Pain Recognition and Management Critical Element Pathway

Use this pathway for a resident who has pain symptoms or can reasonably be expected to experience pain (i.e., during therapy) to determine whether the facility has provided the resident *with* care and services to address and manage the resident's pain in order to support his or her highest practicable level of physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and care plan, current professional standards of practice, and the resident's goals and preferences.

Review the Following in *a*dvance to *g*uide *o*bservations and Interviews*:*

- ☐ *Review* the most current comprehensive *MDS/CAAs. If the* most recent *MDS is a* quarterly, *then review both the most recent* comprehensive *and quarterly MDS. Review s*ections C, GG, J, K, L, N, and O.
- ☐ Physician's orders (e.g., pain management interventions, PRN or routine pain medications, type of pain medications, route, *and pertinent diagnosis of pain*).
- ☐ Care plan (e.g., measurable goals for pain management, current pain management interventions, pharmacological and non-pharmacological interventions, timeframes, and approaches for monitoring the status of the resident's pain, including the effectiveness of the interventions).

Observations:

- ☐ Does the resident exhibit signs or symptoms of pain, verbalize the presence of pain, or request interventions for pain? *If yes, does staff respond promptly and implement interventions?*
- ☐ *Does staff monitor and evaluate the effectiveness of the interventions and make changes if they are not effective?*
- ☐ *D*oes staff respond if there is a report from the resident, family, or staff that the resident is experiencing pain?
- ☐ How long does the resident wait to receive PRN pain medication after requesting it?

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Resident, Resident Representative, or Family Interview:

- ☐ *Have you had any unrelieved pain or discomfort recently? If yes, did the faciltiy address the unrelieved pain?*
- ☐ *We*re you involved in developing and revising pain management? *Do the care plan interventions reflect your goals and preferneces?*
- ☐ What factors may *cause* or alleviate the pain?
- ☐ How have you typically expressed pain and responded to various interventions in the past?
- ☐ What treatment options (pharmacological and/or non-pharmacological) were attempted? *Were the options effective?*

Nursing Aide Interview:

- ☐ Does the resident *exhibit or verbalize* any pain during *care* ? If *yes*, what do you do?
- ☐ Do you *implement* interventions *that* are *listed in* the resident's *pain management* care plan?

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Nurse, DON, Hospice Nurse, Attending Practitioner, Pharmacist, Medical Director Interviews:

- ☐ *How is the resdient's pain assessed? How do you implement the pain management care plan?*
- ☐ How often is the resident's pain regimen reviewed*(dose, frequency of PRN use, schedule of routine medications, and effectiveness)* , and what *determine* a review?
- ☐ How does staff communicate with the prescriber about the resident's pain status, and the *effectiveness of* the current pain management interventions?
- ☐ How do you monitor for *possible* adverse *consequences* related to opioid medications?
- ☐ How do you *select and monitor pain management interventions for resident with acute, subacute and chronic pain* ?
- ☐ For a resident who is receiving care under a hospice benefit, how does the hospice and the facility coordinate their approaches and communicate about the resident's needs and monitor the outcomes (both effectiveness and adverse consequences)?

Record Review:

- ☐ Review information such as MARs, controlled medication records/count sheets, multidisciplinary progress notes, and any specific assessments regarding pain that may have been completed. Determine whether the information accurately and comprehensively reflects the resident's condition, and extent to which pain is managed.
- ☐ *What is the clinical* rationale *for the current pain management, and does it meet* current standards of practice?
- ☐ *Did the faciltiy monitor the resident for possible* adverse consequences, such as a change in mental status/delirium, falling, constipation, anorexia, *and/*or drowsiness? *If yes,* what is the plan to try to minimize those adverse consequences?
- ☐ Is the care plan comprehensive? Does it reflect the resident's needs and preferences? How did the resident respond to care-planned interventions? If interventions weren't effective, the pain was not resolved, or the resident experienced a change of condition, was the care plan revised?
- ☐ Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; *and* requires IDT review *and/*or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?
- ☐ If the resident has elected a hospice benefit, is there evidence that the resident's care is coordinated between the nursing home and the hospice? This includes aspects of pain management, such as:
  - Choice of palliative interventions;
  - Responsibility for assessing pain and providing interventions; and

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- Responsibility for monitoring symptoms and adverse consequences of interventions and for modifying interventions as needed.

Critical Element Decisions:

1) Did the facility identify, treat, monitor, and manage the resident's pain to the extent possible in accordance with the comprehensive assessment and care plan, current professional standards of practice, and the resident's goals and preferences?
If No, cite F697

2) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
If No, cite F655
NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

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3) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
If No, cite F636
NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

4) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
If No, cite F637
NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

5) *Does the most recent assessment accurately reflect the resident's status* (i.e., comprehensive, quarterly, significant change in status)?
If No, cite F641

6) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.

7) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA) and Tasks (Task) to Consider: Advance Directives (CA), Choices (CA), Notification of Change F580, Accommodation of Needs (Environment Task), *Abuse and Neglect F600*, Professional Standards F658, Related Quality of Care (e.g., Dental, Hospice, Pressure Ulcers, Positioning/Mobility/ROM), Unnecessary Medications (CA), Physician Supervision F710, Pharmacy Services F755, Medical Director F841, Resident Records F842.

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