- Identify key staff to participate in an interdisciplinary workgroup.
- Analyze current pain management practices.
- Articulate and implement a standard of practice based on accepted clinical guidelines
- Establish and implement policies and protocols related to pain management.
- Establish accountability for pain management.
- Provide appropriate educational materials to physician and nursing staff.
- Implement plan to evaluate the quality of the pain management program.
- Designate responsibility and accountability for monitoring of the process.

#### *Initial Screening for Pain*

- Evaluate the facility admission/readmission tools to see if they address the question of whether or not the resident has any pain.
- Standardize the screening process for pain (i.e. add screening tool to admission/readmission documentation).
- Institute use of appropriate tools to identify pain in cognitively impaired residents.
- Designate responsibility and accountability for admission screening.

#### *Comprehensive Assessment for Pain*

- Determine schedule for assessments.
- Evaluate assessment tools to determine if the necessary assessment data is incorporated.
- Develop procedure for incorporating assessment data into resident plan of care.
- Determine responsibility and accountability for implementation of the plan of care.
- Determine process for monitoring the resident's response to the plan of care.
- Determine schedule for reassessment of pain.

#### *Development of a plan of care*

- Designate responsibility and accountability for care plan development and oversight.
- Ensure that care plan adheres to accepted clinical guidelines that include both pharmacological and non-pharmacological interventions and addresses resident specific goals and actions.

#### *Ongoing Screening and Monitoring for Pain*

- Institute use of standardized pain scale tools, as appropriate, for cognitively intact and cognitively impaired residents.
- Institute schedule to screen with every MDS Assessment (i.e. Initial, Quarterly, Change of Status, Annual).
- Determine schedule for ongoing screening (i.e. daily, weekly, monthly) and monitoring of pain and response to pain management.
- Designate responsibility and accountability for ongoing screening.

*This material was developed by the QIO program for CMS' NHQI*

**Organizational Commitment to Pain Management in Your Facility**



*This material was developed by the QIO program for CMS' NHQJ and is intended as general information. Any individual using the material must consider the possibility of human error, changes in medical sciences, and the need to use clinical judgment in each specific case.*

**Checklist: Evaluate Key Steps for Organizational System**

**System to Review:      Organizational Commitment to Pain Management**

Key Interventions	Yes	No	Revise
Key staff are identified to participate in an interdisciplinary workgroup.			
A standard of practice based on accepted clinical guidelines is implemented. Identify.			
Policies and protocols related to pain management are established and implemented. <ul style="list-style-type: none"> <li>■ Initial screening</li> <li>■ Comprehensive assessment</li> <li>■ Reassessment</li> <li>■ Monitoring-scales/flow sheets</li> <li>■ Care planning</li> </ul>			
Accountability for pain management is established (person/persons/team) <ul style="list-style-type: none"> <li>■ Policies and procedures are followed.</li> <li>■ Resident’s right to pain management.</li> <li>■ Oversight of treating pain.</li> </ul>			
Appropriate educational materials are provided to physician and nursing staff.			
Plan is implemented to evaluate the quality of the pain management program. <ul style="list-style-type: none"> <li>■ Measure assessment of pain</li> <li>■ Measure treatment/care planning</li> <li>■ Measure resident satisfaction</li> </ul>			
Responsibility and accountability is designated for monitoring the process. <ul style="list-style-type: none"> <li>■ Planning processes</li> <li>■ Implementing processes</li> <li>■ Data collection</li> <li>■ Evaluating data</li> </ul>			

*This form was developed from materials developed by the QIO program for CMS’ NHQI and is intended as general information. Any individual using the material must consider the possibility of human error, changes in medical sciences, and the need to use clinical judgment in each specific case.*

Action Plan — Pain Management

System Being Addressed: Organizational Commitment to Pain Management		pg 1	
Key Interventions/Tasks	What is Needed?/ Action Items	Who is responsible?	Target Date
1. Key staff are identified to participate in an interdisciplinary pain workgroup.			
2. Analyze current pain management practices.			
3. Implement a standard of practice based on accepted clinical guidelines.			
4. Policies and procedures related to pain management are established and implemented.			

*This form was developed from materials developed by the QIO program for the CMS' NHQI and is intended as general information. Any individual using the material must consider the possibility of human error, changes in medical sciences, and the need to use clinical judgment in each specific case.*

Action Plan — Pain Management

System Being Addressed: Organizational Commitment to Pain Management pg 2

Key Interventions/Tasks	What is Needed?/ Action Items	Who is responsible?	Target Date
5. Accountability for pain management is established.			
6. Appropriate educational materials are provided to physicians and nursing staff.			
7. Plan is implemented to evaluate the quality of the pain management program.			
8. Responsibility and accountability are designated for monitoring of the process.			

*This form was developed from materials developed by the QIO program for the CMS' NHQI and is intended as general information. Any individual using the material must consider the possibility of human error, changes in medical sciences, and the need to use clinical judgment in each specific case.*

Action Plan — Pain Management

System Being Addressed: Organizational Commitment to Pain Management

Key Interventions/Tasks	What is Needed?/ Action Items	Who is responsible?	Target Date

## Quality Improvement Monitoring of Pain Management Process

The following areas may be helpful when determining a method for evaluating a facility's pain management practices. This information can be obtained through the development and implementation of an audit tool.

### Clinical Area Being Monitored (such as):

The effectiveness of the facility's pain management program and its compliance with best practices.

Determine the tool(s) that will be used for assessment and the aspects of care being audited. Utilize a tool that outlines the key interventions necessary in building a facility-wide system for pain management. See facility check lists in this workbook.

- Interdisciplinary workgroup
  - Meetings occur
  - Members active
  - A written plan for improvement is developed, implemented, and re-evaluated
- Standard of practice based on clinical guidelines
  - Compare polices and procedures with published best practices
  - Review periodically as determined by policy and changes in best practices
  - Revise when new information is present
  - Accountability for current practice
- Policies and procedures developed and followed
  - Review periodically as determined by policy
  - Revise as necessary
  - Staff instructed on practices
  - Practices implemented
- Accountability for pain management is established
  - Person/persons/team monitors care on units
  - Communication effective to resident, family, physician, staff, MDS assessor, pain workgroup
  - All staff are held accountable through performance review for identifying pain and clinical staff are held accountable for treating pain

- Educational materials are provided for staff, residents, and families
  - Accessible to all shifts
  - Included in resident admission packets
  - Maintained and current
- Include an evaluation process for professional education

**Data collection:** Designate person/team to collect information- an interdisciplinary team has best success

- Identify opportunities for improvement
- Develop a plan of action
  - Identify specific strategies to address, who will address them, and in what timeframe
- Pilot test the plan in one area of your facility
- Determine status of key interventions- ask probing questions
- Refer to time frames for completion- may be development or revision
- Once completed, assess facility's ability to maintain completed key interventions

### Interpretation:

- Analyze findings, relate to probable cause for status of key intervention
- Evaluation and monitoring (determine frequency and methods to re-evaluate processes)

## Quality Improvement Monitoring of Pain Management for Resident

Monitoring for resident satisfaction and improved outcomes is important in assessing success for pain management practices. The following are examples of areas to address:

1. **Resident satisfaction survey**- Focuses on residents' satisfaction with their specific pain management plan. Be sure to ask about levels of pain relief in any survey. Published satisfaction surveys continue to show that people are satisfied with their pain management in spite of being in significant pain.
  
2. **Chart audit of residents' medical record** - Reviews documentation to assess follow through of policies and procedures. The goal of this review should be to determine whether or not a resident's pain has been improved, NOT only whether or not documentation is complete. The following areas target important practices and outcomes:
  - Screening
  - Comprehensive pain assessment
  - Reassessment
  - Rating scales monitoring/ log sheets (outcome of intervention)
  - Information at admission, transfer/discharge
  - Accurate MDS

Determine method for audit:

- Who will perform record reviews
- Percent of facility audited monthly
- Include an admission, discharge, quarterly MDS, annual MDS

Determine acceptable goals.

Interpret findings and plan of action.

3. Report back to Pain Interdisciplinary Workgroup and facility Quality Improvement Committee.

## Tab 2: Pain Management Policies

Policies provide a framework for practice within a long-term care facility. They direct the course of action for the facility within a specific area and can outline goals related to a program.

**Policy and procedure development should follow your organization's requirements for development and approval before being implemented.**

When developing policies, consider the following:

- Provide a purpose statement
  - Address regulations (Department of Public Health, Ombudsman Reconciliation Act etc.), accreditation standards, professional standards, and clinically-accepted guidelines
- Develop a policy statement, including:
  - Mission, philosophy, organizational commitment
  - Resident's right to pain management
  - Interdisciplinary approach
  - Prompt assessment and diagnosis
  - Prevention of complications
  - Individualized assessment and care planning, MDS coding
  - Personal, cultural, spiritual and/or ethnic beliefs in relation to pain management
  - Treatment based on clinically-accepted guidelines
- Address implementation- (This section often references additional procedures or appendices)
  - Screening, assessing, monitoring for pain
  - Tools that are used
  - Treatment-pharmacological and non-pharmacological
  - Process at discharge and transfer
  - Process for resolution of inadequately managed pain

- Address education
  - Who, when, how often
  - Key areas being addressed
  - Competencies
- Address performance improvement
  - Interdisciplinary pain workgroup
  - Accountability for pain management (person(s)/ team)
  - Evaluation of the program
  - Accountability for monitoring of the process

### Actions:

Assess current pain policy

Develop or revise pain policy

Develop additional procedures

Educate staff regarding policy and procedure changes

Identify accountability to implement the policies

### In This Section:

#### Checklist: Assessing Pain Management Policies

This tool will help you thoroughly assess your organization's current pain management policy (if one exists). A "no" answer to any question should flag an area for improvement.

#### Statement on Pain Management Guidelines

### Key Point:

Further tabs address policy and implementation in the areas of screening, assessing, monitoring.

Reference those tabs for checklists and guidance.

## Checklist: Assessing Pain Management Policies

Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Does your facility have a policy for pain assessment and management?

\_\_\_\_\_ **No.** If no, this is an area for improvement. Use this checklist and current accepted clinical guidelines to create your facility's policy.

\_\_\_\_\_ **This is an area we are working on.** Our target date for revising our policy is: \_\_\_\_\_.  
If needed, use this checklist, current accepted clinical guidelines and the Quality Improvement Worksheets to guide your revision and implementation of your facility's policy.

\_\_\_\_\_ **Yes.** Please continue to the questions below.

### Does your facility's policy for pain assessment and management include the following components?

	Yes	No
1. Does your facility's policy include a statement regarding your facility's commitment to pain management?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your facility's policy include screening, assessment and monitoring of residents for pain?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your facility's policy include the goals of the pain assessment and management program such as:		
Prompt assessment and diagnosis of pain	<input type="checkbox"/>	<input type="checkbox"/>
Specification of appropriate pain scale tools for both cognitively intact and cognitively impaired residents	<input type="checkbox"/>	<input type="checkbox"/>
Steps to be taken in order to monitor treatment effectiveness	<input type="checkbox"/>	<input type="checkbox"/>
Pain treatment techniques based on clinically-accepted guidelines	<input type="checkbox"/>	<input type="checkbox"/>
Improving the resident's well being by increasing comfort and reducing depression and anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Optimize the resident's ability to perform ADLs and participate in activities	<input type="checkbox"/>	<input type="checkbox"/>
Monitoring for side effects related to the use of pain medication (i.e. constipation, nausea, vomiting, sedation, respiratory depression)	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your facility's policy address who, how and when pain management program effectiveness should be monitored and evaluated?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does your facility's policy address a protocol for ongoing monitoring of pain?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your facility's policy address a protocol for communication of reporting of pain to the designated MDS personnel to ensure correct coding?	<input type="checkbox"/>	<input type="checkbox"/>

*If any of the above elements in your policy for pain screening and management are missing:*

- Choose **one** element to focus your quality improvement effort on first.
- Start with the Quality Improvement Worksheet A: Identifying Areas for Improvement to collect data to investigate further.
- Follow the Quality Improvement Worksheets to implement missing element(s) and monitor regularly to determine whether implementation is successful.

If none of the above elements are missing from your facility's policy, please continue to another checklist.

# **Statement on Pain Management**

*All patients have  
a right to pain relief.*

## **Health care providers will:**

- Inform patients at the time of their initial evaluation that relief of pain is an important part of their care and respond quickly to reports of pain.
- Ask patients on initial evaluation and as part of regular assessments about the presence, quality, and intensity of pain and use the patients' self report as the primary indicator of pain.
- Work together with the patient and other health care providers to establish a goal for pain relief and develop and implement a plan to achieve that goal.
- Review and modify the plan of care for patients who have unrelieved pain.

University of Wisconsin Hospital and Clinics  
UW Children's Hospital

Pain

Guideline	Overview	Source	Address	Cost
Acute Pain Management in The Elderly	User friendly guideline booklet developed from existing pain guidelines and current research. Divided into purpose; definitions related to pain; recommendations for practice (assessment, education, monitoring, pharmacological management, nonpharmacological management, and assessing effectiveness); Appendices of tools; references; and contact information.	University of Iowa Research Dissemination Core. Acute Pain Management in The Elderly. 2000.	www.nursing.uiowa.edu/gnirc	\$12.50 to cover the cost of photocopying; these materials are copyrighted and permission must be obtained to duplicate; a permission form accompanies the protocols
Chronic Pain Management in the LTC Setting	The AMDA guidelines provide clinical information for the medical and nursing staff. Provides summary information in table format such as analgesics, assessment forms, side effect management. Good overview of information but does not provide detailed implementation information.	American Medical Directors Association. Chronic Pain Management in the LTC Setting. 1999	AMDA 10480 Little Patuxent Pkwy Suite 760 Columbia, MD 21044 800.876.2632 www.amda.com	\$8.00 for AMDA members; \$12.00 for non-members.  Set of all AMDA guidelines available on CD ROM for \$50.00 for members; \$70.00 for non-members.
Joint Commission on Accreditation of Health Organizations (JCAHO)	These guidelines review the standards related to Pain, the theory behind the standards and the intent of the standards.	JCAHO	www.JCAHO.org	Free
MDS Educational Program - Accurately Assessing Pain and the MDS 2.0	Educational program, workbook, and reference guide for long-term care professionals on pain assessment.	Briggs Corporation. MDS Educational Program - Accurately Assessing Pain and the MDS 2.0.	Des Moines, IA 1-800-247-2343	
Practice Guidelines for Chronic Pain Management	Guidelines appropriate for physician staff not direct care nursing or nursing assistant staff.	American Society of Anesthesiologists. Practice Guidelines for Chronic Pain Management. 1997.	www.asahq.org/practice/chronic_pain/chronic_pain.htm.	Free

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<p>The Management of Chronic Pain in Older Persons</p>	<p>Provides background information and chapters on assessment; pharmacological and non-pharmacological treatment; and healthcare systems. May be geared more toward physician providers than nursing home direct care staff.</p>	<p>American Geriatrics Society Panel on Chronic Pain in Older Persons. The Management of Chronic Pain in Older Persons. 1998.</p>	<p>www.americangeriatrics.org/products/chronic_pain.pdf</p>	<p>Free</p>
<p>The Management of Persistent Pain in Older Persons</p>	<p>Provides background information and chapters on assessment; pharmacological and non-pharmacological treatment; healthcare systems and practical application. May be geared more toward physician providers than nursing home direct care staff.</p>	<p>American Geriatrics Society. The Management of Persistent Pain in Older Persons. 2002.</p>	<p>www.americangeriatrics.org/education/manage_pain_shtml</p>	<p>Free</p>
<b>Literature</b>				
<b>Synopsis</b>				
<p>Reviews literature on pain assessment in cognitively impaired institutionalized elders and offers recommendations for the assessment and treatment of this populations.</p> <p>Pain in LTC residents overview, fundamentals of pain assessment, pharmacologic treatment, nonpharmacologic treatment strategies &amp; end of life care. Provides algorithms for pain assessment for pain management for nonmalignant pain.</p> <p>Offers a brief overview of the epidemiology and consequences of pain, followed by a summary of issues and approaches relevant to pain assessment in older adults. Cohort specific recommendations for comprehensive pain assessment and measurement are then addressed.</p> <p>Improving pain management in long-term care facilities has several unique barriers in comparison to the acute hospital setting. To address these barriers the Medical college of Wisconsin Palliative Care Program began a project in 1996, initially working with 87 long-term care facilities, to improve pain management practices through a series of educational and quality improvement steps. This article reviews the overall structure, results, strengths and weaknesses of this approach to improving pain management in the site of clinical care.</p>				
<b>Additional Literature</b>				
<p>Bernabei R, Gambassi G, Lapane K, et al. Management of Pain in Elderly Patients with Cancer. JAMA 1998; 279: 1877-82.</p>				

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Nursing Home Quality Measures: Pain

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Bigos S, Bowyer L, Braen G et al. Acute Low Back Problems in Adults. Clinical Practice Guidelines No. 14, AHCPR Publication No. 95-0642. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services. Dec 1994.
Buffum M, Miaszkowski C, Sands L, and Brod M. A Pilot Study of the Relationship Between Discomfort and Agitation in Patients with Dementia. Geriatric Nursing 2001; 22(2): 80-85.
Codosh J, Ferrell Ba, Shekelle PG, et al. Quality Indicators for Pain Management in Vulnerable Elders. Ann Int Med 2001; 135: 731-35.
Complementary Care: When is it Appropriate? Who Will Provide It? Ann Int Med 1 Jul 1998; 129: 65-66.
Cramer GW, Galer Bs, Mendelson MA, and Thompson GD. A Drug Use Evaluation of Selected Opioids and Nonopioid Analgesics in the Nursing Facility Setting. J Am Ger Soc 2000; 48(4):398-404.
Feldt KS. The Checklist of Nonverbal Pain Indicators (CNPI). Pain Management Nursing 1995; 1(1):13-21.
Ferrell BA, Ferrell BR, and Osterweil D. Pain in the Nursing Home. Journal of Pain and Symptom Management 1990; 10: 591-98.
Gloth FM III, Scheve AA, Stober BS, et al. The Functional Pain Scale: Reliability, Validity, and Responsiveness in an Elderly Population. Journal of the American Medical Directors Association 2001; 2: 110-114.
Gloth FM III. Pain Management in Older Adults: Prevention and Treatment. Journal of the American Medical Directors Association 2001; 49:188-99.
Herr K and Mobily PR. Comparison of Selected Pain Assessment Tools for Use with the Elderly. Applied Nursing Research 1993; 6:39-46.
Herr KA and Mobily Pr. Pain Management for the Elderly in Alternative Care Settings. In: Pain in the Elderly. Ferrell BR and Ferrell BA (Eds.). Seattle, WA: IASP Press.
Herr KA, Mobily PR, Kohout FJ, and Wagenaar D. Evaluation of the Faces Pain Scale for Use with the Elderly. Clin J Pain 1998; 14: 235-42.
Horgas AL and Tsai PR. Analgesic Drug Prescription and Use in Cognitively Impaired Nursing Home Residents. Nursing Research 1998; 47: 235-42.
Huffman J and Kunik M. assessment and Understanding of Pain in Patients with Dementia. The Gerontologist 2000; 40(5): 574-81.
Hurley AC, Volicer BJ, Hanrahan PA, Houde S, and Volicer L. Assessment of Discomfort in Advanced Alzheimer Patients. Research in Nursing and Health 1992; 15: 369-77.
Kirkaldy-Willis W and Swartz A. Orthodox and Complimentary Medicine: An Alliance for a Changing World. North Atlantic Books, Berkeley, CA. 30 Nov 2000.
Kovach CR, Weissman De, Griffie J, Matson S, and Muchka S. Assessment and Treatment of Discomfort for People with Last-State Dementia. Journal of Pain and Symptom Management 1999; 18(6):291-4.
Kovach C, Griffie J, Muchka S, Noonan P, Weissman De. Nurses' Perceptions of Pain Assessment and Treatment in the Cognitively Impaired Elderly: It's Not a Guessing Game. Clinical Nurse Specialist 2000; 14(5): 215-20.
Luggen As. Chronic Pain In Older Adults: A Quality of Life Issue. Journal of Gerontological Nursing 1998; 24: 48-54.
Lytle DD. An Overview of Acupuncture. Center for Devices and Radiological Health, FDA, PHS, DHHS; May 1993.

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3 of 4

Manga P, Angus D, Papadopolous C, Swan W. A Study to Examine the Effectiveness and Cost-Effectiveness of Chiropractic Management of Low Back Pain. Richmond Hill, Ontario: Kenilworth Publishing, 1993.
Meade T, Dyer D, Browne W, Townsend J, Frank A. Randomized Comparison of Chiropractic and Hospital Outpatient Management for Low Back Pain: Results From an Extended Follow up. <i>BMJ</i> 1995; 311: 349-351.
Miller J, Neelon V, Dalton J, et al. The Assessment of Discomfort in Elderly Confused Patients: A Preliminary Study. <i>Journal of Neuroscience Nursing</i> 1996; 28:175-82.
Morrison RS, Siu AL. A Comparison of Pain and Its Treatment in Advanced Dementia and Cognitively Intact Patients with Hip Fracture. <i>Journal of Pain and Symptom Management</i> 2000; 19: 240-8.
Parmalee Pa, Smith B, and Katz IR. Pain Complaints and Cognitive Status Among Elderly Institution Residents. <i>JAGS</i> 1993; 41:517-22.
Patel M, Guzwiler F, et al. A Meta-Analysis of Acupuncture for Chronic Pain. <i>International Journal of Epidemiology</i> 1989; 18: 900-906.
Sengstaken EA and King SA. The Problem of Pain and its Detection Among Geriatric Nursing Home Residents. <i>JAGS</i> 1993; 41: 541-44.
Shekelle et al. The Appropriateness of Spinal Manipulation for Low Back Pain: Project Overview and Literature Review. <i>RAND, R-4025/1-CCR</i> , 1991.
Simons W and Malabar R. Assessing Pain in Elderly Residents Who Cannot Respond Verbally. <i>Journal of Advanced Nursing</i> 1995; 22: 663-9.
Ter Riet G, Kleijnen J, Knipschild P. Acupuncture and Chronic Pain: A Criteria Based Meta-Analysis. <i>Journal of Clinical Epidemiology</i> 1990; 43: 1191-1199.
Vincent, C.A., Richardson, P.H. The Evaluation of Therapeutic Acupuncture: Concepts and Methods. <i>Pain</i> 1986; 24: 1-13.
Weiner D, Herr K, and Rudy T. Persistent Pain in Older Adults: An Interdisciplinary Guide for Treatment. New York: Springer Publishing Company. In press.
Weiner D, Peterson B, and Keef F. Evaluating Persistent Pain in Long Term Care Residents: What Role for Pain Maps? <i>Pain</i> 1998; 76: 349-57.
Weiner D, Peterson B, and Keefe F. Chronic Pain-Associated Behaviors in the Nursing Home: Resident Versus Caregiver Perceptions. <i>Pain</i> 1999; 80: 577-88.

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4 of 4

## Tab 3: Educating Staff

Once pain management policies and procedures are approved, all staff members need to be informed of new practices or revisions. Staff education also creates buy in of the program.

The goal of staff education is a heightened awareness of pain recognition and treatment. The interdisciplinary workgroup has probably already begun to spread word throughout the facility about the work being done to improve pain outcomes. All staff who work directly with residents should have had an opportunity to give suggestions for improving practices in the facility.

Now there is further opportunity to expand awareness of the facility's pain management program. All relevant staff should be informed of the importance of managing pain for residents. Success of a pain management program requires all staff working together to create an environment committed to this mission.

### Key Points for Educating:

- Communicate the pain management program to physicians
- Inform nursing staff at an appropriate level (i.e., licensed nursing vs. CNA)
- Identify competencies for nursing
- Ensure that relevant staff are informed of the facility's program and their role in it

### In This Section:

**Checklist: Assessing Staff Education and Training**

**Outline for In-Service on Pain Management Program**

**Pain Presentation – Improving Pain Management in Nursing Homes**

Provides material that is helpful in explaining the pain quality measures and key improvement steps.

**Clinical Practice Competency**

**Physician Information Letter**

A sample letter informing medical staff of the facility's program

**Nursing Assessment and Communication to Physicians**

Reviews key points in assessing and communicating a resident's condition to the physician

**Types of Pain**

**Pain Assessment Terminology**

## Checklist: Assessing Staff Education and Training

**Does your facility have initial and ongoing education on pain assessment and management for both nursing and non-nursing staff?**

\_\_\_\_\_ **No.** If no, this is an area for improvement. Use this checklist and the Quality Improvement Worksheets to improve your processes and or staff education on pain assessment and management.

\_\_\_\_\_ **This is an area we are working on.** Our target date for implementing an education program on pain assessment and management is:\_\_\_\_\_. If needed, use this checklist, current accepted clinical guidelines and the Quality Improvement Worksheets to guide your facility’s education program.

\_\_\_\_\_ **Yes.** Please continue to the questions below.

**Does your facility’s education program for pain assessment and management include the following components:**

	Yes	No
1. Are all new staff oriented in pain screening, assessment and management?		
2. Are current staff provided with ongoing education on the principles of pain management?		
3. Does education staff provide discipline-specific education for pain assessment and management (ex. Activities, Dietary, Rehab, Social Services, etc.)?		
4. Is there a designated clinical “expert” available at the facility to answer questions from all staff about pain assessment and management?		
5. Does education take into consideration the personal, ethnic, cultural and religious beliefs surrounding pain management?		
6. Is the education provided at the appropriate level for the learner (i.e. CNA vs. RN)?		
7. Does the education include staff training on documentation methods related to pain (i.e. location, duration, intensity, frequency, aggravating/alleviating factors, pain scales)?		
8. Does your facility’s education program include resident education on pain and its management?		
9. Does your facility’s education program include resident education on pain and it’s management?		

If any of the preceding elements in your facility’s education and training program for pain assessment and management are missing:

- Choose *one* element to focus your quality improvement effort on first.
- Start with the Quality Improvement Worksheet A: Identifying Areas for Improvement to collect data to investigate further.
- Follow the Quality Improvement Worksheets to implement missing element(s) and monitor regularly to determine whether implementation is successful.

## Outline for In-Service on Pain Management Program

(This outline provides an example of key areas to include for teaching pain management in LTC. It is not intended to cover all areas necessary or required for staff instruction by regulation or accreditation entities. It is meant to be used as a starting point leading to further development of the specifics for a particular program)

### I. Training Guidelines

- A. Ensure training occurs at:
  - Orientation
  - On-going at determined frequency (i.e., annually)
  - When changes occur to policies and procedures and/or related to outcome measurements.
- B. Adjust materials of in-service for level of nursing staff and other departmental staff.
- C. Maintain materials for a “pain library” that are based upon clinically accepted guidelines and are accessible to staff.
- D. Address competency for pain management.

### II. Review facility’s mission involving new Pain Management Program

- A. Present the Introduction found in this workbook—promotes importance of managing pain for residents in long-term care settings.
- B. Address the facility’s commitment to the Pain Management Program. Use material from Tab 1 of this workbook—*Organizational Commitment to Pain Management*
- C. Inform staff of interdisciplinary pain workgroup and its work in program development and as part of overall facility’s Performance Improvement Committee.
- D. Inform staff of facility’s plan for accountability for pain management—designate person/persons/team.
- E. Discuss the personal, ethnic, cultural and religious beliefs surrounding pain management.

### III. Review policies and procedures

- A. Review facility’s Pain Management Policy.
- B. Discuss clinically-accepted guidelines used in forming the policy.
- C. Review requirements of Massachusetts DPH regulations for Long Term Care Facilities, circular letters, CMS- 42CFR Part 483 Subpart B- Medicare & Medicaid Requirements for Long-Term Care Facilities, other accreditation requirements.
- D. Instruct on processes of screening, assessing and monitoring for pain.
- E. Review pain assessment terminology, types of pain.

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## Outline for In-Service on Pain Management Program

- IV. Discuss implementation of policy, procedures and clinical tools**
- A. Review selected clinical tools and specific staff responsibility:
- Screening tool
  - Assessment tools (Cognitively Intact/Impaired)
  - Reassessment frequencies
  - Pain Rating Scales (Cognitively Intact/Impaired)
  - Flow Sheets and Documentation forms and requirements
  - Relation to MDS requirements
- V. Provide information on treatment and the management of pain**
- A. Pharmacologic treatments
- Prevention of complications (i.e., constipation related to opioid use, other side-effects, specific instructions regarding medication dosing and limits).
- B. Non-Pharmacologic treatments.
- VI. Review the Care Planning Process**
- A. Importance of communicating, documenting and planning interventions for pain.
- B. Importance of educating residents and families regarding pain management.
- C. Review MDS and coding process.
- D. Instruct how MDS process leads to Pain QM reported every 3 months.
- VII. Discuss the facility's performance improvement monitoring for the pain program**
- A. Measures/aspects of the process facility is monitoring.
- B. Resident satisfaction.

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## Pain Presentation

# Improving Pain Management in Nursing Homes

Reference: Rhode Island Quality Partners, Ann Spenard, RN, C, MSN  
Pain PowerPoint Presentation

## Improving Pain Management in Nursing Homes

**Ann Spenard, RN, C, MSN**  
**Rhode Island Quality  
Partners**



## Overview

- Review Reported Quality Measures
- Review Key Steps to effective pain management
- Review results and use of "Checklists"
- Tips on improving care



## Pain Quality Measures

- Short stay "post-acute" population  
% of residents with moderate or excruciating pain on 14d PPS MDS assessments
- Long "chronic" stay population  
% of residents with moderate or excruciating pain on non-PPS and non-admission assessments



## Pain: Post-Acute Residents

- Assessment used: 14-day PPS
- Numerator: Moderate pain at least daily (J2a=2 and J2b=2) **OR** horrible/excruciating pain at any frequency (J2b=3)
- Denominator: all PAC residents in the facility
- Exclusions:  
Cases in which there is missing or inconsistent data on J2a or J2b



## Pain: Long-Term Care Residents

- Assessments Used: OBRA full or quarterly
- Numerator/Resident Level Measure : Moderate pain at least daily (J2a=2 AND J2b=2) **OR** horrible/excruciating pain at any frequency (J2b=3)
- Denominator: All residents in the facility
- Exclusions:
  - admission MDS assessments (AA8a=01)
  - J2a or J2b is missing or inconsistent



## Risk adjustment variables for pain in long-term care residents:

**Covariate 1**

- Independent or modified independence in daily decision-making (B4=0 or 1)



### Quality Improvement Steps

- Step 1 Document current practice
- Step 2 Evaluate and identify areas to improve
- Step 3 Select one area to improve 1<sup>st</sup>
- Step 4 Define current process
- Step 5 Make changes
- Step 6 Pilot test changes
- Step 7 Evaluate changes



### Quality Improvement Steps 1, 2 & 3

- Step 1 Document current practice
- Step 2 Evaluate and identify areas to improve
- Step 3 Select one area to improve 1<sup>st</sup>
  - Use Checklists to document practice
  - Review results of checklist to evaluate
  - Select one item from checklist to improve



### Key Steps to Effective Pain Management

- Screen residents routinely for pain
- Complete assessment for residents found to have pain on screening
  - Plan of care should address pharmacologic and non-pharmacologic treatments
  - Monitor effectiveness of treatments
- Revise plan of care based on monitoring



### Screen Residents

- Define screening
- Consider as "Fifth Vital Sign"
- When to screen
  - Admission
  - MDS assessment
  - Change in status
  - Regular intervals



### Results: Screening

- 27 out of 29 facilities (93%) have a process for screening for pain on admission/readmission
  - 72%-86% of facilities routinely screen for pain, screen at each MDS assessment, and screen at each change of condition
  - 22 out of 29 facilities (76%) have a process that will lead to comprehensive assessment if pain is identified during screening



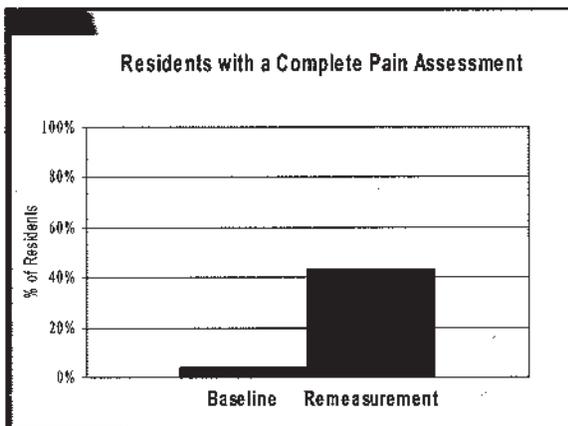
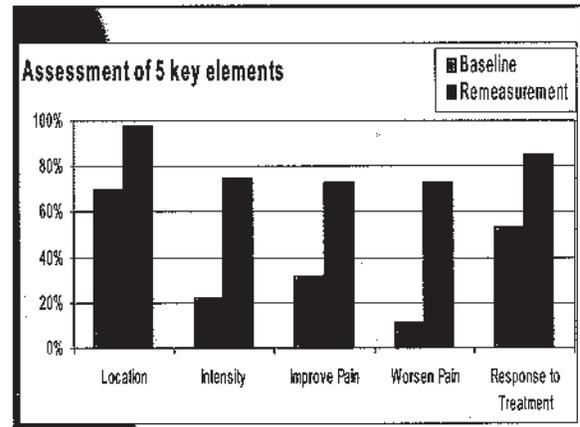
### Key Steps for Screening Residents

- Process at admission defined
- Tools used
- Responsibility for admission screening designated



### Complete Pain Assessment

- If pain is identified upon screening, need comprehensive pain assessment
- Elements of complete assessment
  - Description of pain
  - Location, Intensity, Frequency
  - Pain at it's least/worst
  - Aggravating/Alleviating factors
  - Current treatment
  - Response to current treatment

### Results: Assessment

- 23 of 29 facilities (79%) complete a comprehensive assessment for residents identified as having pain
- Elements most often missing from comprehensive pain assessment:
  - Pain at it's least
  - Aggravating factors
  - Alleviating factors
  - Effects of pain on resident's life.



### Key Steps for Comprehensive Assessment

- Revise assessment tool to ensure it has all recommended elements
- Protocol to complete assessment tool for residents who screen as having pain
- Check that assessment tool is being completed
- Use information in Plan of Care



### How To Revise Assessment

- Step 1 Identify missing areas
- Step 2 Revise form
- Step 3 Remove old forms from units
- Step 4 Discuss if current protocol for completing form is working
- Step 5 Monitor if form is being completed



### Care planning

- Pharmacologic component
- Non-pharmacologic component
- Monitoring component



### Key Steps in Care Planning

- Assessment data incorporated into care plan
- Responsibility for care plan development designated
- Care plan includes pharmacological and non-pharmacological interventions



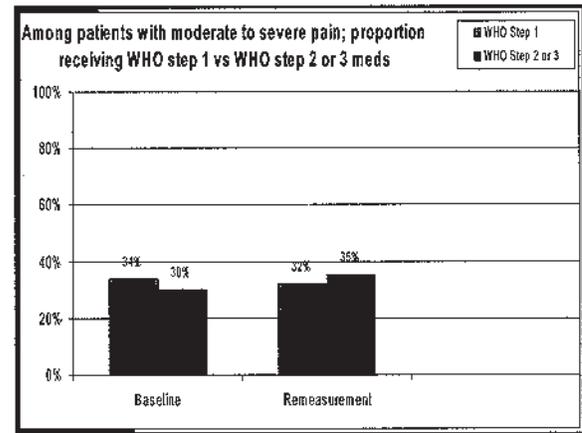
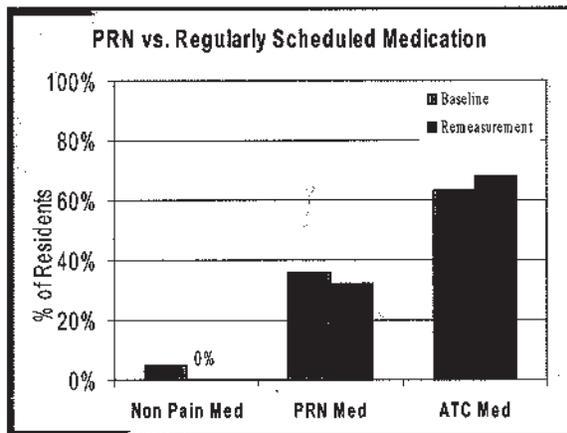
### Results: Care Planning

- 23 out of 29 facilities (79%) have a process for developing and implementing a care plan for pain for residents found to have pain upon screening
- Most facilities' care plans provide for a regular assessment of residents' response to pain medications
- 45% of facilities include education of residents and families about pain management
- 59% of facilities include non-pharmacological approaches to pain management in care plans



### Pharmacologic Treatments

- Using ATC vs PRN frequency
- WHO I vs II or III
  - I = Acetaminophen or NSAID
  - II = Weak Opioid (e.g. codeine)
  - III = Strong Opioid (e.g. morphine)
- Adjuvant complement WHO I, II, III
  - neuroleptics (e.g. neurontin)
  - antidepressants (e.g. amitryptoline)

### Key Steps to Improving Treatment

- Step 1: Administer medications routinely, not prn
- Step 2: Use the least invasive route of administration first
- Step 3: Begin with low dose-Titrate up
- Step 4: Reassess and adjust dose frequently to optimize pain relief while monitoring and managing side effects



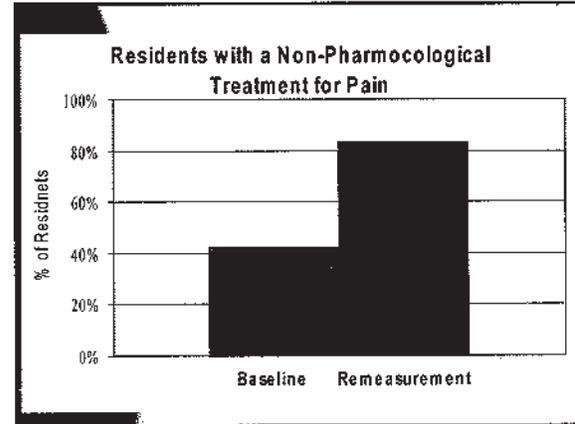
### Non- Pharmacologic Treatments

- Exercise
- Immobilization
- Transcutaneous electrical nerve stimulation (TENS)
- Acupuncture
- Cutaneous Stimulation Techniques
  - Hot/cold
  - Massage
  - Pressure or vibration



### Non- Pharmacologic Treatments

- Relaxation and Imagery
- Distraction and reframing
- Psychotherapy
- Hypnosis
- Peer support groups
- Pastoral counseling

### Monitoring Treatment Effectiveness

- Pain scales
  - Use appropriate tool considering physical and cognitive status of resident

When

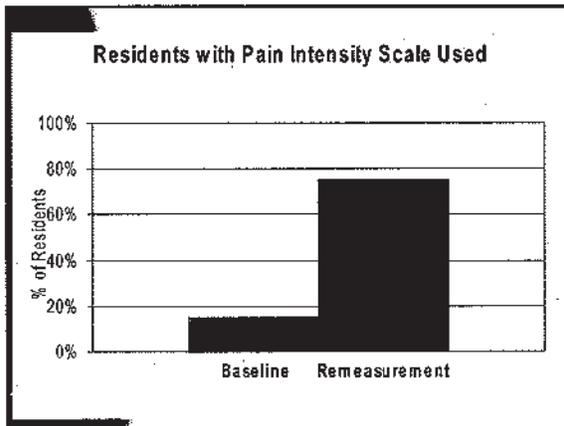
- Minimally daily
- With med changes
- With change in condition



### Key Steps in Monitoring

- Residents monitored for pain at least daily
- Pain scale used
- Responsibility for monitoring designated
- Results of monitoring recorded in medical record





**Results: Monitoring**

- For residents who are being treated for pain, 23 out of 29 facilities (79%) monitor for pain on at least a daily basis
- About the same number use pain scales, use nonverbal cues for pain, and track results of monitoring in medical record

NHPRQI

**Reassessment of Pain**

- Elements of reassessment
  - Includes all elements of comprehensive assessment
- When
  - At regular intervals
  - With any complaints of increasing pain
- Who
  - Anyone requesting increasing doses of prn medication

NHPRQI

**Key Steps in Reassessment**

- Reassessment should include all components in comprehensive assessment
- Pain should be reassessed at regular intervals and when resident complains of persistent or worsening pain
- Reassess residents who are taking increasing doses of PRN medication and who are regularly scheduled medications for pain

NHPRQI

**Results: Reassessment**

- 22 out of 29 facilities (76%) have a process for reassessing residents' pain to evaluate effectiveness of care plan
- Almost all facilities have a policy defining when reassessment should be completed
- 65%-76% of facilities follow policy

NHPRQI

**Clinical Practice Competency:  
Pain Management  
University of Wisconsin Hospital & Clinics**

<b>Criteria for Evaluation</b>	<b>Feedback Date &amp; Signature</b>
NEW ORIENTEE:	
A. Asks all patients on admission and routinely as part of a systems assessment about the presence of pain.	
B. If pain is present, assesses critical characteristics and related factors including: location, quality, intensity, temporal characteristics, alleviating and aggravating factors, impact and meaning of pain, past interventions and responses.	
C. Utilizes a simple and reliable pain intensity measurement tool appropriate to age and cognitive status (i.e. 0-10 rating scale, 0-5 smiley faces).	
D. Collaborates with patient and health care team to define pain relief goal.	
E. Documents initial pain assessment in AIR note, reassessments on daily flowsheet, and frequency of reassess and pain relief goal on critical pathway.	
F. Administers prescribed analgesics as appropriate (e.g., combinations of analgesics, scheduled basis, and titrated to individual needs).	
G. Assesses patients' response to analgesics.	
H. Assesses and teach patient and family about pain management including: <ul style="list-style-type: none"> <li>• pain rating scales and goal setting</li> <li>• importance of aggressive, preventive pain treatment</li> <li>• analgesic misconceptions and plan for pain management</li> </ul>	
I. Utilizes a variety of non-pharmacologic strategies to promote pain relief including: distraction, relaxation, imagery, massage, heat, cold, and positioning.	
J. Makes appropriate referrals to Unit Pain Resource Nurse, Pain Care Team, Acute Pain Service (Anesthesiology), and Pain Clinic, and others.	
J. Makes appropriate referrals to Unit Pain Resource Nurse, Pain Care Team, Acute Pain Service (Anesthesiology), and Pain Clinic, and others.	
K. Demonstrates set-up and use of Bard I PCA pump.	
L. Follows policy and procedure when caring for patients with IV PCA including appropriate	

documentation on pain flowsheet UWH #48.	
M. Defines/recognizes opioid induced respiratory depression and interventions.	
N. *Demonstrates set-up and use of Baxter APII analgesic pump and follows policy and procedure when caring for patients with spinal analgesia including documentation on pain flowsheet UWH #48.	
<b>Additional Pain Resource Nurse Criteria:</b>	
O. Demonstrate comprehensive knowledge of pain management including: <ul style="list-style-type: none"> <li>•basic mechanisms of pain</li> <li>•common misconceptions and barriers of pain management</li> <li>•pain assessment</li> <li>•indications and side effects of opioids, non-opioid analgesics and nonsteroidal anti-inflammatory drugs (NSAIDS), and commonly used adjuvant medications (antidepressants, anticonvulsants, and steroids).</li> <li>•non-pharmacologic strategies including: cutaneous stimulation, cognitive and behavioral techniques, radiotherapy, and neurosurgery.</li> </ul>	
P. Understands the use of the opioid equivalency chart and equianalgesic conversions.	
Q. On an ongoing basis acts as staff and patient resource for pain management issues.	
R. Defines and/or demonstrates nursing management of potential side effects of opiates including: <ul style="list-style-type: none"> <li>•constipation</li> <li>•nausea and vomiting</li> <li>•sedation</li> <li>•respiratory depression.</li> </ul>	
S. Identifies obstacles of optimal pain management including those particular to work setting.	
T. Provides performance evaluation for new unit NCII for pain management competency.	
U. Provides regular feedback to staff on the quality of pain management.	
V. Participates in ongoing self continuing education in pain management.	

## Physician Information Letter

*Purpose: This is a sample of a letter that may be helpful in communicating to physicians. It can be an opportunity to inform attending physicians about the work being done to bring awareness of appropriate pain management to a heightened level in the nursing facility.*

Dear Colleague:

Our nursing facility is pleased to inform you of the work we have done in the area of pain management for long-term care residents.

Recently we have targeted our pain management processes. We have re-evaluated our practices and have promoted a facility-wide commitment to a heightened awareness of pain management for our residents.

When you visit our residents, please take a moment to talk to our staff about our work in this area. Together, with input from residents, families, staff and attending physicians, we hope to continue to work on positive outcomes for residents experiencing pain.

Thank you for being part of our team and working with us on this issue.

Sincerely,

Administrator

Director of Nursing

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## Nursing Assessment and Communication to Physicians

Accurately *Assess* and *Document* pain, pain relief, and the effects of pain on the resident.

Then *Communicate* assessment/information to physician.

### Telephone Report:

- Identify the physician with whom you are speaking.
- Give your name.
- State the nature of the call.
- Identify the resident by name, diagnosis and any pertinent information.
- State the pain management goal (i.e. ambulate 100' with walker, 6 hours of uninterrupted sleep at night, etc.)
- Summarize the resident's condition:
  - changes in quality of pain
  - changes in intensity of pain
  - response to treatment

Effect of the pain on the resident's:

- ability to perform ADLs
  - sleep pattern
  - participation in usual activities
- List the current analgesic doses and the relevant side effects and complementary therapies being used.

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## Types of Pain

**Somatic pain (bone and muscle pain) is:**

- Relatively well localized.
- Worse on movement.
- Tender to pressure over the area.
- Often accompanied by a dull background aching pain.
- Sometimes referred, if it is bone pain, but not along a nerve path; e.g., hip to knee.

**Visceral pain is:**

- Often poorly localized, deep and aching.
- Usually constant.
- Often referred; e.g., diaphragmatic irritation may be referred to the right shoulder, pelvic visceral pain is often referred to the sacral or perineal area.

**Neuropathic pain is:**

- A burning, deeply aching quality that may be accompanied by some sudden sharp lancinating pain.
- Often a nerve path radiation.
- Numbness or tingling over the area of skin.
- Skin sensitivity over the area.
- Severe pain from even slight pressure from clothing or light touch.

## Pain Assessment Terminology

**Location:** Anatomic location of pain. Document on pain map, anatomical drawing or description tool.

**Intensity or severity:** How bad the pain is. Document by numerical, verbal descriptor or faces scale.

**Frequency:** How long the pain lasts.

**Quality:** Description of type of pain. Document symptoms such as: aching, annoying, cramping, exhausting, nauseating, pounding, sharp, throbbing, stabbing, agonizing, blowing, dull, fearful, nagging, penetrating, quivering, shooting, suffocating, numbness, tingling, weakness, spasm, burning, gnawing, pressure, squeezing, radiating, stabbing, tingling, touch sensitive.

**Pain Behaviors:** facial (wrinkled forehead, tightly closed eyes, grimacing, frowning), nonverbal behavior (bracing, rubbing, guarding), vocalizations (crying, yelling, groaning, moaning).

**Nonverbal indicators of discomfort:** aggressive, crying, fearful, noisy respirations, pacing, repetitive, restless, rocking confusion, irritability, increased activity, withdrawal, tense, calling out, grunting, knees pulled up, other change in usual activities, behavior patterns, or routine.

**Duration:** How long the pain has been present and continues to be present (lasting minutes or hours). Document if pain was sudden or a gradual onset, intermittent or continuous.

**Pattern:** How the pain starts, what was being done when it started, what makes it better, what makes it worse.

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## Materials for Professional Education - Listed by Topic

### Acute Pain

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Acute Pain Management: Operative or Medical Procedures and Trauma. February 1992.

Acute Pain Management in Infants, Children, and Adolescents: Operative and Medical Procedures. February 1993.

Acute Pain Management in Adults: Operative Procedures. February 1993.

Pain Control After Surgery: A Patient's Guide (available in English & Spanish), AHCPR, February 1992. 1-800-358-9295.

Principles of Analgesic Use in Acute Pain and Cancer Pain, 5th Edition. American Pain Society, 2003. [www.ampainsoc.org](http://www.ampainsoc.org).

### Cancer Pain

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Guideline for the Management of Cancer Pain in Adults and Children: Clinical Practice Guideline. American Pain Society. 2005.

[www.ampainsoc.org](http://www.ampainsoc.org)

The Patient Guide: Managing Cancer Pain (available in English & Spanish). Cancer Information Service. March 1994.

1-800-4-CANCER

Principles of Analgesic Use in Acute Pain and Cancer Pain, 5<sup>th</sup> Edition. American Pain Society. 2003.

[www.ampainsoc.org](http://www.ampainsoc.org)

## Materials for Professional Education – Listed by Organization

### Alliance of State Pain Initiatives (formerly the American Alliance of Cancer Pain Initiatives)

1300 University Avenue, Rm. 4720  
Madison, WI 53706  
(P) 608-265-4013  
(F) 608-265-4014  
(E-mail) [materials@aacpi.org](mailto:materials@aacpi.org)  
<http://aspi.wisc.edu/>

#### **Publications:**

- Effective Pain Management Practices in Home Health (DVD) Includes discussion guides, case studies and test questions:
  - Pain Assessment: Simplifying the Complex
  - Patient’s Fears and Misconceptions about Pain and Opioids
  - That Extra Pain Medicine Didn’t Help! What to do When Your Patient is Getting Opioids, but is Still in Pain.
  - It Isn’t Pain...Exactly: Treatment of Neuropathic Pain
  - How to Talk to Doctors About Pain Management
  - Managing Opioid Side Effects
  - Pain Management Patient Education
- Building an Institutional Commitment to Pain Management: The Wisconsin Resource Manual, 2<sup>nd</sup> Edition.
- The Handbook of Cancer Pain Management, 5<sup>th</sup> Edition.
- Pain Education Program for Certified Nursing Assistants. 2006.

### American Pain Society

4700 W. Lake Avenue  
Glenview, IL 60025-1485  
(P) 847-375-4715  
(F) 877-734-8758 (Toll free)  
[www.ampainsoc.org/](http://www.ampainsoc.org/)

#### **Publications:**

- Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain, 5th Edition). 2003.
- Guideline for the Management of Acute and Chronic Pain in Sickle-Cell Disease. 1999.
- Guideline for the Management of Fibromyalgia Syndrome Pain in Adults and Children. 2005.
- Guidelines for the Management of Pain in Osteoarthritis, Rheumatoid Arthritis, and Juvenile Chronic Arthritis. 2002.
- Cancer Pain Guideline (see “Cancer Pain” above)
- Pain Control in the Primary Care Setting. 2006)

### American Society for Pain Management Nursing

P.O. Box 15473  
Lenexa, KS 66285  
(P) 888-34ASPMN or 913-752-4975  
(E-mail) [aspmn@goamp.com](mailto:aspmn@goamp.com)  
[www.aspmn.org](http://www.aspmn.org)

#### **Publications:**

- Core Curriculum for Pain Management Nursing. W.B. Saunders. 2002.
- Self-Directed Learning Program: Epidural Analgesia for Acute Pain Management- Study Guide for Certification Review. 2005.  
Cost: \$35.95 (members), \$60.95 (non-members)

**International Association for the Study of Pain  
(IASP) Press**

111 Queen Anne Ave N., Suite 501

Seattle WA 98109-4955

(P) 206 - 283 - 0311

(F) 206 - 283 - 9403

[www.painbooks.org](http://www.painbooks.org) or [www.iasp.org](http://www.iasp.org)

***Publications (priced separately):***

- Core Curriculum for Professional Education in Pain, 3rd Edition. [www.iasp.org](http://www.iasp.org) (download or hard copy)
- Chronic Regional Pain Syndrome: Current Diagnosis and Therapy. 2005.
- Chronic and Recurrent Pain in Children and Adolescents. 1999.
- Core Curriculum for Professional Education in Pain, 3rd Edition. 2005.
- Epidemiology of Pain. 1999.
- Pain in the Older Persons. 2005.

**World Health Organization**

World Health Organization Distribution and Sales

CH-1211 Geneva 27

Switzerland

(P) +41 22 791 24 76

(F) +41 22 791 48 57

(E-mail) [bookorders@who.ch](mailto:bookorders@who.ch)

[www.who.int/](http://www.who.int/)

***Publications:***

- Cancer Pain Relief and Palliative Care. 1990.
- Cancer Pain Relief: With a Guide to Opioid Availability, 2<sup>nd</sup> Edition. 1996.
- Relief and Palliative Care in Children (available in English, Spanish, or French). 1999.
- Symptom Relief in Terminal Illness. 1998.

## Materials from Other Organizations

### American Medical Directors Association

10480 Little Patuxent Parkway, Suite 760  
Columbia, MD 21044  
(P) 410-740-9743 (F) 410-740-4572  
[www.amda.com](http://www.amda.com)

#### **Publications:**

Chronic Pain Management in the Long-Term Care Setting

### British Columbia Children's Hospital

4480 Oak Street  
Vancouver, BC  
V6H 3V4  
Canada  
(P) 604-875-2345 (F) 604-875-3414  
Cost: \$10.00

#### **Publications:**

The British Columbia Children's Hospital Pediatric Oncology Pain Management Guidelines

### Intellicard

PO Box 8255  
Yakima, WA 98908  
(P) 509-965-9266 (F) 509-965-5447  
(E-mail) [info@intelli-card.com](mailto:info@intelli-card.com)  
[www.intelli-card.com/](http://www.intelli-card.com/)

#### **Publications:**

Symptom Management Algorithms, A Handbook for Palliative Care. 2005.  
A pocket-sized book of algorithms

### Medical College of Wisconsin

Palliative Medicine  
9200 W. Wisconsin Avenue  
Milwaukee, WI 53226  
(P) 414-805-4605 (F) 414-805-4608

#### **Publications:**

Improving Pain Management in Long-term Care Settings

### Ohio State Medical Association

3401 Mill Run Drive  
Hilliard, OH 43026  
(P) 614-527-6743 (Suzanne Boyd)  
(F) 614-527-6763

#### **Publications:**

Pain: The Fifth Vital Sign (Pain Management Handbook)

## FREE CEs

*Note: Use sites that have content appropriate to your staff's education needs, competency, and updates. Be sure any new sites are authored by reliable and unbiased sources and the information is reliable and current. Overviews and reviews may or may not offer CEs, but can be excellent resources for education and self-study.*

### Adult Pain Management Staff Education

Posted 2006. University of Michigan.

Access: [www.med.umich.edu/pain/apainmgt.htm](http://www.med.umich.edu/pain/apainmgt.htm)

### Neuropathic Pain: Diagnosis, Treatment, and the Pharmacist's Role in Patient Care

**Access:** <https://secure.pharmacytimes.com/lessons/200509-02.asp>

**Start/End:** Unknown / September 1, 2008

**Credits:** 2.0 ACPE CE (0.2 CEUs)

**Price:** Free

**Program Format:** Brief article

**Sponsor:** Pharmacy Times (See:<https://secure.pharmacytimes.com/main.asp?orderby=&group=all>)

**Author(s):** Hildegard J. Berdine, BS, PharmD, BCPS

**Description:** Neuropathic pain afflicts an estimated 4 million people nationwide and originates from an injury to the peripheral or central nervous system (or both) and develops into a chronic disorder. Neuropathic pain differs from acute nociceptive pain, which is caused in response to a pain-initiating stimulus. This program covers major causes of neuropathic pain, the role of the pharmacist in diagnosis, pharmacologic agents, a treatment algorithm, and new/emerging treatments. Access checked January 9, 2006.

### Osteoarthritis Pain: The Role of Clinical Practice Guidelines in Evolving Treatment

**Access:** <https://secure.pharmacytimes.com/lessons/200511-01.asp>

**Start/End:** Unknown / November 1, 2008

**Credits:** 2.0 ACPE CE (0.2 CEUs)

**Price:** Free

**Program Format:** Brief article

**Sponsor:** Pharmacy Times (See:<https://secure.pharmacytimes.com/main.asp?orderby=&group=all>)

**Author(s):** Mary McHughes, PharmD, MS; Arthur G. Lipman, PharmD

**Description:** There is a new emphasis on systematic, evidence-based clinical practice guidelines (CPG) and this program can help clinicians attain a composite view of current best evidence. The different types of CPG are examined and their use to improve pharmacotherapy in the management of osteoarthritis is described. Access checked January 9, 2006.

### Pain Assessment and Management in Aging (Hanks-Bell, Halvey & Paice)

Published 2004. Online journal of issues on nursing.

Access: [http://nursingworld.org/ojin/topic21/tpc21\\_6.htm](http://nursingworld.org/ojin/topic21/tpc21_6.htm)

## Other Select Educational Web Sites (many offer free CEs)

**Alliance of State Pain Initiatives**

<http://aspi.wisc.edu>

**American Pain Foundation**

[www.painfoundation.org](http://www.painfoundation.org)

**Beckman Research Institute**

[www.cityofhope.org/prc](http://www.cityofhope.org/prc)

**Center for Health Law Studies, Saint Louis University/American Society of Law, Medicine and Ethics**

[www.painandthelaw.org](http://www.painandthelaw.org)

**Department of Pain Medicine & Palliative Care, Beth Israel Medical Center**

[www.stoppain.org](http://www.stoppain.org)

**Emerging Solutions in Pain**

[www.emergingsolutionsinpain.com](http://www.emergingsolutionsinpain.com)

**Massachusetts Pain Initiative**

[www.masspaininitiative.org](http://www.masspaininitiative.org)

**National Institutes of Health (NIH) Pain Consortium**

<http://painconsortium.nih.gov>

**National Pain Education Council**

[www.npecweb.org](http://www.npecweb.org)

**Pain.com**

[www.pain.com](http://www.pain.com)

**PainEDU.org**

[www.painedu.org](http://www.painedu.org)

**Pain Management Grand Rounds, Johns Hopkins Medicine**

[www.hopkinscme.edu](http://www.hopkinscme.edu)

**Pain Research Center, University of Utah**

[www.painresearch.utah.edu/cancerpain/](http://www.painresearch.utah.edu/cancerpain/)

**Pain Treatment Topics**

[www.pain-topix.com](http://www.pain-topix.com)

**Reminder:**

Additional tools for training can be used from the various sections in this workbook.

## Tab 4: Screening, Assessing, and Monitoring Pain

### Screening for Pain

Screening identifies the presence of pain. The process consists of a brief inquiry or question, and often the use of a rating scale or other tool. When properly taught, anyone can screen for pain. A comprehensive assessment must follow to evaluate the pain and develop a plan to manage pain.

#### Screening should occur:

- At admission
- Routinely for all residents- no less often than daily
- On readmission
- At each MDS assessment
- With any change in condition

### Assessing for Pain

A comprehensive assessment for pain is done when pain has been identified at screening, for new symptoms of pain, worsening pain, and with any unrelieved pain.

#### An assessment for pain should be done:

- At admission
- At readmission
- At each MDS assessment
- With reassessment
  - At regularly scheduled intervals when a pain management plan is in place
  - With persistent pain
  - With worsening pain

### Monitoring of Pain

Pain rating scales and pain flowsheets allow for monitoring of a resident's pain. How and when to monitor should be in writing, ongoing, and routine. Each facility must determine frequency as part of policy. The goal of ongoing monitoring is to learn if the resident's care planning goals for managing pain have been achieved. At this time, appropriateness of rating tools and care plan can be assessed and adjusted as necessary.

#### In This Section:

American Society for Pain Management Nursing (ASPMN) Statement on Assessing Pain in Non-Verbal Patients (2006)

Checklist: Screening for Pain

Flow Diagram: Initial Screening/Ongoing Screening for Pain

Checklist: Assessing Pain

Checklist: Reassessing Pain

Flow Diagram: Comprehensive Assessment of Pain

Sample Pain Assessment Tool

Sample Pain Assessment Tool for Cognitively Impaired

Checklist: Monitoring Pain

Flow Diagram- Daily Monitoring of Pain and Response to Pain Management Plan

Sample Pain Rating Scales

Sample Pain Flowsheets

- Cognitively Intact
- Cognitively Impaired

#### Reminders:

Consider having rating scales easily accessible to staff and made of material that can be disinfected.

Determine how to quickly identify which pain rating scale is used for a resident (e.g., faces scale, behaviors).

## Screening, Assessing, and Monitoring Pain

### Pain Screening

Almost all long-term care residents have predisposing factors for developing pain according to the American Geriatrics Society (AGS) clinical practice guidelines, “The Management of Persistent Pain in Older Adults” (AGS; 1998). For this reason, a high index of suspicion regarding the presence of pain is warranted. Since some individuals may be reluctant to acknowledge feeling pain, screening questions for the presence of pain should be phrased in different ways, such as “Does it hurt anywhere?” or “Do you have any aching or soreness?”

If the resident is cognitively impaired, you can ask the family as well as the resident. You should also observe for nonspecific signs and symptoms that suggest pain. These questions and observations should be part of the initial pain screening. Screening for pain should occur at admission, routinely for all residents (no less than daily), on readmission, with each MDS assessment, and with each change in condition.

### Pain Assessment

Once pain has been identified, a comprehensive pain assessment should be completed, as well as a comprehensive plan of care. According to the aforementioned AGS guidelines, a comprehensive pain assessment should include the following characteristics: intensity, character, frequency (or pattern, or both), location, duration, and aggravating and alleviating factors. Published tools are available. Select a published tool for your facility to use for cognitively intact residents and another for cognitively impaired residents. See tools under this tab for examples and the ASPMN “Statement on Assessing Pain in Non-Verbal Patients.”

The initial assessment should also include a thorough analgesic medication history, indicating current and previous use of prescription medications, over the counter

medication and “natural” remedies, and the medications’ effect and side effects, if any. The assessment should incorporate evaluation of physical function including activities of daily living, and performance measures of function (i.e., range of motion). Lastly, the evaluation should include an assessment for psychosocial function, depression, and social networks.

A quantitative assessment of pain should be recorded by the use of a standard pain scale. Residents with cognitive, language, or sensory impairments should be assessed with scales that are tailored for their needs and disabilities (e.g., numerical pain [0-10], visual pain [pain thermometer and faces scale], and verbal descriptor scales).

When pain has been found on screening or a resident is being treated for pain, assessments should be completed on admission, readmission, and reassessment at regular intervals for residents found to have pain, with persistent pain, and with worsening pain. Ideally, pain assessments should be completed at least once a week or more frequently when pain is not controlled, especially if the resident is being monitored for response to pain medication or has active pain symptoms.

### Assessing Other Nonspecific Signs and Symptoms

Staff should be observing for nonspecific signs and symptoms that suggest the presence of pain, including:

- Frowning, grimacing, fearful facial expression, grinding of teeth
- Bracing, guarding, rubbing a body part
- Fidgeting, increasing, or recurring restlessness
- Striking out, increasing, or recurring agitation
- Eating and sleeping poorly
- Change in gait
- Change in behavior (especially in cognitively impaired residents)
- Inability to participate in activities of daily living (ADLs)

Findings such as the above need to be brought to the pain team for further assessment and planning for care.

The RAI (Resident Assessment Instrument) manual also provides definitions for mild and moderate, and times when pain is horrible or excruciating.

### Mild Pain

Code 1 on MDS- Although the resident experiences some (“a little”) pain he or she is usually able to carry on with daily routines, socialization, or sleep.

### Moderate Pain

Code 2 on MDS- Resident experiences “a medium” amount of pain.

### Times When Pain is Horrible or Excruciating

Code 3 on MDS - Worst possible pain. Pain of this type usually interferes with daily routines, socialization, and sleep.

## Monitoring of Pain

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For residents being treated for pain, monitoring pain is necessary to evaluate the resident’s pain treatment plan. This will lead to adjustment of the plan of care as necessary.

### Pain Rating Scales

Monitoring for pain requires the use of an appropriate pain rating scale suitable for cognitively intact and mild-to-moderately cognitively impaired residents. A rating scale capturing behaviors may provide information that allows for monitoring of the pain plan for severely cognitively impaired residents. Behavioral scales do NOT indicate pain intensity and cannot be compared to a verbal descriptor scale. Behavioral tools can indicate if pain worsens, but do not quantify pain.

It is important that the selected scales for nursing home residents are simple, readily available to staff, in large readable print, and in a language that residents understand.

When using a numerical pain rating scale the rating should be documented in a consistent and prominent place in the resident’s record. Example: If a rating of 5 on a 10-point scale is documented, the pain rating is 5/10. Rating scales using faces are available, with the faces correlating to a number.

### Pain Flowsheets

The pain management flowsheet is another way of making pain more visible as the fifth vital sign. Assessment instruments, flowsheets or pain logs provide a consistent way for a facility to document and track a resident’s pain and effectiveness of the treatment plan. It can record pharmacological and non-pharmacologic interventions and their outcomes. Evaluating the flowsheets can help staff adjust the treatment modalities to achieve maximum pain relief for the resident.

## Checklist: Screening for Pain

Does your facility have a process to screen residents for pain?

*(A screening assessment is a brief assessment or question that determines if the resident is having any pain. It does not include a thorough assessment about the pain symptoms or reasons for the pain that needs to be completed if the resident is found to have pain upon screening.)*

\_\_\_\_\_ **No.** If no, this is an area for improvement. Use this checklist and the Quality Improvement Worksheets to guide your team in implementing a process for pain screening.

\_\_\_\_\_ **This is an area we are working on.** Our target date for implementing a process for screening is: \_\_\_\_\_.

\_\_\_\_\_ **Yes.** Please continue to the questions below.

**Does your facility have a process for screening that addresses all the areas listed below?**

	Yes	No
Does your facility have a policy and procedure for when and how the staff will screen residents for pain?	<input type="checkbox"/>	<input type="checkbox"/>
Does your policy and procedure state that residents should be assessed for pain at the following times: At admission At readmission At each MDS assessment With each change in condition	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you routinely ask all residents (using an appropriate tool like the faces scale if necessary) if they have pain at the following times: At admission At readmission At each MDS assessment With each change in condition	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are residents screened using an appropriate tool (e.g., the FACES scale) at regular intervals?		
If pain is identified during screening, does your facility have a process that will lead to a comprehensive assessment?		

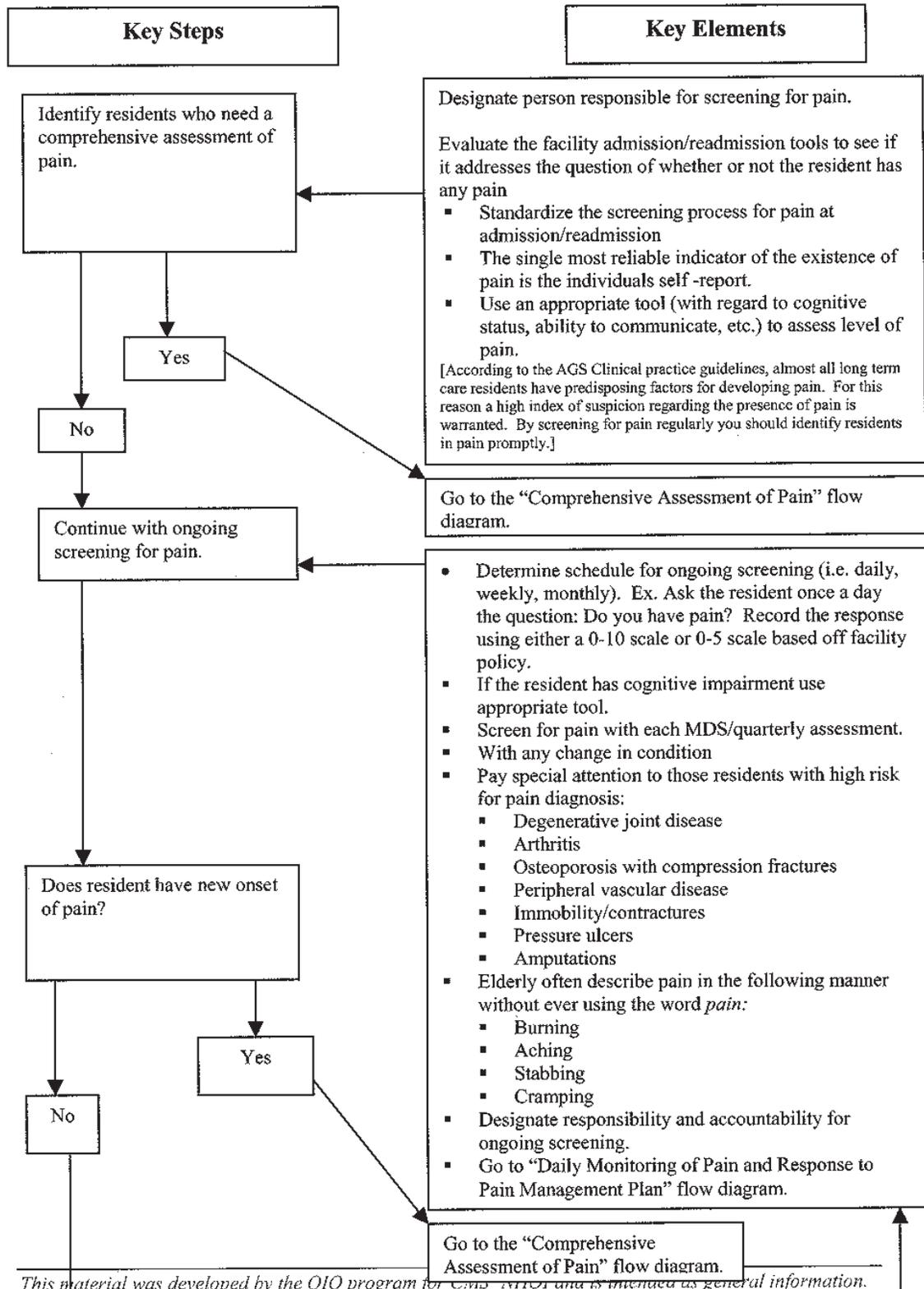
If any of the above elements in your process for screening for pain are missing:

- Choose *one* element to focus your quality improvement effort on first.
- Start with the Quality Improvement Worksheet A: Identifying Areas for Improvement to collect data to investigate further.
- Follow the Quality Improvement Worksheets to implement missing element(s) and monitor regularly to determine whether implementation is successful.

If none of the above elements are missing from your facility's process for care, please continue to another checklist.

Flow Diagram

Initial Screening/Ongoing Screening for Pain



*This material was developed by the QIO program for CMS and is intended as general information. Any individual using the material must consider the possibility of human error, changes in medical sciences, and the need to use clinical judgment in each specific case.*

last modified 9-09-2002

## Checklist: Assessing Pain

**Does your facility complete a comprehensive assessment for pain for residents who are found to have pain upon screening (or, if there is no screening process in place, at another time)?**

*(A comprehensive assessment for pain is often done when someone develops new symptoms of pain or worsening pain that warrants a thorough assessment for this new complaint.)*

\_\_\_\_\_ **No.** If no, this is an area for improvement. Use this checklist and the Quality Improvement Worksheets to guide your team in implementing a process for pain assessment.

\_\_\_\_\_ **This is an area we are working on.** Our target date for implementing a process for assessment is: \_\_\_\_\_. If needed, use the Quality Improvement Worksheets to guide your improvement process.

\_\_\_\_\_ **Yes.** Please continue to the questions below.

**Does your comprehensive pain assessment include all of the elements below?**

	Yes	No
1. On Admission/Readmission/reassessment of the pain management plan, are the following elements on your assessment?		
a. Description of the pain	<input type="checkbox"/>	<input type="checkbox"/>
b. Location of the pain	<input type="checkbox"/>	<input type="checkbox"/>
c. Intensity/severity of the pain using an accepted pain scale	<input type="checkbox"/>	<input type="checkbox"/>
d. Frequency of pain	<input type="checkbox"/>	<input type="checkbox"/>
e. Current pain	<input type="checkbox"/>	<input type="checkbox"/>
f. Pain at its least	<input type="checkbox"/>	<input type="checkbox"/>
g. Pain at its worst	<input type="checkbox"/>	<input type="checkbox"/>
h. Aggravating factors (what makes it worse)	<input type="checkbox"/>	<input type="checkbox"/>
i. Alleviating factors (what makes it better)	<input type="checkbox"/>	<input type="checkbox"/>
j. Effects of the pain on the resident's life (sleep, appetite, physical activity, emotions, mood, nausea)	<input type="checkbox"/>	<input type="checkbox"/>
k. Current treatment	<input type="checkbox"/>	<input type="checkbox"/>
l. Response to current treatment	<input type="checkbox"/>	<input type="checkbox"/>
2. When a comprehensive assessment is done, are all these elements completed and recorded on your assessment form?	<input type="checkbox"/>	<input type="checkbox"/>

If any of the above elements in your process for completing comprehensive pain assessments are missing:

- Choose *one* element to focus your quality improvement effort first.
- Start with the Quality Improvement Worksheet A: Identifying Areas for Improvement to collect data to investigate further.
- Follow the Quality Improvement Worksheets to implement missing element(s) and monitor regularly to determine whether implementation is successful.

If none of the above elements are missing from your facility's process for care, please continue to another checklist.

## Checklist: Reassessing Pain

**Does your facility have a process for reassessing a resident’s pain to determine if the resident’s care plan is effective or needs revision?**

- \_\_\_\_\_ **No.** If no, this is an area for improvement. Use this checklist and the Quality Improvement Worksheets to guide your team in implementing a process for reassessing pain.
- \_\_\_\_\_ **This is an area we are working on.** Our target date for implementing a process for reassessing pain is:\_\_\_\_\_. If needed, use the Quality Improvement Worksheets to guide your improvement process.
- \_\_\_\_\_ **Yes.** Please continue to the questions below.

**Does your facility’s process for reassessing a resident’s pain address all the areas below?**

	Yes	No
1. Does your facility have a policy and procedure defining when a comprehensive reassessment of pain will be completed? <i>(A complete reassessment should be performed for any persistent or worsening pain.)</i>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the reassessment include all the components in the comprehensive assessment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your staff follow the policy and procedure for reassessing pain when the resident is complaining of persistent or worsening pain?	<input type="checkbox"/>	<input type="checkbox"/>
4. Is the resident reassessed for pain at regular intervals after being assessed initially as having pain?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you reassess residents who are taking increasing doses of PRN medication (including those who are also on regularly scheduled medications for pain)?	<input type="checkbox"/>	<input type="checkbox"/>

If any of the above elements in your process for pain reassessment are missing:

- Choose *one* element to focus your quality improvement effort first.
- Start with the Quality Improvement Worksheet A: Identifying Areas for Improvement to collect data to investigate further.
- Follow the Quality Improvement Worksheets to implement missing element(s) and monitor regularly to determine whether implementation is successful.

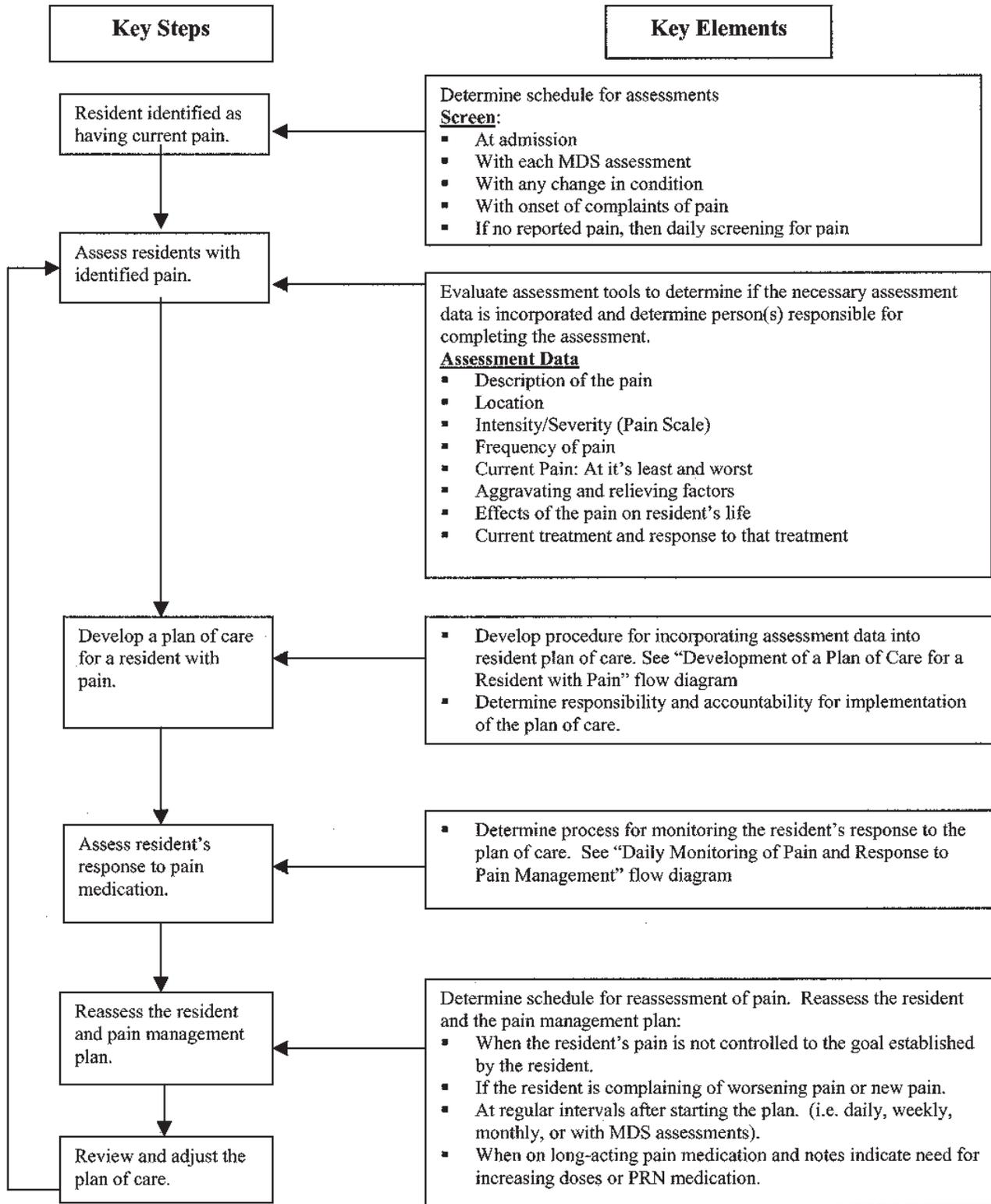
If none of the above elements are missing from your facility’s process for care, please continue to another checklist.

---

*This material was developed by the QIO program from CMS’ NHQI and is intended as general information. Any individual using the material must consider the possibility of human error, changes in medical sciences, and the need to use clinical judgment in each specific case.*

Flow Diagram

**Comprehensive Assessment of Pain**



*This material was developed by the QIO program for CMS' NHQI and is intended as general information. Any individual using the material must consider the possibility of human error, changes in medical sciences, and the need to use clinical judgement in each specific case.*

last modified 9-09-2002

## McCaffrey Initial Pain Assessment Tool

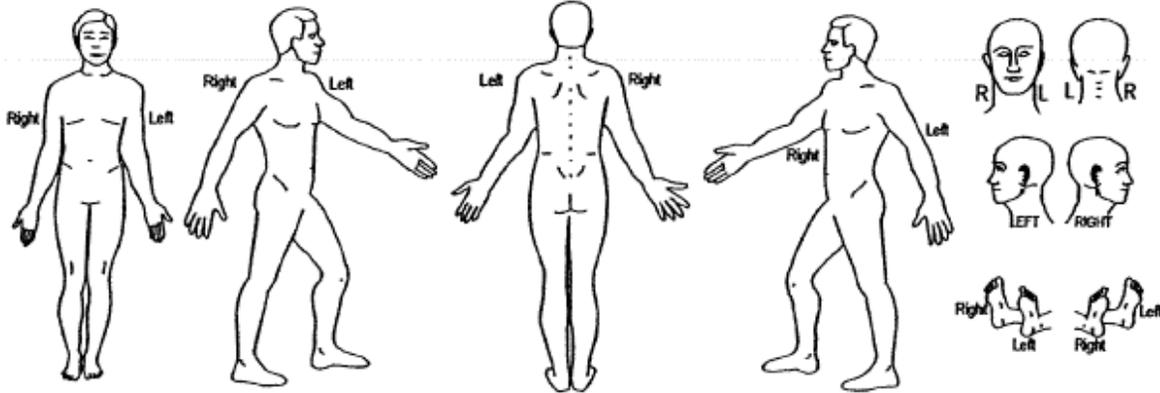
Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Room \_\_\_\_\_

Diagnosis \_\_\_\_\_ Physician \_\_\_\_\_

Nurse \_\_\_\_\_

1. LOCATION: Patient or nurse marks drawing.



2. INTENSITY: Patient rates the pain. Scale used \_\_\_\_\_

Present: \_\_\_\_\_

Worst pain gets: \_\_\_\_\_

Best pain gets: \_\_\_\_\_

Acceptable level of pain: \_\_\_\_\_

3. QUALITY: (Use patient's own words, e.g., prick, ache, burn, throb, pull sharp) \_\_\_\_\_

4. ONSET, DURATION, VARIATIONS, RHYTHMS: \_\_\_\_\_

5. MANNER OF EXPRESSING PAIN? \_\_\_\_\_

6. WHAT RELIEVES THE PAIN? \_\_\_\_\_

7. WHAT CAUSES OR INCREASES THE PAIN? \_\_\_\_\_

8. EFFECTS OF PAIN: (Note decreased function, decreased quality of life.)

Accompanying symptoms (e.g., nausea) \_\_\_\_\_

Sleep \_\_\_\_\_

Appetite \_\_\_\_\_

Physical activity \_\_\_\_\_

Relationship with others (e.g., irritability) \_\_\_\_\_

Emotions (e.g., anger, suicidal, crying) \_\_\_\_\_

Concentration \_\_\_\_\_

Other \_\_\_\_\_

9. OTHER COMMENTS: \_\_\_\_\_

10. PLAN: \_\_\_\_\_

May be duplicated for use in clinical practice. From McCaffrey M, Pasero C: Pain: Clinical manual, p. 60. Copyright ©1999, Mosby, Inc.

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McCaffrey M, Pasero C: Pain: Clinical Manual, St. Louis, Mosby, ed.2, 1999.

## Sample Pain Assessment Tool for Cognitively Impaired

BEAVER DAM COMMUNITY HOSPITAL  
BEAVER DAM, WI 53916

### STANDARDS FOR DISCOMFORT INDICATORS FOR COGNITIVELY IMPAIRED April 10, 1998

#### I. Purpose:

Provide a pain assessment tool for use with residents who are unable to participate in an evaluation of discomfort because of cognitive impairment or inability to communicate.

#### II. Procedure:

A. Resident is observed for 3-5 minutes.  
\* Residents who have a total of >3 indicators will have Initial Pain Assessment Tool begun with as much information gathered from resident/family as possible.

\*Key point: This time frame allows the observer to rule out transitory and meaningless gestures or postures.

B. Observed behaviors are indicated on the Discomfort Indicator Form.

C. Resident's usual pain behaviors are documented in the initial pain assessment and plan of care, along with approaches in the plan of care.

D. Observations are made of the resident after receiving a new analgesic or new dose. Observations are made every hour until the behaviors change. Pain flowsheet will be used.

E. Initially the resident is assessed every shift x 72 hours, then weekly if pain control stable or PRN if pain level fluctuates; the day of assessment will be specified on the treatment sheet.

F. New evidence of pain requires reassessment and re-observation.

#### III. Reference

Hurley, A.C.; Volicer, B.J.; Hanrahan, P.A.; Houde, S.; & Volicer, L. (1992). Assessment of Discomfort in Advanced Alzheimer Patients. Research in Nursing & Health, 15, 369-377.

From: Beaver Dam Community Hospital  
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## Sample Pain Assessment Tool for Cognitively Impaired

BEAVER DAM COMMUNITY HOSPITAL  
BEAVER DAM, WI 53916

GUIDELINES FOR PAIN ASSESSMENT AND INTERVENTIONS  
FOR COGNITIVELY IMPAIRED  
April 10, 1998

Residents observed:

Step I.

If resident exhibits greater than 3 discomfort indicators, attempts are made to:  
rule out physical symptoms, e.g. incontinence, comfort, hot or cold, hunger, stress threshold  
exceeded due to over/under stimulation, need for position change.

Step II.

If multiple (>3) discomfort indicators persist an hour after interventions, a complete head-to-toe  
physical assessment is made. Non pharmacologic methods may also be attempted.

Step III.

- A. If discomfort indicator behaviors persist, the resident will have analgesia med prior to use of PRN  
psychotropic med
- B. Other interventions will be attempted or new orders will be obtained if discomfort indicators persist  
at this level two hours after intervention

Care plans identify behaviors exhibited by that particular resident that seem to indicate discomfort and  
action to take.

From: Beaver Dam Community Hospital  
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## Sample Pain Assessment Tool for Cognitively Impaired

BEAVER DAM COMMUNITY HOSPITALS, INC.  
BEAVER DAM, WI 53916

### DISCOMFORT INDICATOR SCALE FOR COGNITIVELY IMPAIRED

Observe resident for 3-5 minutes and check indicators that relate to observed behavior.

- A. Noisy breathing:
  - Respirations are strenuous, labored, loud, harsh, or gasping
  - Episodic bursts of rapid breaths or hyperventilation
- B. Negative vocalization:
  - Noise or speech with negative or disapproving quality
  - Hushed, low sounds such as constant muttering with a guttural tone
  - Monotone, subdued, or varying pitched noise with a definite unpleasant sound
  - Faster rate than a conversation or drawn out as in a moan or groan
  - Repetitive words with a mournful tone
  - Grunting or groaning
- C. Sad facial expression:
  - Looking hurt, worried, lost, troubled, distressed or lonesome
  - "Hang dog" look, wrinkled forehead
  - Crying
- D. Frightened facial expression:
  - Scared, concerned looking face, fearful or troubled
  - Alarmed appearance with open eyes and pleading face
- E. Tense body language:
  - Extremities tense, wringing hands, clenched fists
  - Knees pulled up tightly
  - Strained and inflexible position
- F. Fidgeting:
  - Restless impatient motion, squirming or jittering
  - Guarding of a body part
  - Forceful touching, tugging, or rubbing
  - Rocking
  - Aggressive behavior
  - Hitting or biting
  - Irritable

G. Other:

Adapted from: Hurley, A.C.; Volicer, B.J.; Hanrahan, P.A.; Houde, S.; & Volicer, L. (1992).  
Assessment of Discomfort in Advanced Alzheimer Patients. *Research in Nursing & Health*, 15, 369-377.  
Reference: Hurley, A.C.; Volicer, B.J.; Hanrahan, P.A.; Houde, S.; & Volicer, L. (1992).  
Assessment of Discomfort in Advanced Alzheimer Patients. *Research in Nursing & Health*, 15, 369-377.  
Parke, B. (1992). Pain the Cognitively Impaired Elderly. *The Canadian Nurse*, 88 (7), 17-20.

From: Beaver Dam Community Hospital  
Permission granted to modify or adopt provided written credit given to Institutionalizing  
Pain Management Project, University of Wisconsin – Madison

## Checklist: Monitoring Pain

**For residents who are being treated for pain, does your facility have a process for monitoring pain on at least a daily basis?**

- \_\_\_\_\_ **No.** If no, this is an area for improvement. Use this checklist and the Quality Improvement Worksheets to guide your team in implementing a process for monitoring pain.
- \_\_\_\_\_ **This is an area we are working on.** Our target date for implementing a process for monitoring pain is:\_\_\_\_\_. If needed, use the Quality Improvement Worksheets to guide your improvement process.
- \_\_\_\_\_ **Yes.** Please continue to the questions below.

**Does your facility’s process for monitoring pain include these components?**

	Yes	No
1. Do you ask residents to rate their pain using a pain scale?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your facility use an appropriate pain scale to monitor for pain on a daily basis for those with cognitive impairment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you use nonverbal cues to monitor for pain?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you track in the medical record the results of your monitoring?	<input type="checkbox"/>	<input type="checkbox"/>

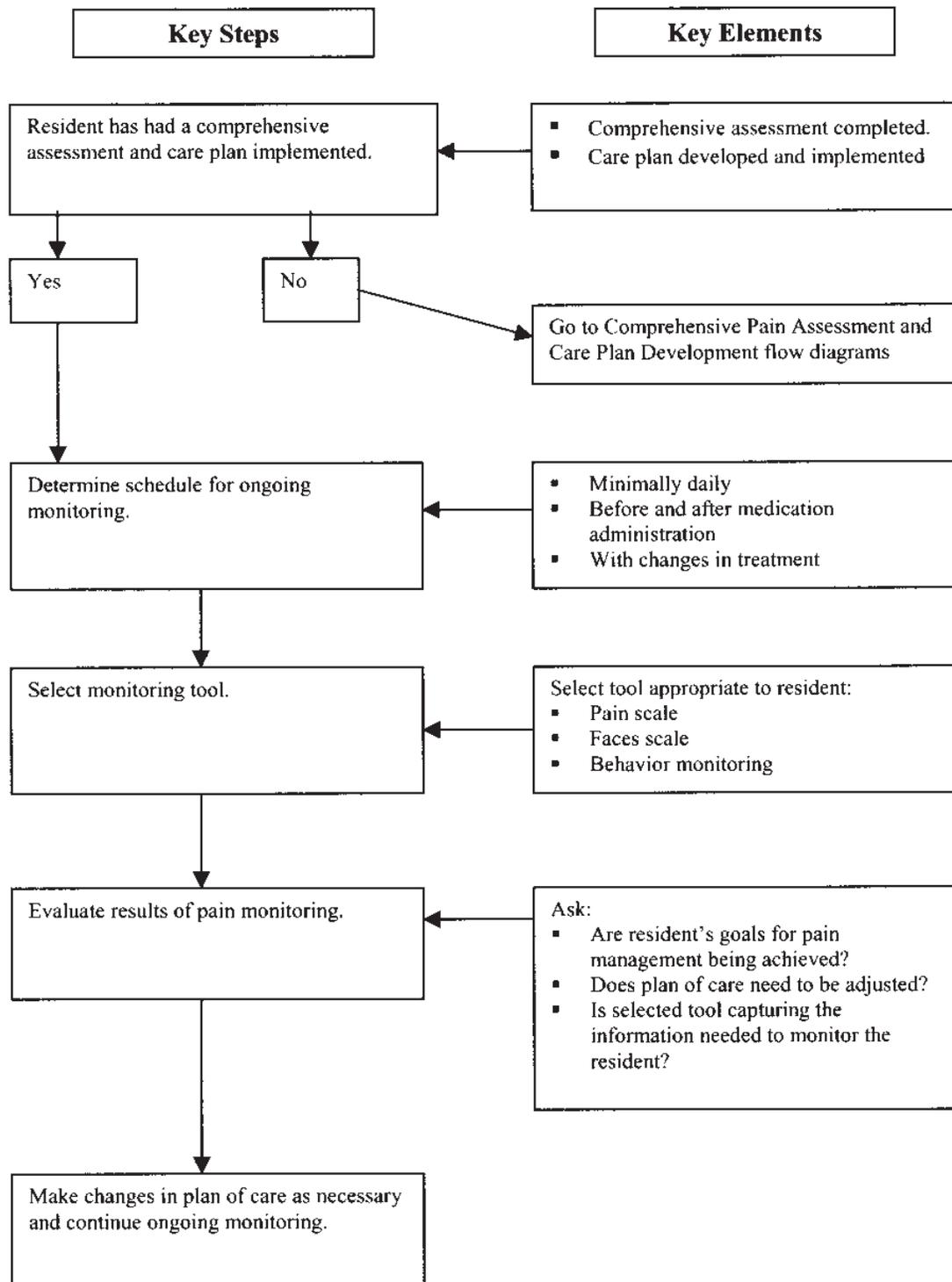
If any of the above elements in your process for monitoring pain are missing:

- Choose *one* element to focus your quality improvement effort first.
- Start with the Quality Improvement Worksheet A: Identifying Areas for Improvement to collect data to investigate further.
- Follow the Quality Improvement Worksheets to implement missing element(s) and monitor regularly to determine whether implementation is successful.

If none of the above elements are missing from your facility’s process for care please continue to another checklist.

Flow Diagram

**Daily Monitoring of Pain and Response to Pain Management Plan**



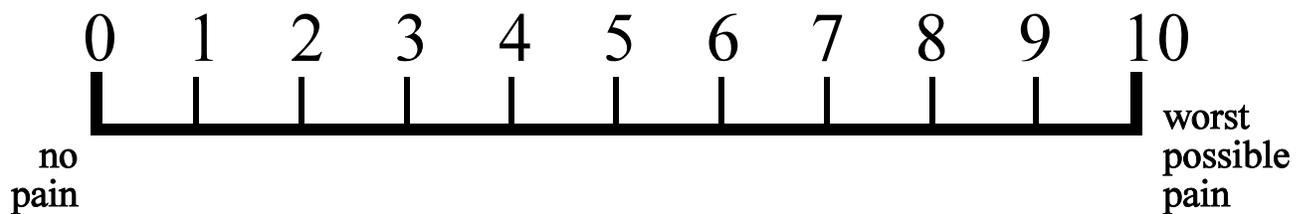
*This material was developed by the QIO program for CMS' NHQI and is intended as general information. Any individual using the material must consider the possibility of human error, changes in medical sciences, and the need to use clinical judgment in each specific case.*



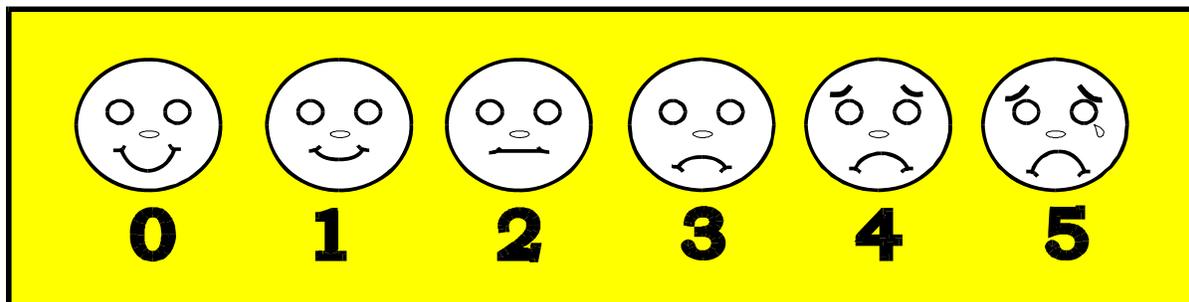
## PAIN SCALES

Encourage adult patients to use the 0-10 Scale to rate pain if they are able. If they cannot understand or are unwilling to use this scale, use the Smile-Sad Faces Scale or the Verbal Scale. Note which scale the patient is using on the reverse side in the margin next to the “Patient’s Rating of Pain Intensity” section

### 0-10 Visual Analog Scale



### Smile-Sad Faces Scale



### Verbal Scale



### Sample Pain Flowsheet for Cognitively Intact

\* Pain Rating Scale Used (0-10, 0-5, type- visual analog, faces, behaviors, etc.) \_\_\_\_\_

Date/Time	Location of Pain	Pain Rating* Before Treatment	Pharmacologic Intervention	Non-Pharmacologic Intervention **	Side Effects/ Bowel Status ***	LOC Mental Status	Initials	Follow-up Pain Rating After Treatment	Initials

\*\* List specific non-pharmacy interventions (i.e. cold, heat, exercise, distractions etc)

\*\*\* List specific side-effects (i.e. N/V/D/constipation, Respiratory Depression, pruritis, urinary retention, etc.)

\*\*\*\* List mental status levels (i.e. alert, lethargic, semicomatose, coma, etc. Give definitions.)



## Tab 5: Treatment and Clinical Tools for Pain Management

### Treatment of Pain

There is a wide range of pharmacologic, physical, behavioral, and other effective treatments for different types of pain. It's important to remember that responses to pain and pain interventions, including medications, are highly individual and do not always correlate with the type of pain or pain intensity. ALL PAIN MANAGEMENT MUST BE BASED ON INDIVIDUAL RESPONSES OF RESIDENTS.

This section intends to provide an overview of some of the strategies for pain management in the older adult and is not intended as a comprehensive source for treatment modalities.

#### In This Section:

##### Pharmacologic and Complementary Approaches

Describes:

- Pharmacologic treatment
- Complementary therapies
- Physical modalities
- Physical/occupational exercise therapy
- Psychosocial/spiritual interventions

##### Sample Algorithms for Pain Management

- Mild pain
- Moderate pain
- Severe pain

#### Reminder:

Tools in this section offer general information only. Medical information and pharmacologic options for pain management require continued verification of appropriateness.

## Pharmacologic and Complementary Approaches

There is a wide range of pharmacologic, physical, behavioral, and other treatments that are effective for different types of pain. The following is an abbreviated overview of some strategies for pain management in the older adult. Base the selection of interventions on the resident's individual assessment information and responses to treatment.

### Pharmacologic Treatment

Pharmacological treatment involves the use of analgesic and other drugs. Any pharmacologic intervention carries a balance of benefits and burdens. The resident should be given an expectation of pain relief, but it is unrealistic to suggest or sustain an expectation of complete pain relief for some residents with chronic pain. Severe, untreated pain, however, is unacceptable. A trial and error period should be anticipated when new medications are initiated and while titration occurs. Dosing for most residents requires careful adjustments to optimize pain relief while monitoring and managing side effects. The adage "start low and go slow" is appropriate when using pain medications in older persons.

Pharmacologic therapy is most effective when combined with non-pharmacologic strategies to optimize pain management. The timing of medication is important. For continuous pain, medications are best given on regular basis, not PRN (as the situation arises). Additional doses may be required before participation in activities that are known to exacerbate pain.

Adjuvant drugs are medications not classified formally as analgesics but found to be helpful in certain types of pain. Some of these adjuvant drugs include: tricyclic antidepressants, anticonvulsants, corticosteroids, anti-arrhythmics and baclofen. With all medication, the least invasive route of administration (usually oral) should be used.

### Complementary Therapies

Therapies used in conjunction with medication could include physical modalities, physical/occupational exercise therapy, and psychosocial/spiritual interventions. The use of these therapies may decrease the need for pain-reducing drugs but should not be used as substitutes for medication. Complementary modalities should be introduced early to treat generalized weakness and deconditioning as well as aches and pains. Many residents come to facilities with a knowledge of some complementary therapies.

#### Physical Modalities

Cutaneous stimulation includes the application of superficial heat or cold. Superficial application of heat, acting via conduction, increases blood flow to the skin and superficial organs and decreases blood flow to inactive tissue, such as the underlying musculature. Heat also decreases joint stiffness.

Cold therapy, which causes vasoconstriction and local numbing, is effective in reducing inflammation, edema soon after and injury, and muscle spasm, and is recommended when heat is ineffective in reducing spasm. Cold should not be used if there has been damage by radiation therapy. It is also contraindicated for any condition in which vasoconstriction increases symptoms, such as peripheral vascular disease.

In addition to hot/cold therapies, counterstimulation techniques can be implemented. Techniques such as Transcutaneous Electrical Nerve Stimulation (TENS) therapy, a method of applying controlled, low-voltage electrical stimulation to large, myelinated peripheral nerve fibers via cutaneous electrodes, and acupuncture, are believed to activate endogenous pain-modulating pathways by direct stimulation of peripheral nerves. Chiropractic is also

a complementary treatment that incorporates cutaneous stimulation as well as manipulation of the vertebral column in the belief that this will maintain proper functioning of the neuronal pathways to organs. It is also believed to provide direct relief to specific joints and vertebrae via direct manipulation of those areas.

### Physical/Occupational Exercise Therapy

Exercise is important for the treatment of subacute and chronic pain because it strengthens weak muscles, mobilizes stiff joints, helps restore coordination and balance, and enhances resident's comfort. When residents are unable to maintain function, simple range-of-motion exercises and massage can be provided to minimize discomfort and preserve muscle length and joint function. Positioning, by using braces, splints, wedges, etc., is another simple method to promote comfort and to prevent or relieve pain.

### Psychosocial/Spiritual Interventions

Staff may utilize cognitive/behavioral interventions as well as spiritual interventions to assist a resident in alleviating pain. Focusing on perception and thought, cognitive techniques are designed to influence how one interprets events and bodily sensations. Giving residents information about pain and its management helps residents think differently about their pain. Behavioral techniques, by contrast, are directed at helping residents develop skills to cope with pain and helping them modify their reaction to pain.

Relaxation and guided imagery can be used to achieve a state of mental and physical relaxation. Mental relaxation means alleviation of anxiety; physical relaxation means reduction in skeletal muscle tension. Relaxation techniques include simple deep-breathing exercises, music, and assisted relaxation. Pleasant mental images can be used to aid relaxation therapies.

Distraction is the strategy of focusing one's attention on stimuli other than pain or the accompanying negative emotions. Some examples of distraction might be listening to music, aromatherapy, watching television, and talking

to family and friends. Other distraction techniques may include psychotherapy for a short term, such as hypnosis, which can be used to manipulate the perception of pain. Reframing is the process of taking a negative thought and replacing it with a more positive one.

Peer support groups offer practical help for residents as well. They can provide experience, empathy, and credible support. Pastoral counseling and prayer can also be helpful, especially since pain may raise issues of spirituality for the resident and the family.

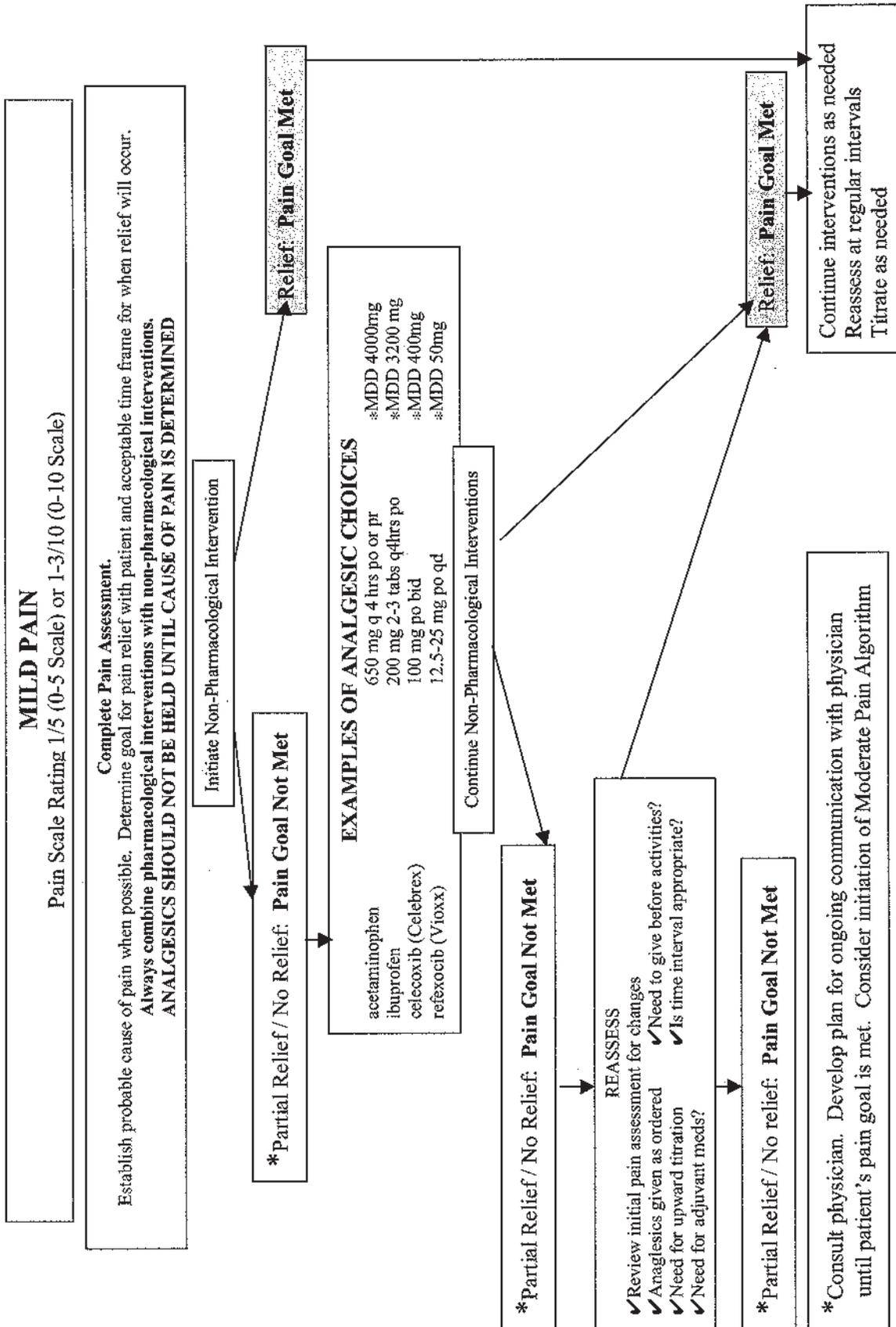
## Sample Algorithms for Pain Management

Mild Pain

Moderate Pain

Severe Pain

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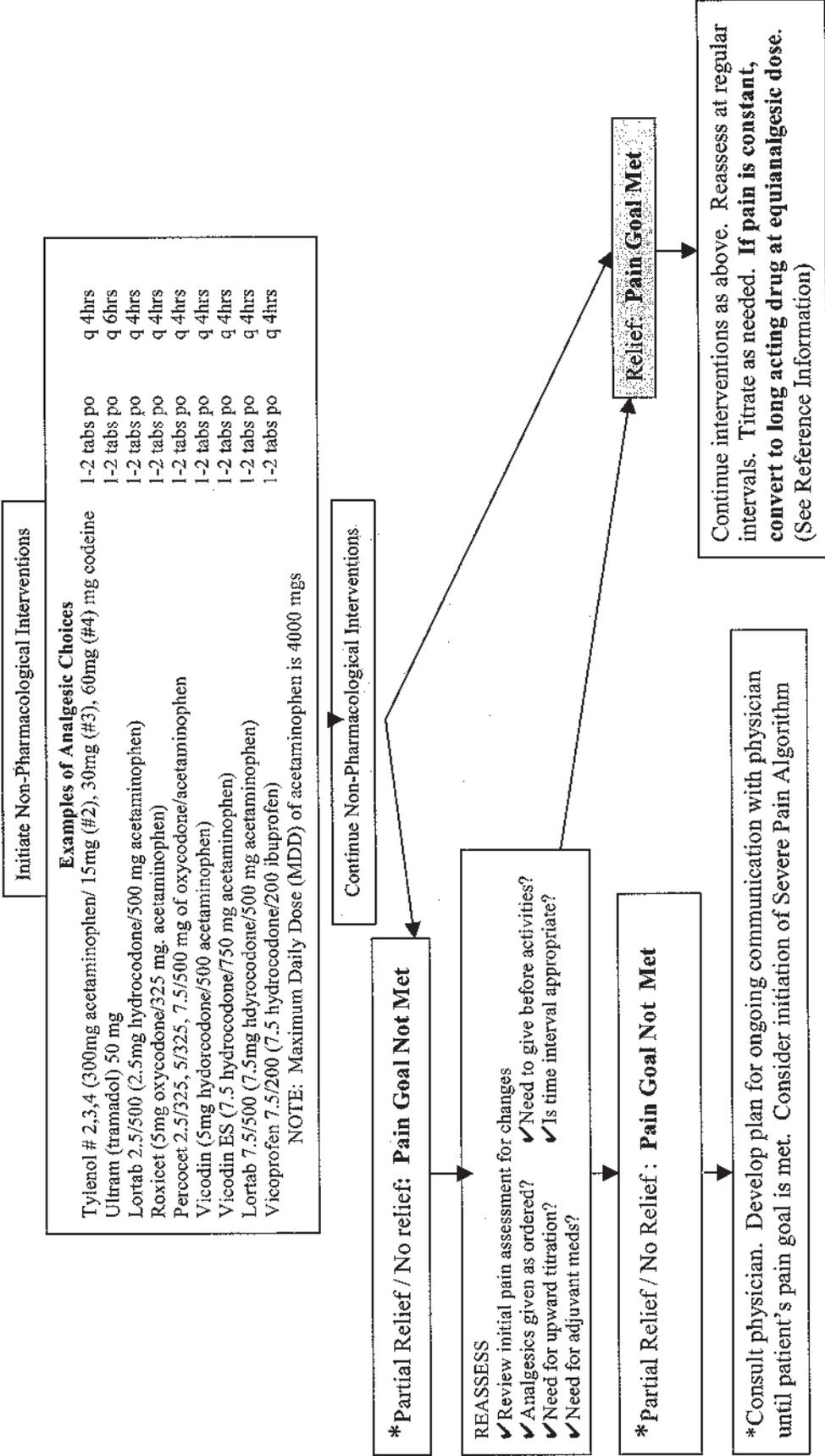


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\*MDD = Maximum Daily dose  
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**MODERATE PAIN**  
**Pain Scale Rating 2-3/5 (0-5 Scale) or 4-6/10 (0-10 Scale)**

**Complete Pain Assessment.**  
 Establish probable cause of pain when possible. Determine goal for pain relief with patient and acceptable time frame for when relief will occur.  
**Always combine pharmacological interventions with non-pharmacological interventions.**  
**ANALGESICS SHOULD NOT BE HELD UNTIL CAUSE OF PAIN IS DETERMINED.**



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**SEVERE PAIN**  
**Pain Scale rating 4-5/5 (0-5 Scale) or 7-10/10 (0-10 Scale)**

**Complete Pain Assessment.**

Establish probable cause of pain when possible. Determine goal for pain relief with patient and acceptable time frame for when relief will occur.  
**Always combine pharmacological interventions with non-pharmacological interventions.**  
**ANALGESICS SHOULD NOT BE HELD UNTIL CAUSE OF PAIN IS DETERMINED.**

**Initiate Non-Pharmacological Interventions**

**Examples of Analgesic Choices**

Immediate Release, Short Acting Drugs (lowest dose available is listed)  
 Note: There is no ceiling dose or maximum daily dose for these drugs

morphine sulfate	10 mg	q 2-4hr po or sl
Tabs	20mg/ml or 2mg/ml	q 2-4 hrs po or sl
Elixir	10 mg	q 2-4 hrs pr
Suppository	1-2mg	q 15-30 min SC or IV
Parenteral		
oxycodone	5mg	q 2-4 hrs po
Tabs	5mg/ml or 20mg/ml	q 2-4 hrs po
Elixir	3mg	q 4 hrs pr
Suppository		
hydromorphone (Dilaudid)		

**NOTE: Dilaudid 3mg suppository is equianalgesic to morphine sulfate 15 mg po or pr**

**Continue Non-Pharmacologic Interventions**

**\*Partial Relief / No Relief: Pain Goal Not Met**

- REASSESS**
- ✓ Review initial pain assessment for changes
  - ✓ Analgesics given as ordered
  - ✓ Need for adjuvant drugs?
  - ✓ Need for change to different opioid
  - ✓ Need to change route of administration
  - ✓ Need for upward titration
  - ✓ Need to give before activities?
  - ✓ Is time interval appropriate?

**\*Partial Relief / No Relief. Pain Goal Not Met. Consult with physician. Develop plan for ongoing communication with physician until patient's main goal is met.**

**Relief. Pain Goal Met**

Reassess at regular intervals. Titrate as necessary to maintain pain control. **If pain is constant convert to long acting drugs, at equianalgesic dose.** (See Reference Information)

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### ***Principles of Pharmacologic Management.***

1. Base the initial choice of analgesic on the severity and type of pain: non-opioids for mild pain (rating 1-4); opioids, often in combination with a non-opioid, for moderate (rating 5-6) to severe (rating 7-10) pain. Neuropathic pain may require an antidepressant or anticonvulsant drug.
2. Dose to ceiling of non-opioid if side effects permit. There is no maximum dose or analgesic ceiling with opioids. Increase opioid dose until pain relief is achieved or side effects are unmanageable before changing medications.
3. Administer drugs orally whenever possible. Avoid intramuscular injections.
4. Administer analgesics “around the clock” rather than prn.
5. Avoid using multiple opioids or multiple non-opioids (drugs from the same class at the same time) when possible.
6. Anticipate and vigorously treat side effects.
7. Avoid dosing with meperidine (no more than 48 hours or at doses greater than 600mg/24 hours). Accumulation of toxic metabolite normeperidine (half-life=12-16 hrs) can lead to CNS excitability and convulsions. Contraindicated in patients with impaired renal function or those receiving MAO inhibitors.
8. Addiction occurs very rarely in patients who receive opioids for pain control. Drug addiction, when suspected should be investigated and ruled in or out but not implied and “left hanging” because it interferes with pain management. The hallmarks of addiction include: a) compulsive use, b) loss of control, and c) use in spite of harm.
9. Do not use placebos to determine if the pain is “real”.
10. Assess pain, pain relief, and side effects frequently and adjust the dose accordingly. Change to another drug if side effects are unmanageable.

***Fifth Edition: Pain Patient Care Team, November 1999  
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## ***Pain Management Reference***

### ***Principles of Pain Management:***

1. **Ask patients about the presence of pain.**
2. **Believe the patient’s report of pain.** Patient’s self report is the single most reliable indicator of pain. Take pain seriously even when you do not know its cause. Autonomic or behavioral signs of pain may be helpful when present, but are often absent.
3. **Assess the pain including:**
  - location, quality, intensity (patient’s self report using rating scale; e.g. 0-10, mild- moderate-severe), temporal characteristics, what makes the pain better or worse, how the pain affects function and quality of life
  - response to prior and present analgesic medications and non-pharmacologic interventions
4. **Perform a complete physical exam.**
5. **Treat the pain while completing the diagnostic evaluation.**
6. **If possible, determine the cause of the pain** (e.g. nerve damage, tumor extension, obstruction, etc.).
7. **Institute diagnosis specific therapy.**
8. **Discuss with the patient realistic goals and limitations of pain therapy for the specific pain diagnosis.**
9. **Reassess, re-examine, and re-adjust therapy frequently until pain is relieved!**

## Tab 6: Care Planning for Pain

### Development of a Care Plan

This section discusses the resident's individualized care plan. Information obtained from screening, assessing and monitoring the resident for pain (with use of a pain rating scale) brings comprehensive information to the care planning team.

The care planning team, together with the resident and family (if available and with the resident's consent as appropriate) develop acceptable interventions and measurable goals in managing the resident's pain.

Implementation of the care plan comes next. Ongoing monitoring of the resident's pain plan continues, leading to information that helps the team evaluate the effectiveness of the plan and the need for further adjustment to maximize relief of pain.

#### In This Section:

##### Checklist: Developing Pain Care Plans

Important components of a pain plan reviewed.

##### Decision Tree for Pain Care Processes

##### Flow Diagram: Development of a Plan of Care for a Resident

Key elements for care planning are cited

##### MDS Coding Instructions For Quality Measures

#### Reminders:

- Ensure that care plan approaches adhere to accepted clinical guidelines and the facility's policies and procedures
- Follow the facility's process for the resolution of inadequately managed pain
- Ensure that the resident's pain plan is communicated during transfer and discharge
- Ensure that the resident's pain is communicated to the MDS Coordinator

## Key Care Plan Approaches

### Pharmacologic Management

- Individualize the regime to the resident.
- Use the simplest dosage schedule and least invasive treatment modalities first (oral medication vs. intravenous medications). Adjust doses of medications to individual resident responses.
- Pharmacologic management of mild-to-moderate pain may include a non-steroidal anti-inflammatory drug (NSAID) or acetaminophen unless they are contraindicated. Each has maximum daily dose limits.
- When pain persists or increases, an opioid is recommended.
- Increase the opioid dose for treatment of persistent, or moderate-to-severe pain.
- For persistent pain, it is recommended that medication be administered around the clock with additional "as needed doses" for pain that reoccurs between routine dosing.
- Oral route is the preferred route of analgesic administration; if the resident cannot take medications orally, then rectal, transdermal, subcutaneous, or intravenous routes may be considered. Avoid intramuscular (IM) injections for pain control.
- Monitor for medication side effects.
- Since constipation is an expected problem with the use of opioid pain medication, treat constipation prophylactically and monitor it constantly. A softener and stimulant together are usually required to manage opioid-induced constipation.
- When a resident is transferred from one setting to another, communication about pain management history is necessary.
- Medication not recommended:
  - Indomethacin, piroxicam, tolmetin, meclizolam
  - Propoxyphene, neperidin, Pentazocine, butorphanol

### Adjuvant Drugs

- Corticosteroids: Provide a range of effects including anti-inflammatory, anti-emetic activity, appetite stimulant, and mood elevation.
- Anticonvulsants: Used to manage neuropathic pain, especially when the resident reports burning pain.
- Antidepressants: Tricyclic antidepressants and SSNRI antidepressants are useful as adjuvant analgesics in the management of neuropathic pain, as well as potentially enhancing opioid analgesia, and elevating mood. (Monitor carefully for anticholinergic adverse effects.) SSRI antidepressants have little pain relieving qualities and are not often used for pain management.

### Non-Pharmacologic Management – Physical

Should be used with or without medications, but should not be used in place of medications.

- Cutaneous stimulation techniques
  - Hot/cold
  - Massage
  - Pressure or vibration
- Exercise
- Immobilization
- Transcutaneous electrical nerve stimulation (TENS)
- Acupuncture
- Assistive devices

### Psychosocial Interventions

- Relaxation and imagery
- Distraction and reframing
- Psychotherapy
- Hypnosis
- Reiki
- Peer support groups
- Pastoral counseling

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## Non-Pharmacologic Interventions – Invasive

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- Radiation therapy
- Nerve blocks
- Neurosurgery/surgery

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## Education

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Resident and family education including:

- The many misconceptions regarding pain and its treatment
- Medications
- Non-pharmacological management (physical and invasive)
- Psychosocial interventions

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## Routine Care

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- Positioning
- Frequent oral care
- Prevention of pressure ulcers and contractures
- One-on-one visits
- Emotional support to the resident and family
- Review advanced directives

---

## Reassessment of Pain

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- It is recommended that on a daily basis, the resident's response to pain medication be monitored within an hour of receiving the medication
- If the resident is complaining of worsening pain or new pain, it is recommended that a comprehensive assessment of pain be completed and a plan of care developed or revised
- Reassessment should occur at regular intervals after starting the plan (quarterly and with significant changes or unrelieved pain)

## Checklist: Developing Pain Care Plans

**Does your facility have a process for developing and implementing a care plan for pain for residents who have been found to have pain upon screening?**

- \_\_\_\_\_ **No.** If no, this is an area for improvement. Use this checklist and the Quality Improvement Worksheets to guide your team in implementing a process for developing a care plan for pain.
- \_\_\_\_\_ **This is an area we are working on.** Our target date for implementing a process for developing a care plan for pain is: \_\_\_\_\_. If needed, use the Quality Improvement Worksheets to guide your improvement process.
- \_\_\_\_\_ **Yes.** Please continue to the questions below.

**Does the plan of care for pain address all the areas below?**

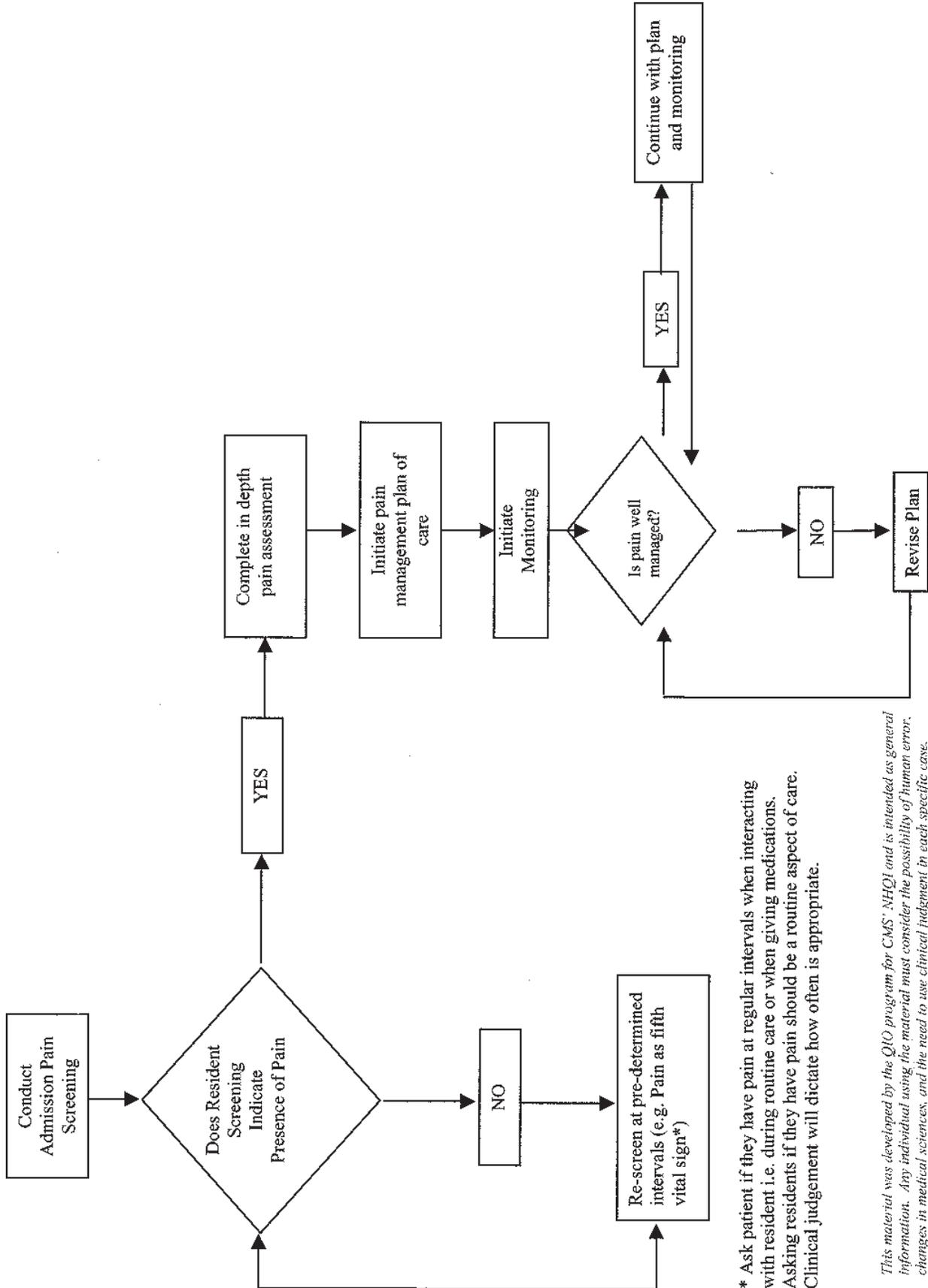
	Yes	No
1. Does the care plan for pain include a pain control goal as defined by the resident/caregiver/family member?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the care plan include education of the resident and family related to these areas of pain management:		
Goal of therapy	<input type="checkbox"/>	<input type="checkbox"/>
Side effects (e.g., drowsiness)	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Overall treatment plan	<input type="checkbox"/>	<input type="checkbox"/>
3. For residents with daily pain, does the plan provide for medication on a regular schedule (e.g., around the clock), not just PRN?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the plan provide for medication use by mouth if at all possible?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the plan provide for using non-pharmacological approaches to pain management (e.g., massage, music, aromatherapy, ice or heat, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the plan provide for keeping the resident as mobile as possible?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the plan address positioning and proper movement to minimize the resident's pain?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does the plan provide for a regular assessment (e.g., monitoring) of residents' response to pain medications?	<input type="checkbox"/>	<input type="checkbox"/>
9. Does the plan outline when the monitoring reassessment of resident's pain will be completed?	<input type="checkbox"/>	<input type="checkbox"/>

If any of the above elements in your process for care planning for pain are missing:

- Choose *one* element to focus your quality improvement effort first.
- Start with the Quality Improvement Worksheet A: Identifying Areas for Improvement to collect data to investigate further.
- Follow the Quality Improvement Worksheets to implement missing element(s) and monitor regularly to determine whether implementation is successful.

If none of the above elements are missing from your facility's process for care, please continue to another checklist.

Decision Tree for Pain Care Processes

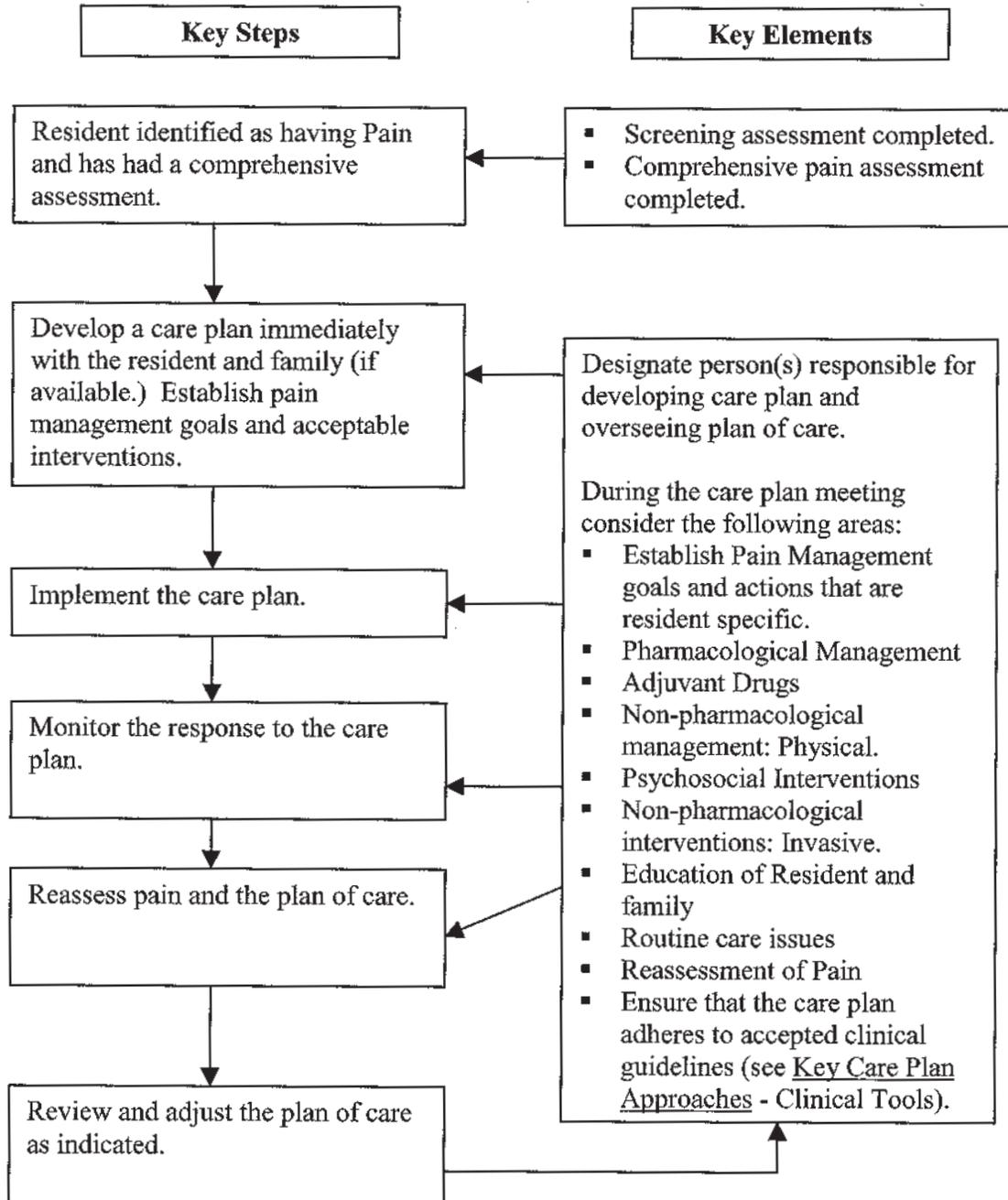


\* Ask patient if they have pain at regular intervals when interacting with resident i.e. during routine care or when giving medications. Asking residents if they have pain should be a routine aspect of care. Clinical judgement will dictate how often is appropriate.

*This material was developed by the QIO program for CMS' NHQI and is intended as general information. Any individual using the material must consider the possibility of human error, changes in medical sciences, and the need to use clinical judgment in each specific case.*

Flow Diagram

**Development of a Plan of Care for a Resident with Pain**



*This material was developed by the QIO program for CMS' NHQI and is intended as general information. Any individual using the material must consider the possibility of human error, changes in medical sciences, and the need to use clinical judgment in each specific case.*

last modified 9-09-2002

## CHAPTER 6B

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### PERCENT OF SHORT STAY RESIDENTS WHO HAD MODERATE TO SEVERE PAIN

#### QM Description

This measure reflects the percent of short stay residents who are reported to have pain occurring daily, reaching a moderate level at least once during the 7-day assessment period *or* horrible/excruciating pain at any frequency.

#### Rationale for Pain QM

Pain is a common experience with older people because the prevalence of musculoskeletal problems (e.g., arthritis, fractures) and other medical conditions such as peripheral vascular disease, wounds, neurological conditions and cancer diagnoses tend to increase with age. Studies have shown that pain is significantly under-reported in nursing facilities especially amongst the oldest old, females, minorities and the cognitively impaired. Although pain can be relieved in up to 90% of cases, a significant number of nursing home residents receive inadequate or no treatment. Additional information about this clinical condition, as well as quality improvement strategies, can be found on the Medicare Quality Improvement Community Web site at [www.MedQIC.org](http://www.MedQIC.org).

#### MDS Assessments Used

- **SNF PPS 14-day Assessment (AA8b = 7):** Latest assessment with assessment reference date (A3a) within the 6-month target period.

#### QM Specifications

##### NUMERATOR

Short stay residents at SNF PPS 14-day assessment with pain occurring daily, reaching a moderate level at least once during the 7-day assessment period (J2a = 2 and J2b = 2) *OR* horrible/excruciating pain at any frequency (J2b = 3).

##### DENOMINATOR

All residents with a valid SNF PPS 14-day assessment (AA8b = 7) after exclusions are applied.

**RISK ADJUSTMENT STRATEGIES USED**

Exclusion....Yes

Stratification....No

Regression....No

**EXCLUSIONS***Residents satisfying any of the following conditions are excluded:*

- ◆ Either J2a or J2b are missing on the SNF PPS 14-day assessment.
- ◆ The values of J2a and J2b are inconsistent on the SNF PPS 14-day assessment (an example of inconsistent coding would include the coding of pain frequency as “no pain” while intensity of pain is simultaneously coded as “moderate” pain).

**COVARIATES USED IN REGRESSION**

There are no covariates for the post-acute care pain quality measure.

**MDS Elements Related to QM****J2a Pain Symptoms** - Frequency with which resident complains or shows evidence of pain**J2b Pain Symptoms** - Intensity of pain

## CHAPTER 6J

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### PERCENT OF RESIDENTS WHO HAVE MODERATE TO SEVERE PAIN

#### QM Description

This measure reflects the percent of long-term residents who are reported to have pain occurring daily, reaching a moderate level at least once during the assessment period *or* horrible/excruciating pain at any frequency.

#### Rationale for Pain QM

Pain is a common experience with older people because the prevalence of musculoskeletal problems (e.g. arthritis, fractures) and other medical conditions such as peripheral vascular disease, wounds, neurological conditions and cancer diagnoses which tend to increase with age. Studies have shown that pain is significantly under-reported in nursing facilities especially amongst the oldest old, females, minorities and the cognitively impaired. Although pain can be relieved in up to 90% of cases, a significant number of nursing home residents receive inadequate or no treatment. Additional information about pain management, as well as quality improvement strategies, can be found on the Medicare Quality Improvement Community Web site at [www.MedQIC.org](http://www.MedQIC.org).

#### MDS Assessments Used

- **Target assessment:** OBRA Full (AA8a = 01, 02, 03, or 04) or Quarterly Assessment (AA8a = 05 or 10). Latest assessment with assessment reference date (A3a) within the 3-month target period. Note that admission assessments (AA8a = 01) are excluded from measure calculations.
- **Prior assessment:** OBRA Full (AA8a = 01, 02, 03, or 04) or Quarterly Assessment (AA8a = 05 or 10). Assessment reference date (A3a) must be in the window of 46 days to 165 days preceding the target assessment reference date. Prior assessments are used for covariate calculations.

## QM Specifications

### NUMERATOR

Residents with pain occurring daily, reaching a moderate level at least once during the assessment period (J2a = 2 and J2b = 2) OR horrible/excruciating pain at any frequency (J2b = 3) on the target assessment.

### DENOMINATOR

All residents with a valid target assessment after exclusions are applied.

### RISK ADJUSTMENT STRATEGIES USED

Exclusion....Yes                      Stratification....No                      Regression....Yes

### EXCLUSIONS

*Residents satisfying any of the following conditions are excluded:*

- ◆ The target assessment is an admission (AA8a = 01) assessment.
- ◆ Either J2a or J2b are missing on the target assessment.
- ◆ The values of J2a and J2b are inconsistent on the target assessment (An example of inconsistent coding would include the coding of pain frequency as “no pain” while intensity of pain is simultaneously coded as “moderate” pain).

### COVARIATES USED IN REGRESSION

Clinical covariate:

1. Indicator of independence or modified independence in daily decision making on the prior assessment:  
Covariate = 1\* if B4 = 0 or 1  
Covariate = 0 \*if B4 = 2 or 3

\*If covariate = 1, the covariate is present and it contributes to the risk-adjustment.  
If covariate = 0, the covariate is not present and therefore does not contribute to the risk-adjustment.

See Chapters 4 and 5 for more information on risk adjustment and the use of covariates.

## MDS Elements Related To QM

**J2a Pain Symptoms** - Frequency with which resident complains or shows evidence of pain

**J2b Pain Symptoms** - Intensity of pain

**B4 Cognitive Skills for Daily Decision-Making** - Resident’s actual performance in making everyday decisions about tasks or activities of daily living.

## J2. Pain Symptoms (7-day look back)

**Intent** To record the frequency and intensity of signs and symptoms of pain. For care planning purposes this item can be used to identify indicators of pain as well as to monitor the resident's response to pain management interventions.

**MDS 2.0 only captures pain symptoms.** Documentation of pain management/interventions are recorded elsewhere in the resident's clinical record, such as in the nurses' notes, progress notes, medication records, and care plans. CMS anticipates that few residents on pain management measures will not have some level of breakthrough pain during the 7-Day assessment period that should then be coded on the MDS. For example, if through assessment or clinical record review you note that the resident has received pain medications or other pain relief measures, investigate the pain need and capture the pain event on the MDS. However, if the resident does not experience ANY breakthrough pain in the 7-Day assessment window, the assessor would indeed code "0", no pain. Remember that the assessment covers a 7-day period and should reflect the highest level of pain reported by any staff member, not just the assessment of the professional completing the MDS.

**Definition** **Pain** - For MDS assessment purposes, pain refers to any type of physical pain or discomfort in any part of the body. Pain may be localized to one area, or may be more generalized. It may be acute or chronic, continuous or intermittent (comes and goes), or occur at rest or with movement. The pain experience is very subjective; pain is whatever the resident says it is.

**Shows Evidence of Pain** - Depends on the observation of others (i.e., cues), either because the resident does not verbally complain, or is unable to verbalize.

**Process** Ask the resident if he or she has experienced any pain in the last seven days. Ask him/her to describe the pain. If the resident states he or she has pain, take his or her word for it. Pain is a subjective experience. Also observe the resident for indicators of pain. Indicators include moaning, crying, and other vocalizations; wincing or frowning and other facial expressions; or body posture such as guarding/protecting an area of the body, or lying very still; or decrease in usual activities.

In some residents, the pain experience can be very hard to discern. For example, in residents who have dementia and cannot verbalize that they are feeling pain, symptoms of pain can be manifested by particular behaviors such as calling out for help, pained facial expressions, refusing to eat, or striking out at a nurse assistant who tries to move them or touch a body part. Although such behaviors may not be solely indicative of pain, but rather may be indicative of multiple problems, code for the frequency and intensity of symptoms if in your clinical judgment it is possible that the behavior could be caused by the resident experiencing pain.

Ask nurse assistants and therapists who work with the resident if the resident had complaints or indicators of pain in the last week.

**Coding** Code for the frequency of pain during the observation period in J2a. Code the highest intensity of pain that occurred during the observation period in J2b. Code for the presence or absence of pain, regardless of pain management efforts; i.e., breakthrough pain. If the resident has no pain, code "0" (No Pain) then Skip to Item J4.

**a. FREQUENCY** - How often the resident complains or shows evidence of pain.

Codes: 0. No pain (Skip to Item J4)  
1. Pain less than daily  
2. Pain daily

**b. INTENSITY** - The severity of pain as described or manifested by the resident.

- Codes:
1. Mild Pain - Although the resident experiences some (“a little”) pain he or she is usually able to carry on with daily routines, socialization, or sleep.
  2. Moderate Pain - Resident experiences “a medium” amount of pain.
  3. Times When Pain is Horrible or Excruciating - Worst possible pain. Pain of this type usually interferes with daily routines, socialization and sleep.

Facilities should have a consistent, uniform and standardized process to measure and assess pain. Use your best clinical judgment when coding. If you have difficulty determining the exact frequency or intensity of pain, code for the more severe level of pain. **Rationale:** Residents having pain will usually require further evaluation to determine the cause and to find interventions that promote comfort. You never want to miss an opportunity to relieve pain. Pain control often enables rehabilitation, greater socialization and activity involvement. The 5 coding examples shown below were designed to assist you in making appropriate coding decisions. Please note that the last 3 examples are new, and did not appear in the original MDS manual.

Examples	Pain Frequency	Pain Intensity
<p>Mrs. G, a resident with poor short-and-long-term memory and moderately impaired cognitive function asked the charge nurse for “a pill to make my aches and pains go away” once a day during the last 7 days. The medication record shows that she received Tylenol every evening. The charge nurse states that Mrs. G usually rubs her left hip when she asks for a pill. However, when you ask her about pain, Mrs. G tells you that she is fine and never has pain. <b>Rationale for coding:</b> It appears that Mrs. G has forgotten that she has reported having pain during the last 7 days. Best clinical judgment calls for coding that reflects that Mrs. G has mild, daily pain.</p>	2	1
<p>Mr. T is cognitively intact. He is up and about and involved in self-care, social and recreational activities. During the last week he has been cheerful, engaging and active. When checked by staff at night, he appears to be sleeping. However, when you ask him how he’s doing, he tells you that he has been having horrible cramps in his legs every night. He’s only been resting, but feels tired upon arising. <b>Rationale for coding:</b> Although Mr. T may look comfortable to staff, he reports to you that he has terrible cramps. Best clinical judgment for coding this “screening” item for pain would be to record codes that reflect what Mr. T tells you. It is highly likely that Mr. T warrants a further evaluation.</p>	2	3
<p>Mr. C is cognitively intact. He has long-term degenerative joint disease and his pain is well managed on Celebrex daily. He stated that on most days he feels little to no pain. However, Mr. C was unable to ambulate for long distances on two days last week, as he was experiencing moderate pain in his knees. Mr. C stated that he needed additional assistance from the CNA to walk to the dining room on those days and required additional pain medication. He says that he no longer feels that intensity of pain.</p>	1	2
<p>Mrs. S is severely cognitively impaired. She is unable to make decisions and requires extensive assistance in daily ADL care. The CNA responsible for her care and daily ambulation reports to the charge nurse that she has noticed Mrs. C to have “pain in her back” when the CNA attempts to position her in bed and transfer her to a chair. The nurse observes Mrs. C’s physical, facial and verbal expressions during care and determines that the resident is experiencing moderate pain. The physician is notified and orders Tylenol q 6 hours. The resident appears relieved later in the day. The resident is observed by nursing staff and they determine that she is no longer experiencing a moderate level of pain. The physician determines that the resident should continue on the medication for several days.</p>	1	2
<p>Mr. W had abdominal surgery 5 days ago. He is alert with short-term memory problems. He is on pain medication daily and is able to participate in daily activities. On the evening shift, Mr. W complained to the nurse that he was experiencing severe pain near his wound site. Upon examination, the nurse determined that the wound appeared clean with no signs of infection. The physician was notified and determined that Mr. W required a change in the type of medication. Mr. W reported relief and remained on the new medication for 3 additional days</p>	1	3

### J3. Pain Site (7-day look back)

<b>Intent</b>	To record the location of physical pain as described by the resident, or discerned from objective physical and laboratory tests. Sometimes it is difficult to pinpoint the exact site of pain, particularly if the resident is unable to describe the quality and location of pain in detail. Likewise, it will be difficult to pinpoint the exact site if the resident has not had physical or laboratory tests to evaluate the pain. In order to begin to develop a responsive care plan for promoting comfort, the intent of this item is to help residents and caregivers begin a pain evaluation by attempting to target the site of pain.
<b>Definition</b>	<p><b>a. Back Pain</b> - Localized or generalized pain in any part of the neck or back.</p> <p><b>b. Bone Pain</b> - Commonly occurs in metastatic disease. Pain is usually worse during movement but can be present at rest. May be localized and tender but may also be quite vague.</p> <p><b>c. Chest Pain While Doing Usual Activities</b> - The resident experiences any type of pain in the chest area, which may be described as burning, pressure, stabbing, vague discomfort, etc. "Usual activities" are those that the resident engages in normally. For example, the resident's usual activities may be limited to minor participation in dressing and grooming, short walks from chair to toilet room.</p> <p><b>d. Headache</b> - The resident complains or shows evidence (clutching or rubbing the head) of headache.</p> <p><b>e. Hip Pain</b> - Pain localized to the hip area. May occur at rest or with physical movement.</p> <p><b>f. Incisional Pain</b> - The resident complains or shows evidence of pain at the site of a recent surgical incision.</p> <p><b>g. Joint Pain (Other Than Hip)</b> - The resident complains or shows evidence of discomfort in one or more joints either at rest or with physical movement.</p> <p><b>h. Soft Tissue Pain</b> - Superficial or deep pain in any muscle or non-bony tissue. Examples include abdominal cramping, rectal discomfort, calf pain, and wound pain.</p> <p><b>i. Stomach Pain</b> - The resident complains or shows evidence of pain or discomfort in the left upper quadrant of the abdomen.</p> <p><b>j. Other</b> - Includes either localized or diffuse pain of any other part of the body. Examples include general "aches and pains," etc.</p>
<b>Process</b>	Ask the resident and observe for signs of pain. Consult staff members. Review the clinical record. Use your best clinical judgment.
<b>Coding</b>	Check all that apply during the last 7 days. If the resident has mouth pain check Item K1c in Section K, "Oral/Nutritional Status."

## Tab 7: Educating Residents and Families

Educating residents and families is an important element in the successful management of a resident's pain.

When discussing care planning for pain, the resident/care-giver/family should participate in defining the pain plan goal. Resident and family members should be informed of the facility's commitment to pain management beginning at admission.

An explanation of the facility's pain management program can reinforce the facility's philosophy regarding pain management and allow for clarification of questions and concerns.

For residents with cognitive impairment, input from family can be very helpful. The following are examples of ways to inform residents and families about the facility's commitment to managing pain:

- Consider sharing information on pain management at resident council meetings.
- Discuss the facility's program during family council meetings.
- Use the facility newsletter or a letter to families to communicate efforts to enhance facility-wide awareness of pain.
- Provide consumer educational materials on pain.
- Use posters or bulletin boards to inform them of the facility's commitment and enhanced programming.

### In This Section:

Resources and Web Sites on Pain

Family Information Letter

**Materials for Patient & Family Libraries**

***Written materials for patient and family education***

**AHRQ (formally AHCPR)**

***Cancer Pain***

*The Patient Guide: Managing Cancer Pain* (English and Spanish, March 1994)

Available from the Cancer Information Service (1-800-4-CANCER) or online:

[www.ahrq.gov/clinic/index.html#online](http://www.ahrq.gov/clinic/index.html#online)

***Acute Pain***

*Pain Control After Surgery: A Patient's Guide* (English and Spanish, February 1992)

Available from AHCPR (1-800-358-9295) or online:

[www.ahrq.gov/clinic/index.html#online](http://www.ahrq.gov/clinic/index.html#online)

**NCI and ACS Patient Education Booklets**

Both publications listed below are available free of charge from the Cancer Information Service (1-800-4-CANCER) and the American Cancer Society (1-800-422-6237).

Quantities are limited to 100 each.

***Get Relief From Cancer Pain:***

A simple patient education booklet that contains the essential facts about pain control.

***Questions and Answers About Pain Control:***

A guide for people with cancer and their families.

**Other Sources**

***Cancer Doesn't Have to Hurt* (176 pp.)**

Hunter House Publishers

P.O. Box 2914

Alameda, CA 94501

Phone: (800) 266-5592

Also available in bookstores

Cost: \$14.95 paperback, \$24.95 hardcover

***Eight Facts Everyone Should Know About Cancer Pain***

Wisconsin Cancer Pain Initiative

1300 University Avenue

Room 4720 MSC

Madison, WI 53706

Phone: (608) 262-0978

Fax: (608) 265-4014

Web: [www.wisc.edu/wcpi](http://www.wisc.edu/wcpi)

Cost: \$0.15 each plus shipping. You may also download this free from:

[www.wisc.edu/wcpi/publiced/publiced.htm](http://www.wisc.edu/wcpi/publiced/publiced.htm)

***Children's Cancer Pain Can Be Relieved* (for parents)**

Wisconsin Cancer Pain Initiative

1300 University Avenue

Room 4720 MSC

Madison, WI 53706

Phone: (608) 262-0978

Fax: (608) 265-4014

Web: [www.wisc.edu/wcpi](http://www.wisc.edu/wcpi)

Cost: Preview copy free of charge. Additional copies \$0.50 plus shipping. You may also download the text for free from:

[www.wisc.edu/wcpi/patients/childpeb.htm](http://www.wisc.edu/wcpi/patients/childpeb.htm)

***Managing Pain Before it Manages You***

(English and Spanish)

Guilford Publications

72 Spring Street

New York, NY 10012

Phone: (800) 365-7006 or (212) 431-9800

Fax: (212) 966-6708

Email: [info@guilford.com](mailto:info@guilford.com)

Cost: \$18.95

From: Building an Institutional Commitment to Pain Management Resource List  
 Permission granted to modify or adopt provided written credit given to Institutionalizing  
 Pain Management Project, University of Wisconsin – Madison

*Managing Your Chronic Pain:*

*Regaining Control of Your Life*  
Staywell

1100 Grundy Lane

San Bruno, CA 94066-3030

Phone: (800) 333-3032

Fax: (650) 244-4512

Cost: \$1.35 per copy plus shipping and handling.

Discounts for quantities >100.

*Pain Management: Patient Education Manual*

Aspen Reference Group

200 Orchard Ridge Drive, Suite 200

Gaithersburg, MD 20878

Phone: (800) 638-8437

Fax: (301) 417-7628

Cost: \$179.00

*Pain, Pain, Go Away: Helping Children With Pain*

Izaak Walton Killam Children's Hospital and

Dalhousie University

Halifax, Nova Scotia, Canada

You may view this on the web at

[is.dal.ca/~pedpain/ppga/ppga.html](http://is.dal.ca/~pedpain/ppga/ppga.html)

*Patient Education Teaching Kit*

City of Hope National Medical Center

Marketing Department

1500 E. Duarte Road

Duarte, CA 91010

Phone: (626) 359-8111 ext 2356

Fax: (626) 301-8462

Cost: \$45.00

*Taking Control of Your Headaches:*

*How to Get the Treatment You Need*

Guilford Publications

72 Spring Street

New York, NY 10012

Phone: (800) 365-7006 or (212) 431-9800

Fax: (212) 966-6708

Email: [info@guilford.com](mailto:info@guilford.com)

Cost: \$14.95Video/CD ROM

*Why Not Freedom From Cancer Pain?*

World Health Organization Publishing Center

USA:

49 Sheridan Ave.

Albany, NY 12210

Phone: (518) 436-9686

Cost: \$36.00, pre-payment is required.

## ***Patient and Family Education Videos***

*Cancer Pain Management (14 minute video)*

and

*New Modalities of Cancer Pain Management*

10 minute video

Knoll Pharmaceutical Company

30 North Jefferson Road

Whippany, NJ 07981

Phone: (800) 526-0221

*Catch Your Pain Before It Catches You*

9 minute video

Henry Ford Health System

Cottage Hospital Hospice

23000 Mack Ave.

St. Clair Shores, MI 48080

Phone: (810) 774-4141

Fax: (810) 774-0515

Cost: booklet \$5.00, video \$15.00.

Add \$1.00 for postage.

From: Building an Institutional Commitment to Pain Management Resource List  
Permission granted to modify or adopt provided written credit given to Institutionalizing  
Pain Management Project, University of Wisconsin – Madison

*Communicating About Cancer Pain  
and*

*Is Cancer Pain Inevitable?*

Two 30 minute videos  
University of Wisconsin Hospital  
Outreach Education Department  
702 Blackhawk Avenue, Suite 215  
Madison, WI 53705  
Phone: (800) 757-4354  
Web: [www.uwhealth.wisc.edu/outreach](http://www.uwhealth.wisc.edu/outreach)  
Cost: 1 tape = \$19.95, 2 tapes = \$17.95 each, add  
\$0.75 postage, \$5.00 handling (subject to change)

*Easing Cancer Pain: Fireside Retreat*

Interactive CD and Web  
The American Cancer Society  
Michigan Division  
Communication Technology Laboratory  
Michigan State University  
Phone: (800) 723-0360  
Cost: \$15.00 for patient and family education

*Helping to Control Cancer Pain (English and Spanish)  
and*

*I Got My Life Back*

Videos  
Purdue Frederick  
1000 Connecticut Avenue  
Norwalk, CT 06850  
Phone: (203) 853-0123  
Fax: (203) 838-1576

Web: [partnersagainstpain.com](http://partnersagainstpain.com)

Cost: No charge

*Controlling Cancer Pain*

12 minute video  
Johns Hopkins Oncology Center  
600 North Wolfe Street  
Baltimore, MD 21287  
Phone: (410) 955-8837 (Pat Devis)  
Cost: \$10.00

*Managing Cancer Pain: A Rural Perspective*

28 minute video  
Virginia Cancer Pain Initiative  
P.O. Box 6359  
Glen Allen, VA 23058-6359  
Phone: (804) 628-1122  
(Ashby Watson, President VCPI)  
Web: [www.vcpi.org/vcpifp1.htm](http://www.vcpi.org/vcpifp1.htm)  
Cost: \$10.00

*Relieving Cancer Pain*

Patient notebook, ¾" videotape, and script  
Fred Hutchinson Cancer Research Center  
1100 Fairview Avenue North, FM815  
P.O. Box 19024  
Seattle, WA 98109-1024  
Phone: (206) 667-5022  
Fax: (206) 667-4356  
Cost: \$45.00 for institutions, \$30.00 for  
cancer patients and their families

From: Building an Institutional Commitment to Pain Management Resource List  
Permission granted to modify or adopt provided written credit given to Institutionalizing  
Pain Management Project, University of Wisconsin – Madison

## Family Information Letter

**Purpose:** The following sample may be useful in sharing information with families and/or residents.

To Family Member and/or Designated Decision Maker,

Our nursing facility is pleased to inform you of the work we have been doing in the area of pain management. Pain is an important area that could effect the quality of life of our residents.

We have re-evaluated our practices and have promoted a facility-wide commitment to a heightened awareness of pain management for our residents.

Through continuing education for our employees and affiliated professionals, we have addressed the importance of the prompt recognition of pain, the assessment of pain, and the treatment options for pain management.

Together, with input from residents, families, staff and attending physicians, we will continue to work on positive outcomes for residents experiencing pain.

If you have any questions do not hesitate to stop in my office or the Director of Nursing's office or give us a call.

Sincerely,

Administrator

Director of Nursing

## Tab 8: Identifying and Reporting Pain: A Facility-wide Responsibility

### The Mandate

Any staff member who has contact with residents or their families has a responsibility to know basic information about pain and pain management and to identify and report pain in residents as a core part of competency. CNAs, housekeepers and maintenance staff, dietary staff, activities staff, physical and occupational therapy assistants, counselors, volunteers interacting with residents, and others should be educated about pain and pain treatment and be able to identify and report pain to a licensed staff member. Reports should result in a comprehensive pain assessment of the resident and a plan to address pain problems.

### Desired Outcome

1. All staff will identify and promptly report to licensed staff, any suspected or actual pain in any resident.
2. When a resident's pain is reported by any staff or visitor, licensed staff will complete a comprehensive pain assessment and develop or revise a plan of care to treat the resident's pain.
3. Residents pain will be promptly addressed and treated.

### Content for Education

1. As part of orientation of all staff who interact with residents, include information about pain, pain treatment, the facility's expectations, and policies and procedures related to pain.
2. Update staff regularly.
3. Content for education:
  - a. The role of all staff interacting with residents
    - i. Residents often form strong relationships with non-clinical staff and may report pain to you rather than the nurse or doctor.
    - ii. Be suspicious that pain could be a problem when the resident's behavior, mood, function, or usual activity changes, or when a resident reports pain.
      1. Identify possible pain and report your observations.
      2. Be sure basic needs are met (CNAs).
      3. Assist with interventions as instructed to improve comfort (CNAs).
      4. Report the results of interventions (CNAs).
      5. Persist!
    6. Role play:
      - a. Ask participants to imagine they are a resident in your facility and they have pain. Ask each to discuss what they would do to let someone know about their pain and to try to get relief.
      - b. Ask participants to imagine they are cognitively impaired and have pain. Ask how they would let someone know they had pain.
      - c. Ask participants to identify similar behaviors in residents they have met or seen.
    7. Importance of identifying pain and reporting it to the nurse
  - b. The impact of pain on residents' lives
    - i. Physical impact
    - ii. Psychological impact
    - iii. Social impact
    - iv. Spiritual/existential impact
  - c. What is pain?
    - i. Different for every person
    - ii. Difficult to know another's pain
    - iii. The better you know a resident, the easier it is to detect changes that might indicate pain.
  - d. Pain responses
    - i. Different for every person
    - ii. With persistent pain (chronic pain), the person may not look in pain. Responses are even more blunted in the cognitively impaired.
    - iii. Review the variety of responses and behavior changes a cognitively impaired resident may exhibit when in pain. For example:
      1. Resisting or refusing care
      2. Swearing, shouting out
      3. Repeating words or phrases

4. Moaning, groaning
  5. Isolating self
  6. Belligerence or striking out
  7. Facial expression – sad, worried, anxious
  8. Eyes: either wide open or shut tight
  9. Rocking or rubbing an area
  10. Wandering
  11. Other changes from normal for that resident
  12. “Not themselves”
- e. Reporting pain
- i. The resident is the expert and knows his or her pain best – “pain is what the person says it is, occurring whenever the person says it does” (McCaffery; 1999).
  - ii. Residents may use words other than “pain” such as “ache,” “sore,” “hurt,” “discomfort,” or other words.
  - iii. Some residents may not report pain because they are concerned that it will result in additional testing and that nothing can be done, or they are stoic.
  - iv. Role play  
Think of residents you have cared for or interacted with in the past. What behaviors, words or actions have you seen that might signal the resident is in pain?
- f. Treatments for managing pain: Most pain can be treated using rather simple strategies
- i. Medicines used for pain – an overview
    1. Fear of addiction: the incidence of addiction to prescription medications is extremely low in persons who do not already have a diagnosed addiction disorder
    2. Discuss differences between physical dependence
  - ii. Non-pharmacologic strategies for pain management – an overview
    1. Basic needs
    2. Comfortable environment
    3. Support
    4. PT, OT, assistive devices
    5. Heat, cold, massage
    6. Relaxation, imagery, Reiki, and others
    7. Activities and distraction
    8. Music or art therapy
    9. Other
- g. Myths and misperceptions about pain and aging - examples
- i. “Older people don’t feel pain as much as others”
  - ii. “Older people can’t take opioids”
  - iii. “Pain is an expected part of aging”
  - iv. “They’re just looking for attention”
- h. Question and answer session

### Additional Content for CNA Education

- Policies for routine screening
- How to use the specific rating scales used in your facility
- Level of pain on the scale that must be reported to the nurse
- What to do with the information – documentation as well as action
- Non-pharmacologic strategies for CNA intervention
  - Basic needs
- Blanket or sweater for warmth; other strategies if too warm
- Fluids, food
- Clean and dry
- Toileting
- Re-positioning
- Comfortable environment
- Support or interaction with others
  - Massage
  - Other comfort measures
  - Distraction
  - Assist with other non-drug therapies as instructed
- Additional focus on behavior or activity changes in the cognitively impaired resident
- Importance of the CNA in identifying and reporting pain in residents
- Facility expectations

## Tab 9: Regulations and Resources Related to Pain

Long-term care facilities participating in Medicare and Medicaid must meet certain federal requirements necessary to assure the health and safety of individuals to whom services are furnished. The information in this section is taken from federal regulations, guidance to surveyors, and survey protocols for long-term care facilities (42 CFR Part 483 Subpart B).

The federal regulations related to the quality measures can be categorized according to clinical steps. There are federal regulations that govern assessment, care planning, and delivery of care. Some of the quality measures are governed by federal regulations that are very specific to the clinical issue. Other quality measures, as the pain quality measure, are addressed under federal regulations that are more general in nature. This section references the pertinent regulations and related guidance to surveyors. Regulations -CMS- 42 CFR, Subpart B.

### In This Section:

#### Long-term care facilities participating in Medicare

#### Massachusetts Department of Public Health (DPH)

This section also references circular letter #2-9-379 and Best Practice Recommendation #2 issued by the Massachusetts DPH regarding standards of pain management.

#### Resources

National organizations are referenced to assist with obtaining materials and information regarding pain and health conditions of elders. Additional helpful web sites are listed.

Regulations — CMS Medicare & Medicaid Requirements for Long-Term Care Facilities  
 42CFR Part 483 Subpart B

GUIDANCE TO SURVEYORS - LONG TERM CARE FACILITIES

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F272	<p>(b) <u>Comprehensive assessments.</u></p> <p>(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following:</p> <p>(i) Identification and demographic information</p> <p>(ii) Customary routine.</p>	<p><u>§483.20(b) Intent:</u></p> <p>To ensure that the RAI is used in conducting comprehensive assessments as part of an ongoing process through which the facility identifies the resident's functional capacity and health status.</p> <p><u>§483.20(b) Guidelines:</u></p> <p>The information required in §483.20(b)(i-xvi) is incorporated into the MDS, which forms the core of each State's approved RAI. Additional assessment information is also gathered using R-APs.</p> <p>Each facility must use its State-specified RAI (which includes both the MDS and utilization guidelines which include the R-APs) to assess newly admitted residents, conduct an annual reassessment and assess those residents who experience a significant change in status. The facility is responsible for addressing all needs and strengths of residents regardless of whether the issue is included in the MDS or R-APs. The scope of the RAI does not limit the facility's responsibility to assess and address all care needed by the resident. Furthermore, the facility is responsible for addressing the resident's needs from the moment of admission.</p> <p>"Identification and demographic information" corresponds to MDS v 2.0 Sections AA, BB and A, and refers to information that uniquely identifies each resident and the facility in which he/she resides, date of entry into the facility and residential history.</p> <p>"Customary routine" corresponds to MDS v 2.0 Section AC, and refers to information regarding the resident's usual community lifestyle and daily routine in the year prior to the date of entry to the nursing home.</p>

From: QIO Material for CMS

Regulations — CMS Medicare & Medicaid Requirements for Long-Term Care Facilities  
42CFR Part 483 Subpart B

GUIDANCE TO SURVEYORS - LONG TERM CARE FACILITIES

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F272	<p>(iii) Cognitive patterns.</p> <p>(iv) Communication.</p> <p>(v) Vision.</p> <p>(vi) Mood and behavior patterns.</p> <p>(vii) Psychosocial well-being</p> <p>(viii) Physical functioning and structural problems.</p> <p>(ix) Continence.</p> <p>(x) Disease diagnosis and health conditions.</p>	<p>“Cognitive patterns” (iii) corresponds to MDS v. 2.0 Section B. “Cognitive patterns” is defined as the resident’s ability to problem solve, decide, remember, and be aware of and respond to safety hazards.</p> <p>“Communication” (iv) corresponds to MDS v. 2.0 Section C, and refers to the resident’s ability to hear, understand others, make him or herself understood (with assistive devices if they are used).</p> <p>“Vision” (v) corresponds to MDS v. 2.0 Section D, and I.1.jj, kk, ll and mm, and refers to the resident’s visual acuity, limitations and difficulties, and appliances used to enhance vision.</p> <p>“Mood and behavior patterns” (vi) corresponds to MDS v. 2.0 Section E, and refers to the resident’s patterns of mood and behavioral symptoms.</p> <p>“Psychosocial well-being” (vii) corresponds to MDS v. 2.0 Sections E1o and p, and F and refers to the resident’s positive or negative feelings about him or herself or his/her social relationships.</p> <p>“Physical functioning and structural problems” (viii) corresponds to MDS v. 2.0 Section G, and refers to the resident’s physical functional status, ability to perform activities of daily living, and the resident’s need for staff assistance and assistive devices or equipment to maintain or improve functional abilities.</p> <p>“Continence” (ix) corresponds to MDS v. 2.0, Section H, and refers to the resident’s patterns of bladder and bowel continence (control), pattern of elimination, and appliances used.</p> <p>“Disease diagnoses and health conditions” (x) corresponds to MDS v. 2.0, Sections AB.9 and 10, I.1 and 2, and J.</p>

From: QIO Material for CMS

Regulations — CMS Medicare & Medicaid Requirements for Long-Term Care Facilities  
42CFR Part 483 Subpart B

GUIDANCE TO SURVEYORS - LONG TERM CARE FACILITIES

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
(xi)	Dental and nutritional status.	<p>“Dental and nutritional status” (xi) corresponds to MDS v. 2.0, Sections K1 and L.</p> <p>“Dental condition status” refers to the condition of the teeth, gums, and other structures of the oral cavity that may affect a resident’s nutritional status, communication abilities, or quality of life. The assessment should include the need for, and use of, dentures or other dental appliances.</p> <p>“Nutritional status” corresponds to MDS v. 2.0, Section K2-5.</p> <p>Nutritional status refers to weight, height, hematologic and biochemical assessments, clinical observations of nutrition, nutritional intake, resident’s eating habits and preferences, dietary restrictions, supplements, and use of appliances.</p>
(xii)	Skin conditions.	<p>“Skin conditions” (xii) corresponds to MDS v. 2.0 Sections M, G1a, G6a, H1a, H1b, and P4c, and refers to the resident’s development, or risk of development of a pressure sore.</p>
(xiii)	Activity pursuit.	<p>“Activity pursuit” (xiii) corresponds to MDS v. 2.0 Sections N and AC.</p> <p>“Activity pursuit” refers to the resident’s ability and desire to take part in activities which maintain or improve physical, mental, and psychosocial well-being. Activity pursuits refer to any activity outside of activities of daily living (ADLs) which a person pursues in order to obtain a sense of well-being. Also, includes activities which provide benefits in self-esteem, pleasure, comfort, health education, creativity, success, and financial or emotional independence. The assessment should consider the resident’s normal everyday routines and lifetime preferences.</p>
(xiv)	Medications.	<p>“Medications” (xiv) corresponds to MDS v. 2.0, Section O, and Section U, if completed.</p> <p>“Medications” refers to all prescription and over-the-counter medications taken by the resident, including dosage, frequency of administration, and recognition of significant side effects that would be most likely to occur in the resident. This information need not appear in the assessment. However, it must be in the resident’s clinical record and included in the care plan.</p>

From: QIO Material for CMS

Regulations — CMS Medicare & Medicaid Requirements for Long-Term Care Facilities  
42CFR Part 483 Subpart B

GUIDANCE TO SURVEYORS - LONG-TERM CARE FACILITIES

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
	<p>(xv) Special treatments and procedures.</p> <p>(xvi) Discharge potential.</p> <p>(xvii) Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.</p> <p>(xviii) Documentation of participation in assessment.</p>	<p>“Special treatments and procedures” (xv) corresponds to MDS v. 2.0 Sections K.5, M.5, and P.1, and Section I, if completed.</p> <p>“Special treatments and procedures” refers to treatments and procedures that are not part of basic services provided. For example, treatment for pressure sores, nasogastric feedings, specialized rehabilitation services, respiratory care, or devices and restraints.</p> <p>“Discharge potential” (xvi) corresponds to MDS v. 2.0 Section Q.</p> <p>“Discharge potential” refers to the facility’s expectation of discharging the resident from the facility within the next 3 months.</p> <p>“Documentation of summary information (xvii) regarding the additional assessment performed through the resident assessment protocols (RAPs)” corresponds to MDS v. 2.0 Section V, and refers to documentation concerning which RAPs have been triggered, documentation of assessment information in support of clinical decision making relevant to the RAP, documentation regarding where, in the clinical record, information related to the RAP can be found, and for each triggered RAP, whether the identified problem was included in the care plan.</p> <p>“Documentation of participation in the assessment” corresponds to MDS v. 2.0 Section R, and refers to documentation of who participated in the assessment process. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.</p>
F273	<p>(2) <i>When required.</i> A facility must conduct a comprehensive assessment of a resident as follows:</p> <p>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident’s physical or mental condition. (For purposes of this section, “readmission” means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)</p>	<p><u>§483.204(b)(2) Intent:</u></p> <p>To assess residents in a timely manner.</p>

From: QIO Material for CMS

Regulations — CMS Medicare & Medicaid Requirements for Long-Term Care Facilities  
42CFR Part 483 Subpart B

GUIDANCE TO SURVEYORS - LONG TERM CARE FACILITIES	
TAG NUMBER	REGULATION
F278 (Cont.)	<p>GUIDANCE TO SURVEYORS</p> <ul style="list-style-type: none"> <li>- Submitting MDS Assessments (including any reason(s) for assessment, routine or non-routine), Discharge or Reentry Tracking forms, where the information does not accurately reflect the resident's status as of the Assessment Reference date, or the Discharge or Reentry date, as applicable;</li> <li>- Submitting correction(s) to information in the State MDS database where the corrected information does not accurately reflect the resident's status as of the original Assessment Reference date, or the original Discharge or Reentry date, as applicable, or where the record it claims to correct does not appear to have been in error;</li> <li>- Submitting Significant Correction Assessments where the assessment it claims to correct does not appear to have been in error;</li> <li>- Submitting Significant Change in Status Assessments where the criteria for significant change in the resident's status do not appear to be met;</li> <li>- Delaying or withholding MDS Assessments (including any reason(s) for assessment, routine or non-routine), Discharge or Reentry Tracking information, or correction(s) to information in the State MDS database.</li> </ul> <p>When such patterns or practices are noticed, they should be reported by the State Agency to the proper authority.</p> <p><u>§483.20(k) Guidelines:</u></p> <p>An interdisciplinary team, in conjunction with the resident, resident's family, surrogate, or representative, as appropriate, should develop quantifiable objectives for the highest level of functioning the resident may be expected to attain, based on the comprehensive assessment. The interdisciplinary team should show evidence in the RAP summary or clinical record of the following:</p> <ul style="list-style-type: none"> <li>o The resident's status in triggered RAP areas;</li> <li>o The facility's rationale for deciding whether to proceed with care planning; and</li> <li>o Evidence that the facility considered the development of care planning interventions for all RAPs triggered by the MDS.</li> </ul>
F279	<p>k) Comprehensive care plans.</p> <p>(1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following:</p>

From: QIO Material for CMS

**Regulations — CMS Medicare & Medicaid Requirements for Long-Term Care Facilities**  
**42CFR Part 483 Subpart B**

GUIDANCE TO SURVEYORS - LONG TERM CARE FACILITIES		GUIDANCE TO SURVEYORS
TAG NUMBER	REGULATION	
F279 (Cont.)	<p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and</p> <p>(ii) Any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p>	<p>The care plan must reflect intermediate steps for each outcome objective if identification of those steps will enhance the resident's ability to meet his/her objectives. Facility staff will use these objectives to monitor resident progress. Facilities may, for some residents, need to prioritize their care plan interventions. This should be noted in the clinical record or on the plan or care.</p> <p>The requirements reflect the facility's responsibilities to provide 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. However, in some cases, a resident may wish to refuse certain services or treatments that professional staff believe may be indicated to assist the resident in reaching his or her highest practicable level of well-being. Desires of the resident should be documented in the clinical record (see guidelines at §483.10(b)(4) for additional guidance concerning refusal of treatment).</p> <p>§483.20(k)(1) Probes:</p> <ul style="list-style-type: none"> <li>o Does the care plan address the needs, strengths and preferences identified in the comprehensive resident assessment?</li> <li>o Is the care plan oriented toward preventing avoidable declines in functioning or functional levels? How does the care plan attempt to manage risk factors? Does the care plan build on resident strengths?</li> <li>o Does the care plan reflect standards of current professional practice?</li> <li>o Do treatment objectives have measurable outcomes?</li> <li>o Corroborate information regarding the resident's goals and wishes for treatment in the plan of care by interviewing residents, especially those identified as refusing treatment.</li> <li>o Determine whether the facility has provided adequate information to the resident so that the resident was able to make an informed choice regarding treatment.</li> <li>o If the resident has refused treatment, does the care plan reflect the facility's efforts to find alternative means to address the problem?</li> </ul> <p>For implementation of care plan, see §483.20(k)(3).</p>

*From: QIO Material for CMS*

# Regulations — CMS Medicare & Medicaid Requirements for Long-Term Care Facilities

## 42CFR Part 483 Subpart B

GUIDANCE TO SURVEYORS - LONG TERM CARE FACILITIES		GUIDANCE TO SURVEYORS
TAG NUMBER	REGULATION	
F309	<p><b>Quality of Care</b></p> <p>Each resident must receive and the facility must provide 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.</p> <p>Use F309 for quality of care deficiencies not covered by §483.25(a)-(m).</p>	<p><b>Guidelines: §483.25</b></p> <p>Use F309 when the survey team determines there are quality of care deficiencies not covered by §483.25(a)-(m). "Highest practicable" is defined as the highest level of functioning and well-being possible, limited only by the individual's presenting functional status and potential for improvement or reduced rate of functional decline. Highest practicable is determined through the comprehensive resident assessment by competency and thoroughly addressing the physical, mental or psychosocial needs of the individual.</p> <p>The facility must ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process.</p> <p>In any instance in which there has been a lack of improvement or a decline, the survey team must determine if the occurrence was unavoidable or avoidable. A determination of unavoidable decline or failure to reach highest practicable well-being may be made only if all of the following are present:</p> <ul style="list-style-type: none"> <li>o An accurate and complete assessment (see §483.20);</li> <li>o A care plan which is implemented consistently and based on information from the assessment;</li> <li>o Evaluation of the results of the interventions and revising the interventions as necessary.</li> </ul> <p>Determine if the facility is providing the necessary care and services based on the findings of the RAI. If services and care are being provided, determine if the facility is evaluating the outcome to the resident and changing the interventions if needed. This should be done in accordance with the resident's customary daily routine. Use Tag F309 to cite quality of care deficiencies that are not explicit in the quality of care regulations.</p> <p><b>Procedures: §483.25</b></p> <p>Assess a facility's compliance with these requirements by determining if the services noted in the plan of care, based on a comprehensive and accurate functional assessment of the resident's strengths, weaknesses, risk factors for deterioration and potential for improvement, is continually and aggressively implemented and updated by the facility staff. In looking at assessments, use both the MDS and RAI's information, any other pertinent assessments, and resulting care plans.</p> <p>If the resident has been in the facility for less than 14 days (before completion of all the RAI is required), determine if the facility is conducting ongoing assessment and care planning, and if appropriate, care and services are being provided.</p> <p>If quality of care problems are noted in areas of nurse aide responsibility, review nurse aide competency requirements at §483.75(e).</p>

From: QIO Material for CMS

circular letter #2937-Adoption

Page 1 of 2

TO: All Licensed Health Care Facilities

FROM: Paul Dreyer, Ph.D., Director, Division of Health Care Quality

DATE: March 13, 1998

CIRCULAR LETTER #2-9-379

Adoption of Standards of the American Pain Society

In an effort to improve the quality of patient care as in the area of pain management, the Department of Public Health is formally adopting the Quality Improvement Guidelines for the Treatment of Acute and Cancer Pain developed by the American Pain Society . Adoption of these standards is the result of the Department's participation on the special Subcommittee on the Management of Acute and Terminal Pain, co-chaired by Representative Harriette Chandler, Chairwoman of the Joint Committee on Health Care and Senator Marc Pacheco.

Many residents in the Commonwealth suffer from acute pain associated with injury, illness, and surgery, as well as from terminal pain due to cancer and other conditions. Unrelieved pain impedes recovery from surgery, injury, or illness; interferes with physical functioning and productivity; destroys the quality of life; and increases the use and cost of health care services. Proper management of pain includes both drug and non-drug therapy, as well as proper initial and ongoing assessments, including: (1) more individualized pain treatment that is based on a patient's presenting condition, and current and past physical, social and psychological condition and treatment; (2) standardized questionnaires assessing the physical, psychological, social and cultural factors affecting pain, administered by appropriately trained health care personnel; and (3) interdisciplinary involvement by physicians, nurses, pharmacists, psychotherapists, and others.

The Department believes that use of standards developed by the American Pain Society by all licensed health care facilities in the Commonwealth will improve treatment of acute and terminal pain for all patients.

Among the recommendations made in these standards are the following:

1. Recognize and Treat Pain Promptly
  - Chart and Display Patient's Self-Report of Pain

circular letter #2937-Adoption

Page 2 of 2

- Commit to Continuous Improvements of One or Several Outcome Variables
  - Document Outcomes Based on Data and Provide Prompt Feedback
2. Make Information About Analgesics Readily Available
  3. Promise Patients Adequate and Prompt Analgesic Care
  4. Define Explicit Policies for Use of Advanced Analgesic Technologies
  5. Examine the Process and Outcomes of Pain Management With the Goal of Continuous Improvement

The Department urges all licensed health care facilities to familiarize themselves with these guidelines and to adopt them as a model in the treatment of acute and terminal pain in patients at their respective facilities. The Department will be working closely with the legislature, various state and federal regulatory and law enforcement agencies, as well as professional associations and others to continue in our efforts to improve the treatment and management of acute and terminal pain. A copy of the final report to the Joint Committee on Health Care by the Subcommittee on the Management of Acute and Terminal Pain is available on the Department's Web Page at <http://www.magnet.state.ma.us/dph/dcp/dcp.htm>. For further information, contact Kathy Keough, Assistant Director for Operations, Drug Control Program (617) 983-6733.

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[Final Report of the Pain Management Commission](#)

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[Provider Information](#)

[Health Care Quality](#)

[Drug Control Program](#)

[Privacy Policy](#)

## **CIRCULAR LETTER: DHCQ 99-8-395**

To: Hospital Administrators, Long-Term Care Facilities

From: Paul I. Dreyer, Ph.D., Director

Date: August 5, 1999

Re: Best Practice Recommendation #2:  
Methods to facilitate the appropriate administration of morphine sulfate.

This is the second in a series of Best Practice Recommendations from the Department of Public Health, Division of Health Care Quality ("Division"). The purpose of these recommendations is to assist facilities in their efforts to reduce medication errors in Massachusetts long-term care facilities.

Several of the medication errors that the Division has investigated in the past three years have resulted from the failure to properly administer morphine sulfate. Specifically, many errors were the result of the administration of the incorrect dosage of morphine due to a miscalculation by the person who administered the medication. These errors resulted in serious harm to residents of the facilities. In response to these errors, the Division strongly recommends that each facility:

- Work with its consultant pharmacist to encourage prescribers to prescribe the strength of morphine sulfate that is the least complex for the nurse to convert to the prescribed dose.
- Work with its consultant pharmacist to standardize the strengths of morphine sulfate that are ordered by the facility and dispensed by the pharmacy. Such standardization might include using manufacturers' original packaged syringes for injectable morphine sulfate (not multidose syringes), where appropriate, in order to minimize dosing calculations.
- Use the enclosed morphine conversion charts as an aid in the administration of morphine. The charts should be posted where medication is prepared for administration and used in order to double check calculations that are made when converting from milligrams of morphine ordered to milliliters of morphine administered.

Enclosed you will find the following:

1. **Emergency Kit Conversion Chart-** a conversion chart for insertion in the facility Emergency Kit. This conversion chart lists the milligram and milliliter dosages of the morphine sulfate strengths that are available in most emergency kits.
2. **Oral Morphine Sulfate Conversion Chart-** this conversion chart provides the milligram and milliliter dosages of the three most commonly dispensed strengths of morphine sulfate that are administered orally.

3. **Morphine Sulfate Conversion Chart for SC & IM Administration-** this conversion chart provides the milligram and milliliter dosages of the three most commonly dispensed strengths of morphine sulfate that are administered by subcutaneous or intramuscular injection.

The Division urges all licensed long term care facilities to familiarize themselves with these tools, to incorporate them into their medication administration policies and procedures, and to use these or other equivalent tools as part of their overall medication administration process. The Advisory Committee will continue to work to assist facilities in their efforts to reduce medication errors in long-term care facilities in the Commonwealth.

If you have any further questions, please contact your regional manager at (617) 753-8000.

## Resources

### National Organizations

#### American Geriatrics Society (AGS)

[www.americangeriatrics.org](http://www.americangeriatrics.org)

The Empire State Building  
350 Fifth Avenue, Suite 801  
New York, NY 10118  
(212) 308-1414

A nationwide, not-for-profit association, with an active membership of over 6,000, providing leadership to health care professionals, policy makers, and the public by developing, implementing and advocating programs in patient care, research, professional and public education, and public policy.

#### Administration on Aging

[www.aoa.dhhs.gov](http://www.aoa.dhhs.gov)

330 Independence Avenue, SW  
Washington, DC 20201  
(800) 677-1116

Provides lists of community services for older Americans in your area.

#### Agency for Healthcare Research and Quality (AHCPR)

[www.ahrq.gov](http://www.ahrq.gov)

Department of Health and Human Services  
2101 E. Jefferson Street - Suite 501  
Rockville, MD 20852  
(301) 594-1364

Federal agency that conducts research on health care quality issues, health care cost and patient safety. Their mission includes translating research into better patient care.

#### American Society on Aging

[www.asaging.org](http://www.asaging.org)

833 Market Street, Suite 511  
San Francisco, CA 94103-1824  
(415) 974-9600

National association providing educational programs, publications, and training resources on age-related issues.

#### National Council on Aging (NCOA)

[www.ncoa.org](http://www.ncoa.org)

409 Third Street SW, Suite 200  
Washington, DC 20024  
(202) 479-1200

NCOA works primarily with community organizations and professionals to help them enhance the lives of older persons. Provides on-line links to other useful web sites.

#### National Institute on Aging

[www.nia.nih.gov](http://www.nia.nih.gov)

Building 31, Room 5C27  
31 Center Drive, MSC 2292  
Bethesda, MD 20892  
(301) 496-1752

One of the 25 institutes and centers of the National Institute of Health. Conducts research on age-related issues, disseminates information and communicates with the public and other interested groups on health and research advances.

#### The AGS Foundation for Health in Aging

[www.healthinaging.org](http://www.healthinaging.org)

The Empire State Building  
350 Fifth Avenue, Suite 801  
New York, NY 10118  
(212) 755-6810  
(800) 563-4916

National non-profit organization established in 1999 by the American Geriatrics Society to build a bridge between research and practice of geriatrics and the public and to advocate on behalf of older adults and their social health needs.

#### American Medical Directors Association (AMDA)

[www.amda.com](http://www.amda.com)

10480 Little Patuxent Parkway - Suite 760  
Columbia, MD 21044  
(410) 740-9743, (800) 876-2632

National professional association for medical directors and other MD's who practice in long term care, committed to continuous improvement of quality in patient care.

**National Guideline Clearinghouse (NGC)**

[www.guidelines.gov](http://www.guidelines.gov)

Web-based comprehensive database of evidence-based clinical practice guidelines and related abstract, summary and comparison materials widely available to healthcare professionals. NGC is operated by the U.S. Department of Health and Human Services (DHHS) and the Agency for Healthcare Research and Quality (AHRQ) in partnership with the American Medical Association (AMA) and the American Association of Health Plans (AAHP).

**National Chronic Pain Outreach Association (NCPOA)**

[www.neurosurgery.mgh.harvard.edu/ncpainoa.htm](http://www.neurosurgery.mgh.harvard.edu/ncpainoa.htm)

7979 Old Georgetown Road, Suite 100  
Bethesda, MD 20814-2429  
(301) 652-4948

Publishes quarterly newsletter, Lifeline, and serves as a clearing house of information on any kind of chronic pain.

**American Chronic Pain Association**

[www.theacpa.org](http://www.theacpa.org)

P.O. Box 850  
Rocklin, CA 95677  
(800) 533-3231

Offers support and information for people with chronic pain and raises awareness among the healthcare community, policy makers and public at large about issues of living with chronic pain.

**American Pain Society**

[www.ampainsoc.org](http://www.ampainsoc.org)

4700 W. Lake Avenue  
Glenview, IL 60025  
(847) 375-4715

A multidisciplinary educational and scientific organization serving people in pain by advancing research, education, treatment and professional practice.

**Arthritis Foundation**

[www.arthritis.org](http://www.arthritis.org)

P.O. Box 7669  
Atlanta, GA 30357-0669  
(404) 872-7100

National non-profit organization that supports the more than 100 types of arthritis related conditions with advocacy programs, services and research.

**National Headache Foundation**

[www.headaches.org](http://www.headaches.org)

428 West St. James Place, 2nd Floor  
Chicago, IL 60614-2750  
(888) 643-5552

Non-profit organization dedicated to educating headache sufferers and healthcare professionals about headache causes and treatments.

**American Chiropractic Association**

[www.amerchiro.org](http://www.amerchiro.org)

1701 Clarendon Blvd  
Arlington, VA 22209  
(800) 986-4636

The ACA is a professional organization representing Doctors of Chiropractic. Its mission is to preserve, protect, improve and promote the chiropractic profession and the services of Doctors of Chiropractic for the benefit of patients they serve. The purpose of the ACA is to provide leadership in health care and a positive vision for the chiropractic profession and its natural approach to health and wellness.

**American Health Care Association (AHCA)**

[www.ahca.org](http://www.ahca.org)

1201 L Street, NW  
Washington, DC 20005  
(202) 842-4444

Federation of state health organizations together representing nearly 12,000 non-profit and for profit Assisted Living, Skilled Nursing, Long Term Care, and Subacute Care providers that care for over 1 million elderly and disabled individuals nationally.

**American Association of Homes and Services for the Aging (AAHSA)**

[www.aahsa.org](http://www.aahsa.org)

2519 Connecticut Avenue, NW  
Washington, DC 20008-1520

(202) 783-2242

Non-Profit organization composed of 5,600 Nursing Homes, Continuing Care Retirement Communities, Assisted Living Residences, Senior Housing Facilities and Community Service Organizations.

**American Occupational Therapy Association (AOTA)**

[www.aota.org](http://www.aota.org)

4720 Montgomery Lane, P.O. Box 31220  
Bethesda, MD 20824-1220

(301) 652-2682

The national, professional organization for occupational therapists. AOTA provides clinical resources, educational materials, articles, publications, information on government regulations/reimbursement, and other general information to therapists, health care professionals, and the public related to occupational therapy and rehabilitation.

**American Physical Therapy Association (APTA)**

[www.apta.org](http://www.apta.org)

1111 North Fairfax Street  
Alexandria, VA 22314

(703) 684-2782

(800) 999-2782

The national, professional organization for physical therapists. Organization provides clinical resources, education materials, articles, publications, information on government regulations/reimbursement, and other general information to therapists, health care professionals, and the public related to physical therapy and rehabilitation.

**American Association of Oriental Medicine**

[www.aaom.org](http://www.aaom.org)

5530 Wisconsin Avenue, Suite 1210  
Chevy Chase, MD 20815

(301) 941-1064

(888) 500-7999

The American Association of Acupuncture and Oriental Medicine (AAAOM), was formed in 1981 to be the unifying force for American acupuncturists who are committed to high ethical and educational standards, and a well regulated profession to ensure the safety of the public

**Joint Commission on Accreditation of Health Organizations(JCAHO)**

[www.JCAHO.org](http://www.JCAHO.org)

One Renaissance Boulevard  
Oakbrook Terrace, IL 60181

(630) 792-5000

Non-profit organization, that is the predominant standards-setting and accrediting body in healthcare. Develops professional standards and evaluates compliance of healthcare organizations.

**American Association of Nurse Assessment Coordinators (AANAC)**

[www.aanac.org](http://www.aanac.org)

1780 South Bellaire Street, Suite 150  
Denver, CO 80222-4307

(303) 758-7647

Non-profit professional association representing nurse assessment coordinators and others involved in resident assessment. Provides access to information on clinical assessment, regulatory requirements, reimbursement, etc. (RNs, Administrators)

**National Association of Area Agencies on Aging**

927 15th Street, NW, 6th Floor  
Washington, DC 20005

(202) 296-8130

Umbrella organization for area agencies on aging and Title VI Native American Aging programs in the US to ensure that needed resources and support services are available to older Americans.

[www.n4a.org](http://www.n4a.org)

**National Gerontological Nursing Association (NGNA)**

[www.ngna.org](http://www.ngna.org)

7794 Grow Drive  
Pensacola, FL 32514

(850) 473-1174

(800) 723-0560

Professional organization of nurses whose mission is to improve the care and wellbeing of older adults through professional and public education, dissemination of research findings and support of innovative approaches in gerontological health care.

## Web Sites

### [www.jr2.ox.ac.uk/cochrane](http://www.jr2.ox.ac.uk/cochrane)

Pain, Palliative Care and Supportive Care Group of the Cochrane Collaborative.

Focuses on reviews for the prevention and treatment of pain, the treatment of symptoms at the end of life, and supports patients, caregivers and families through the disease process.

### [www.cochrane.org](http://www.cochrane.org)

Regularly updated collection of evidence-based medical databases. The Cochrane Collaborative provides information, education, research and funding.

### [www.chcr.brown.edu/dying/severepain.htm](http://www.chcr.brown.edu/dying/severepain.htm)

Report that gives information regarding persons living with severe persistent pain in long-term care facilities

### [www.chcr.brown.edu/pcoc/toolkit.htm](http://www.chcr.brown.edu/pcoc/toolkit.htm)

These measurement tools help to identify opportunities for improving medical care and examining the impact of interventions or demonstration programs, as well as providing tools to hold institutions accountable for their quality of care.

### [www.chcr.brown.edu/commstate/homepage-withframes.htm](http://www.chcr.brown.edu/commstate/homepage-withframes.htm)

The Rhode Island Partnership to Improve Care at the End-of-Life offers multifaceted educational campaigns and resources to help begin the conversation about end-of-life issues.

### [www.chcr.brown.edu/dart/dartpreview.htm](http://www.chcr.brown.edu/dart/dartpreview.htm)

Service supports quality improvement efforts among health care facilities that provide care for dying patients and their families.

### [www.jama.ama-assn.org/pi/index.html](http://www.jama.ama-assn.org/pi/index.html)

JAMA web article: Persistent Pain in Nursing Home Residents by Teno, J., Weitzen, S., Wetle, T., Mor, V., August 25, 2001.

### [www.snfinfo.com](http://www.snfinfo.com)

Super site for LTC issues, i.e. regulations, MDS, etc. Provides links to other resources. (RNs, Administrators, MDS Coordinators)

### [www.advancefornurses.com](http://www.advancefornurses.com)

Site for nurses. Has archived articles related to nursing, LTC, etc.

### [www.advanceforot.com](http://www.advanceforot.com)

Site for occupational therapists. Has archived articles related to OT, etc.

### [www.advanceforpt.com](http://www.advanceforpt.com)

Site for physical therapists. Has archived articles related to PT, etc.

### [www.quality-care.org](http://www.quality-care.org)

Site for manuals, care plans, assessment tools, video inservices, etc. (RNs, Administrators)

### [www.spine-health.com](http://www.spine-health.com)

Comprehensive resource for back pain

### [www.spine-health.com/topics/conserv/chiro/feature/chirtr01.html](http://www.spine-health.com/topics/conserv/chiro/feature/chirtr01.html)

Article regarding chiropractic treatments

### [www.texasback.com/index/html](http://www.texasback.com/index/html)

The largest, freestanding spine specialty clinic in the United States of America. The Institute was established more than 20 years ago to provide comprehensive medical care for individuals with back and neck pain. The professional staff includes board-certified orthopedic surgeons with spine fellowship training, general surgeons, general medicine physicians, internists, chiropractors, physiatrists, pain specialists, exercise physiologists and a team of physical and occupational therapists

### [http://odp.od.nih.gov/consensus/cons/107/107\\_intro.htm](http://odp.od.nih.gov/consensus/cons/107/107_intro.htm)

The National Institutes of Health. NIH Consensus Statement (15)5: Acupuncture. November 3-5, 1997.

### [www.partnersagainstpain.com/html/assess/scales/as\\_scale2.htm](http://www.partnersagainstpain.com/html/assess/scales/as_scale2.htm)

Partners against pain - 18 multi-language pain assessment scales

*This material was developed by the QIO program for CMS' NHQI and is intended as general information. Any individual using the material must consider the possibility of human error, changes in medical sciences, and the need to use clinical judgement in each specific case.*

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[www.cityofhope.org](http://www.cityofhope.org)

Serves as a clearinghouse to disseminate information and resources that will enable other individuals and institutions to improve the quality of pain management. An index to more than 300 materials can be found on the site.

[www.hcmarketplace.com/Prod.cfm?id=484&S=EV7452A](http://www.hcmarketplace.com/Prod.cfm?id=484&S=EV7452A)

Healthcare Marketplace location to purchase JCAHO's new standards on pain management. Pain Management: How to meet the new JCAHO Standards and Improve Patient Care.

## Tab 10: References

- Agency for Healthcare Quality and Research. <http://www.ahrq.gov>.
- AGS Panel on Persistent Pain in Older Persons. 2002. Clinical practice guideline: the management of persistent pain in older persons. *Journal of the American Geriatrics Society*; 50: S205-224.
- American Geriatric Society, Clinical Practice Guidelines. 1998. The management of chronic pain in older persons: AGS panel on chronic pain in older persons. *Journal of the American Geriatrics Society*; 46: 635-651.
- Chronic Pain Management in the Long-Term Care Setting: Clinical Practice Guideline American Medical Director's Association. <http://www.amda.com>.
- American Pain Society. Information available online: [www.ampainsoc.org](http://www.ampainsoc.org). Published guidelines: Acute pain; Cancer pain; Arthritis pain; Sickle cell pain; Fibromyalgia. Consensus statements with AAPM, ASAM: addiction, dependence and tolerance. Quality Improvement Standards published in *JAMA*, December 20, 1995.
- Crook, J., Rideout, E., and Browne, G. 1984. The prevalence of pain complaints in a general population. *Pain*. 18(3): 299-314.
- Joint Commission on Accreditation of Healthcare Organization (JCAHO). <http://www.JCAHO.org>.
- McCaffery, M. and Pasero, C. eds. 1999. *Pain: Clinical manual*. Philadelphia: Mosby.
- Merskey, H. and Bogduk, N. eds. 1994. Classification of chronic pain, Second Edition. Seattle, WA: IASP Press.
- Mobily, PR, Herr, KA, Clark, MK, and Wallace, RB. 1994. An epidemiologic analysis of pain in the elderly: The Iowa 65+ rural health study. *Journal Aging Health*; 6: 139-145.
- Stein, WM and Ferrell, BA. 1996. Pain in the nursing home. *Clin Geriatric Med*; 12 (3): 601-13.
- Sternbach RA. 1978. Clinical aspects of pain. In: Sternbach, RA, ed. *The psychology of pain*. New York: Raven Press.
- Teno, J., Bird, C., and Mor, V., The prevalence and treatment of pain in US nursing homes. Center for Gerontology and Healthcare Research, Brown University.
- Turk, DC, and Melzack, R. 1992. The Measurement of pain and the assessment of people experiencing pain. In: Turk, DC and Melzack, eds. *Handbook of pain assessment*. New York: Guilford Press.
- Weissman, DE. 2001. Improving pain management in longterm care facilities. *Innovations in end of life care*; 3(10). <http://www2.edc.org/lastacts>.