

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 and the resident has received care and services to address and manage the resident's pain in order to support his or her highest practicable level of physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and care plan, current professional standards of practice, and the resident's goals and preferences.

Review the Following in Advance to Guide Observations and Interviews:

- The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections 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 [opioid, non-steroidal anti-inflammatory], and route [injectable, oral, topical]).
- Pertinent diagnoses.
- 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? Does the pain appear to affect the resident's function or ability to participate in routine care or activities? If so, describe.
- For non-verbal or cognitively-impaired residents who cannot verbalize their pain, how does staff assess for the presence of pain and effectiveness of interventions for pain?
- If there is evidence of pain, how does staff assess the situation, identify, and implement interventions to try to prevent or address the pain, and evaluate the status of the resident's pain after interventions?
- If care and services are being provided that reasonably could be anticipated to cause pain, such as therapy, how does staff identify and address these issues, to the extent possible?
- How does staff respond if there is a report from the resident, family, or staff that the resident is experiencing pain?
- If there are pain management interventions for the resident, how does staff ensure they are implemented as ordered or care planned?
- Does the resident exhibit any potential adverse consequences associated with treatment for pain (e.g., respiratory depression)?
- How does staff respond if the interventions implemented did not reduce the pain consistent with the goals for pain management?
- How long does the resident wait to receive PRN pain medication after requesting it?

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Resident, Resident Representative, or Family Interview:

- How does the facility involve you in the development of the care plan and defining the approaches and goals?
- How does the facility ensure the interventions reflect your/the resident's choices and preferences?
- How are you involved in developing and revising pain management strategies and revisions to the care plan if the interventions did not work?
- Describe the characteristics of the pain, including the intensity, pain rating, type (e.g., burning, stabbing, tingling, aching), patterns of pain (e.g., constant or intermittent), location, radiation of pain, and frequency, timing, and duration of pain.
- What factors may precipitate or alleviate the pain?
- How have you typically expressed pain and responded to various interventions in the past?
- Who have you told about the pain/discomfort? How has staff responded? How long does it take for you to receive pain medication when you have asked for it?
- What treatment options (pharmacological and/or non-pharmacological) were discussed and attempted?
- For a resident with a documented history of addiction or opioid use disorder (OUD): Has the facility used strategies to treat your pain while also addressing the OUD?
- How effective have the interventions been?
- Have you refused any interventions (i.e., certain types of medications or nonpharmacological ways to reduce pain without medication)? If so, was there a discussion of the potential impact on you, and what alternatives or other approaches were offered?

Nursing Aide Interview:

- Does the resident experience any pain during assistance with activities of daily living? If so, what do you do?
- Does the resident have any complaints, or exhibit any signs or symptoms of pain?
- Are you aware of the signs and symptoms of adverse side effects of the pain medication this resident is prescribed?
- To whom do you report the resident's complaints and signs or symptoms?
- Do you know what interventions are on the resident's care plan for pain/discomfort management (e.g., allowing a period of time for a pain medication to take effect before bathing or dressing)? Do you implement any interventions to relieve the resident's pain?

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

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- Is there a tool that is used to assess residents with pain? Is the same tool used for everyone? How is the resident assessed for pain? How and when do staff try to identify circumstances in which pain can be anticipated?
- Do staff assess for history of addiction and past or ongoing OUD treatment? How is this addressed?
- For residents receiving pain medication (including PRN and adjuvant medications), how, when, and by whom are the results of medications evaluated (dose, frequency of PRN use, schedule of routine medications, and effectiveness)?
- How often is the resident's pain regimen reviewed, and what triggers a review?
- What is done if pain persists or recurs despite treatment? What is the basis for decisions to maintain or modify approaches?
- How does staff communicate with the prescriber about the resident's pain status, current measures to manage pain, and the possible need to modify the current pain management interventions?
- How do you monitor for the emergence or presence of adverse events related to opioid medications or the consequences of interventions?
- Do you keep naloxone on hand to reverse the effects of an opioid overdose?
- For residents with significant, or difficult to manage pain: How were the interventions developed? What was the basis for selecting them?
- How do you guide and oversee the selection of pain management interventions?
- Are you aware of any situation where the resident had pain, but interventions were not utilized? If so, why did this occur? Was there a rationale?
- Have any of this resident's interventions been ineffective, or caused adverse consequences? If so, when and with whom was this discussed?
- 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)?

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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 indicators and characteristics of the resident's pain, including causes and contributing factors related to pain, have been identified, and addressed in the care plan?
- Did the facility identify the resident's history of pain and related interventions? If not, describe.
- What was the resident's response to interventions, including efficacy and adverse consequences and any modification of interventions as indicated?
- Do pain management interventions have a documented rationale and is it consistent with current standards of practice?
- Does the record show a combination of opioid and benzodiazepine medications for one resident? This combination can increase the risk of respiratory distress -- is there a documented rationale to show these medications are clinically indicated for the resident?
- What clinically significant medication-related adverse consequences, such as a change in mental status/delirium, falling, constipation, anorexia, or drowsiness, has the resident experienced? What was 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; requires IDT review 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
 - Responsibility for monitoring symptoms and adverse consequences of interventions and for modifying interventions as needed.

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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.
- 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) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (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.

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- 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), 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.