Specific Quality Indicator Guide for

Prevalence of Pain

Prepared by:

Center for Health Systems Research and Analysis
University of Wisconsin-Madison
610 Walnut Street, 11th Floor WARF Building
Madison, Wisconsin 53726-2397
(608) 263-5722 (Phone)
(608) 263-4523 (Fax)
www.chsra.wisc.edu (Website)
Prevalence of Pain
(Domain: Quality of Life)

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Review of the Care Process

The following guide will help you analyze the information presented in your facility level reports (Facility Characteristics and Facility Quality Indicator Profile) and resident level report (Resident Level Quality Indicator Summary). By following the systematic steps in this guide, you will be able to better determine whether a care problem exists in a specific area of the Quality Indicators (i.e., pressure ulcers, weight loss, pain, etc.) and assess the nature of the problem.

Process Overview


2. Choose QI domains and/or individual QIs within the domain that are most likely to represent a problem in your facility (e.g., areas that have “flagged” on the QI report).

3. Select a sample of residents that flag on the QIs you have selected for review.

4. Follow the systematic steps in each QI guide to determine if an actual problem exists. If you determine that a problem exists for a given resident, this process will further assist you in determining if the facility has a problem with an aspect of the care process on a broader or facility-wide scale. Each QI guide divides your review into the following elements of the Care Process:
   • Resident assessment, including the accuracy of the information
   • Decision making process on the need for a care plan
   • Development of the care plan
   • Implementation of the care plan
   • Monitoring and evaluation of the results of the care plan

5. Use the data collection tools at the end of the guide to record your observations and conclusions.

6. With team input, prioritize problems and their causes according to the extent that each impact resident care at your facility.

7. Access resources to address the concerns using RAPs, CHSRA Specific QI Guides, AHCPR Guidelines, Quality Monitoring Pathways and other resources if helpful.
Specific Quality Indicator Guide – Prevalence of Pain

Introduction

Pain or comfort is a subjective symptom based on the resident’s sensory and emotional experience. The definition of pain is generally accepted to be whatever the resident indicates it is. The caregiver must believe the resident, and both the caregiver and the resident must trust in each other to relieve pain. This guide will use both pain and comfort as interchangeable terms.

Care should be provided which includes identification and assessment of resident comfort or level of pain. Pain is also a multidimensional experience that can be assessed even in cognitively impaired residents.

Pain assessment and management principles include the following:

- Pain is viewed as a multidimensional experience that has many components in addition to nociception (pain impulse to the brain). These include sensory, emotional, cognitive, developmental, behavioral, and cultural components, all of which may influence pain perception and response.
- Pain must be regularly and appropriately assessed in systematic ways, and the assessment is a necessary part of comfort management. Pain is to be thought of as the fifth vital sign and assessed accordingly.
- Pain assessment and management, integral aspects of nursing care, must involve the resident and/or representative and be ongoing.
- Pain assessment and management must be recorded in a readily accessible and visible manner.
- Pain assessment serves as a guide to intervention, not as an end in itself.

Quality of care depends on whether all issues relating to a determination the cause of pain and appropriate treatments to reduce or eliminate the cause of the pain have been addressed and complications prevented and/or treated. The second consideration is management of the pain itself as it occurs on a daily basis. The quality of the care would depend on whether attempts have been or are being made to identify the type and location of pain present, describe it and provide an intervention to reduce and control it; to assess the adequacy of the intervention; to regularly review the pain experience and response and modify the program as needed; and to identify and treat any side effects of treatment and/or complications.

This guide will help the investigator determine whether there is a quality of care problem associated with a flagged QI by looking closely at the care process. The following sections restate the standard for each step in the care planning process and contain case examples taken from actual nursing facility experience. Some of the examples demonstrate the positive application of a process of care. Others describe a process of care that is ineffective or contrary to the intended purpose. They are intended to assist the facility in recognizing patterns that may be contributing to less than desired care. The positive examples are provided as suggestions.
Investigation of a Resident Level Quality of Care/Quality of Life Problem

1. Assessment – Accuracy

Standard: The Minimum Data Set accurately reflects the status of the resident during the assessment period. It is important to understand and remember that the MDS/QI information must be accurate. Inaccurate assessment information will produce inaccurate QIs and reports. Most importantly, inaccurate assessments will produce erroneous perceptions of resident status that can have serious consequences for care.

1.1 MDS Date

The date of the MDS under review matches the date of the MDS on the Resident Report.

1.2 QI Definition

For each resident in your sample, the MDS should contain all of the items necessary to match the QI definition.

Variable Definition for Prevalence of Pain

| Numerator: Residents who had moderate or excruciating pain less than daily or mild, moderate or excruciating pain daily on most recent assessment. | Denominator: All residents on most recent assessment. | Most Recent MDS Assessment: J2a (frequency of pain) = 1 AND J2b (intensity of pain) = 2 or 3 OR J2a (frequency of pain) = 2 AND J2b = 1, 2, or 3 |

1.3 Corroborating Evidence

There is evidence other than the MDS that the resident experienced pain within the 30 days prior to the most recent assessment.

Examples:

- Mr. W’s pain assessment revealed that he experienced moderate breakthrough pain 4 times the week following an increase in his analgesics by the physician.
- Nursing notes in Mrs. A’s chart reflect that she complained of hip and knee pain daily in the evening after her physical therapy session. When questioned about its intensity, she stated that it “hurt really bad” and kept her from enjoying her evening meal.

There is an inaccuracy in the assessment MDS information if the answers to questions 1-3 above indicate that:

- The dates do not match, or
• The MDS information does not match the QI definition, or
• The resident record does not contain clinical information supporting the conclusion that the resident experienced pain that meets the MDS criteria.

Key Question #1: Is the MDS/QI information accurate? If not, is the inaccuracy of a nature or a degree that it affects the quality of care for THIS resident?

<table>
<thead>
<tr>
<th>Examples of inaccuracies that DO NOT affect quality of care:</th>
<th>Examples of inaccuracies that DO affect quality of care:</th>
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<tr>
<td>• The assessor inadvertently checked that Mr. G had pain less than daily (J2a=1), when records show that he was having daily pain. Based on a pain assessment, the interdisciplinary team had previously developed an appropriate care plan for him and pain was controlled.</td>
<td>• Mr. G’s MDS was coded with less than daily pain (J1a=1). Additional evidence supporting the presence of daily pain for Mr. G was inconclusive. Upon interview, the resident stated that the staff didn’t believe him when he told them he had pain; some told him he was just seeking attention. Mr. G stated he had been asking for PRN pain medications more lately. According to the medical record, he had not received medication more often lately. No additional pain assessment had been done. There was little written documentation about his requests for pain medication and the notes didn’t describe the pain type, frequency or duration of effect of the medication.</td>
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<tr>
<td>• Mr. J’s MDS indicated that he was experiencing daily moderate pain (J2a=2 and J2b=2). However, no supportive evidence of Mr. J being in pain could be found following two interviews with him and direct care staff or a review of the record. Further investigation found that the assessor had confused two Mr. J’s living on the same unit and coded both assessments the same.</td>
<td>• (False negative) The resident was selected because he appeared to be in pain. The MDS didn’t indicate that he was experiencing pain. According to the record, in the past month, the resident had become increasingly agitated, anxious and refused to come out of his room. He was placed on psychotropic medications for behavioral symptoms, fell and sustained a broken hip.</td>
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An assessment of the resident’s clinical condition must be performed in order for the team to make appropriate clinical decisions about the condition(s) present and the need for intervention.

2. Assessment – Clinical Status

Standard: The interdisciplinary team has gathered and taken stock of all observations, information and knowledge about this resident’s symptoms or condition, the need for further testing or examination, and its impact on quality of life, quality of care, and functional ability. The team understands the resident’s limitations, strength and status.

The following probes will serve to guide the investigation of a potential quality of care or a quality of life problem related to pain or comfort for this resident.
2.1 Protocols and Tools

2.1.1 Has the problem of pain triggered further assessment, even though there is not a Resident Assessment Protocol developed for this concern (i.e., urinary incontinence, bedfast, falls, behavior symptoms)?

2.1.2 Has the location of the pain assessment documentation been identified on or next to the RAP Summary Sheet?

2.1.3 Is there documentation that explains how pain is related to other RAPs that are pertinent to the resident’s functioning at the highest practical level?

(Related RAPs: Delirium, Cognitive Loss, Visual Function, Communication, ADL Functional/Rehabilitation Potential, Bowel/Bladder Incontinence, Bedfast, Psychosocial Well-Being, Mood State, Behavior Symptoms, Activities, Falls, Nutritional Status, Dehydration/Fluid Maintenance, Dental Care, Pressure Ulcers, Psychotropic Use, and Physical Restraints.)

Pertinent information related to the resident’s pain, comfort, or use of a pain medication, might include information about the following:

- Description of the pain – location, intensity frequency, aggravating and relieving factors (see Appendices C, D and I)
- Description of behavioral changes that may be related to pain in the person with cognitive impairment (See Appendix E)
- Description of pain interventions and effectiveness (See Appendices D, E, F, G, and H)
- Assessment for potential side effects when there is a change in cognition, urinary incontinence, appetite, gait, falls, verbal/physical aggression (See related RAPs, QIs, and Appendix I)

2.1.4 There is no RAI for pain. Has the MDS item that triggered this QI resulted in further assessment to determine the site/location, severity, intensity, frequency, description and cause of pain? Is this assessment documented in the record? If there is more than one cause or source of pain, has each cause been assessed and addressed?

For example, the nurses’ notes document a thorough assessment of Mr. M’s right leg phantom pain as occurring every evening after dinner. The pain is sharp and shooting with no relief unless the resident received acetaminophen 500 mg and the right leg stump is raised on a pillow.

2.1.5 Have other relevant assessment protocols/tools been used as necessary? Does the facility use a pain protocol that includes a measurable assessment tool? Is the tool useful for both cognitively intact and impaired residents? (See Appendices C, D, E and I.)

For example, the visual analog scale is used to assess Mr. M’s pain before and after the pain medications. The results are documented in his record.
2.2 Primary Assessor

Is the interdisciplinary team member who did the initial gathering of assessment information knowledgeable about the resident and about the condition represented by the QI? Is this person the most knowledgeable about the resident’s pain or comfort?

For example, Mrs. B had leg cramps between 1-3 a.m. every night. The night shift gave her a massage and exercise that relieved the pain. The nurse completing the MDS did not gather information from the night shift, so the assessment was incorrectly coded for the frequency of pain.

2.3 Interdisciplinary Team

Was the assessment information gathered by the initial assessor integrated with the ideas of team members of the various disciplines?

Each discipline represented on the interdisciplinary team may consider the causes and consequences of the resident’s pain from a different viewpoint. It is very important that every opinion, including that of the direct care staff on every shift, is considered and valued.

Examples include:

- The family and social worker feel that the risks of side effects from Mrs. F’s pain medication outweigh the psychological trauma of her limited mobility due to pain.
- The physical therapist thinks that Mr. T’s ability to stand, transfer, and walk safely can be improved with administration of the pain medication 1 hour before treatment.
- The nursing staff is concerned about the safety of the nurse aides who care for Mr. D after he began to strike out at them because of pain when he moved.
- The physician plans to speak with Mr. A and his family about the benefits of non-pharmacologic interventions for the pain.
- The dietitian notices that Mrs. L is not eating because of increasing pain.
- The activities department can no longer get Mrs. C to attend activities outside of her room because of her anxiety that that she will “begin to hurt.”
- Mr. K has not been eating well. The morning nurse aide tells the charge nurse that he will eat soft cereal like oatmeal/cream of wheat rather than cold cereal because of pain in his mouth.

Key Question #2: Is there a problem with obtaining assessment information from the individual and interdisciplinary team related to presence of pain for THIS resident?

3. Decision Making

Standard: The interdisciplinary team has used the assessment information to make sound decisions about the care for this resident’s needs related to pain. This would refer to the initial assessment
of new pain as well as the assessment of pain when it is occurring and requires intervention.

3.1 Pertinent Information and Probes

3.1.1 Is there a summary of the interdisciplinary team’s discussion or conclusions related to the resident’s level of comfort and treatment options for pain?

3.1.2 If the analysis/decision-making documentation is incomplete, interview interdisciplinary team members as necessary to supplement the record with evidence that a thorough assessment was completed.

3.2 Role of the Resident/Resident’s Representative

Interview the resident/resident’s representative to determine if his/her understanding of the interdisciplinary team’s assessment related to pain and comfort were accurate and that the resident’s choices concerning treatment preferences were identified and followed.

3.3 Documentation

Has the team decided to address the resident’s pain in the care plan, or has the team decided that the condition does not warrant a care plan intervention? Is the documented decision clear?

3.4 Process

Having retraced the steps of the decision made by the interdisciplinary team about the care needed for this resident to minimize the pain, can you conclude that it was the correct decision?

Key Question #3: Is there a problem with the synthesis of assessment information and care plan decision for THIS resident related to the presence of pain?

4. Care Planning

Standard: The resident’s history and continued risk of pain has been addressed in the resident’s care plan if the interdisciplinary team has concluded from the assessment information that interventions are necessary. (Note: This is dependent on the quality of the decision-making process.)

The care plan describes the following:
• The concerns or problems to be addressed by the plan,
• The anticipated outcome of the plan and the time frame for accomplishment,
• The related risk factors for any plan developed for the resident,
• A description of the types of care to be provided for the resident,
• Specific instructions for staff involved in ensuring that the resident care plan is accomplished.

4.1 Statement of Resident’s Problem

Is the resident’s problem with pain or comfort stated in behavioral or a functional term, describing specifically what the problem or limitation is for the individual resident?
Examples:

- Mr. W has had three episodes of GI pain after taking an as-needed aspirin in the last month.
- Mrs. L gets severe pain in her legs during PT; she will not attend PT if her pain medication is not given an hour before her therapy session.
- Mr. B gets severe pain in his hips when he walks without his cane or walker. If he goes to the dining room without his cane/walker, he has so much pain in his legs and lower back that he does not eat. He refuses to ambulate without his cane/walker. If staff tries to make him use the cane or walker, he becomes very irritable and difficult to provide care for.
- Mrs. M will strike out at staff during the dressing change of the pressure sore on her right heel.

4.2 Goals

Are the goals measurable? Is there an established baseline for comparison?

4.3 Time frame

Has a reasonable time frame been established for the accomplishment of the goal, or the review of the goal if it has not been achieved?

Examples:

- **Goal**: Mrs. L will participate in all scheduled PT sessions with a pain level of 3 or less on a scale of 0-10.
  - **Baseline**: Mrs. L has not consistently participated in PT sessions due to pain experienced at these sessions rated as 6-7 by the resident. Mrs. L has missed 1-2 sessions a week.
  - **Time frame**: PT to review in two weeks to see if the interventions of giving the pain medication 1 hour before the sessions is working and Mrs. L is comfortable and participating in the sessions.

- **Goal**: Mr. B’s pain levels will not exceed a level of more than 2 (on a scale of 0-10) when going to the bathroom or dining room with his cane/walker. Mr. B is to use cane/walker at all times for ambulation of more than 10 feet.
  - **Baseline**: Mr. B has attempted to go to the bathroom or dining room at least three times this week without his cane/walker, resulting in a pain level of 5-6 in his legs and lower back. When the pain levels are this high, he does not want to leave his room nor does he feel like eating his meals—he says he does not want to “push his luck.”
  - **Time frame**: Team to review nursing data, dietary review and weight weekly for the first month to see if he is using the ambulation aids, his pain is reduced or he is able to eat and take fluids better. If it is working, review the data monthly to be sure he maintains comfort level and eating/taking fluids, etc.
4.4 Interventions

Can interventions related to a history or risk of pain, the presence of pain, or its treatment be found in the care plan? If there is more than one source of pain, is each type of pain addressed separately?

4.5 Care Plan

4.5.1 Are the approaches listed for the accomplishment of the goal specific to the individual resident and relevant to the identified need and goal? Is reviewing the pain data and modifying the plan specifically addressed in the care plan?

Examples of the history of pain and interventions which might be found in the care plan:

Interventions (both drug and non-drug), that have been unsuccessful in the past and should be avoided in the future:
- Aspirin does not help the pain and causes GI distress in Mr. W.
- Application of heat to the area did not help Ms. B, it made it hurt worse.
- Walking without a cane or walker always makes the pain worse for Mrs. B

Intervention that has been successful and should be continued:
- Ms. L gets 500mg of Acetaminophen 1 hour before PT session and it relieves her pain and lets her participate in the session.

Examples for cases described above:

Mrs. L:
- Pain medication to be given one hour before the scheduled PT session.
- PT to record the results of the pain scale before and after each session.
- Mrs. L has agreed to the pain scales that will be administered by PT.
- PT to review data on pain and sessions with charge nurse in 2 weeks.

Mr. B:
- Nurse aide worksheets to indicate that Mr. B likes his walker/cane to be kept on the left side of his bed so he can access them easily. Nurse aide to record use of cane/walker on worksheet.
- Dietary to review eating in the dining room weekly to see if his intake changes. On days he does not eat, determine if he used cane/walker to get to the dining room.
- Team to review results in 2 weeks.

4.5.2 Do the conclusions of the assessment process match the care plan or does it appear that the care plan was written independently of the assessments?

For example, the physical therapy notes state Mr. B is able to ambulate and transfer safely with the use of a walker but has frequent falls with the cane. The care plan refers only to the use of a cane for Mr. B to ambulate.
4.5.3 Do interdisciplinary progress notes and incidental notes differ from the care plan and assessment summaries indicating that the care plan has not been kept up-to-date?

**For example**, a physician ordered an analgesic that was only used PRN. The pain had become more frequent and therefore the physician ordered the analgesic to be administered every 6 hours around the clock. The care plan review states that the resident continues to receive adequate pain control from the use of PRN medication and that he is comfortable and sleeps through the night without any pain medication.

4.6 Staff Expertise

Were the interdisciplinary team members most knowledgeable about the resident’s history and comfort level involved in the development of the care plan? Did all shifts contribute to the plan’s development?

4.7 Standards of Professional Practice

Does the care plan reflect current standards of professional practice? Are up-to-date treatment modalities utilized? Does staff receive training on management of pain on a regular basis?

**For example**, a newly hired nurses aide expressed frustration with an agitated resident complaining of pain. An interview with this aide revealed that she did not understand the dynamics of the type of pain the resident was experiencing. The aide thought this was an attention getting behavior and not pain. Following an in-service about pain management, the aide was more responsive and alert to the resident’s needs for pain relief. She was able to notify the nurse when the resident behaved like this and get PRN pain medication. She was also able to give valuable input when the team reassessed the resident’s behavior and level of pain.

4.8 Role of the Resident/Resident’s Representative

Has the resident/resident’s representative been given adequate information so that he/she was able to make an informed choice regarding treatment?

**For example**, does the resident/resident’s representative understand the risks and benefits of using alternative treatments verses routine use of pain medications when the resident has a history of frequent pain? Does the resident or resident’s representative understand that common side effects of the use of narcotics are constipation, nausea and sedation, and that these may require the use of other medication to control the side effects? Does the resident or his/her representative understand the risk of not adequately controlling the pain?
4.9 Alternative Interventions

If the resident/resident’s representative has refused treatment, do the comprehensive assessment and the care plan reflect all efforts to find alternative means to address the problem?

**For example,** Mrs. K has refused to take a narcotic medication on a scheduled basis because she became constipated and did not like the taste of the laxative offered. Dietary staff has arranged for her to receive fruit juices and fruits with a laxative effect, but Mrs. K refused to eat them. The staff has increased her fluid intake and attempted to exercise her more often in an attempt to reduce the constipation. Staff will discuss the use of acupressure or acupuncture with her and the physician.

Key Question #4: Is there a problem with the development of a care plan for this resident related to the control of pain?

5. Implementation

Standard: Staff is knowledgeable about the care plan and is providing the care and services designed to provide the resident maximum comfort and functioning.

5.1 Delegation of Responsibility

Are the interventions clearly delegated? Is it clear who is responsible for completing the various approaches, and what is the time frame for completion? Is periodically reviewing the pain assessment tool clearly delegated? Is the plan accessible to all staff who works with the resident?

5.2 Communication

5.2.1 Do all staff members understand who is responsible for each task and its schedule? Can staff access and understand the approaches and goals for which they are responsible?

**For example,** are the staff nurses are responsible for administration of pain medications and the assessment of the results of the drug therapy? The nurse aides, activity, PT and housekeeping staff is responsible for monitoring for signs of pain and reporting to a nurse.

5.2.2 Is there adequate communication among appropriate interdisciplinary team members and direct care staff to make sure the approaches are carried out? Is staff aware of the established goal(s)?
For example, do the nurses aides and PT aides know it takes about one hour for the pain medication to take effect? Do they report the resident’s level of comfort an hour after taking pain medication? This is critical in controlling comfort and the success of the treatment for a resident with pain going to PT. Are PT staff and nurses aides familiar with the pain scale being used for assessing pain for the resident?

5.2.3 Were the nurse aides, PT staff, and others included in the development of the care plan? Was staff given adequate information about the care plan? If pool help is used frequently or if there is a high turnover of staff in the facility, how is this staff informed about the approaches and goals in the care plan?

5.3 Staff Preparation

Did the staff receive adequate training regarding identification and control of pain?

For example, did the physical therapist train the aide staff to help the resident use a walker to prevent painful ambulation?

Before the training sessions on pain management, nurses were not asking for detail about the pain, such as location, type and severity of pain. The records had the same entry: “resident complains of pain. Pain medication given.” After the training, a review of the records shows that the nurses report:

- Resident has a dull aching pain in left chest, nonradiating, associated with shortness of breath, giving nitroglycerin with relief of pain in 5 minutes.
- Resident has aching pain in left hip, 5 on a scale of 10, with radiation into buttocks and thigh. Given ibuprofen. Relief of pain 1 hour after administration.

5.4 Resources

Were adequate equipment and resources available to provide the care needed?

5.5 Allotted Time

Was direct care staff rushed? Did they have to prioritize care?

For example, the nurse aide asked Mr. B to walk to the dining room alone using the handrail because his walker could not be located and, other residents needed more assistance than he did. As a result, Mr. B’s hip pain became so severe that he was unable to leave his room for several days.

5.6 Compliance with Care Plan

5.6.1 Is there documentation of implementation efforts? Did the daily worksheets of direct care staff match the care plan? Are pain assessments documented on a timely basis?
5.6.2 Was the team able to implement approaches in the care plan that they considered to be the ideal care and treatment for the resident’s comfort?

For example, Mrs. R’s pain has been extremely difficult to manage. The team has found a combination of pain medications and massage techniques that offers a significant degree of relief. However, the pain medication does cause Mrs. R to be constipated, often to the point of manual removal of stool. Mrs. R has stated that she would rather have some pain than be constipated.

5.6.3 Does staff have reasonable explanations why care may not have been provided or provided differently than described in the care plan?

For example, Mr. J’s care plan indicated that for discomfort at night, he should be given a PRN analgesic. The nurse noticed a reduction in the use of the medication. Investigation of this change identified that the PM nurses aides found that a short walk followed by a 2-minute conversation with a neck and shoulder rub worked just as well if not better than the PRN analgesic.

5.6.4 Was staff neglectful of their duties? Did they miss interventions even when not rushed?

For example, a nurse aide for Mrs. V answered her call requesting a pain medication. The aide could not locate the nurse and went on a scheduled lunch break. This resulted in Mrs. V experiencing severe pain for several hours.

5.6.5 Were goals and approaches unrealistic and therefore impossible to carry out?

5.6.6 Did the resident/resident’s representative refuse to participate in the delivery of care?

Examples of unrealistic goals:

- Mrs. R will be free from all rheumatoid arthritic pain and will have no drug side effects. (Realistic goal: Resident will score 2-3 on the pain scale and maximize her function and ability to do the things she would like to do [attend activities twice a week, perform some crafts in her room].)
- Mr. S will feel no phantom pain following the BKA of his left leg. (Realistic goal: Resident will not miss his planned activities more than once a week because of phantom pain. When it is present, his pain will be at a level of 2-3 on a scale of 10. The resident will have activities he can pursue to distract himself; he will participate in counseling to address his sense of loss.)
Key Question #5: Is there a problem with the provision of care related to control of pain or comfort as described in the care plan for this resident?

6. Monitoring and Evaluation

Standard: Staff has responded to changes in this resident’s condition related to pain or comfort. The effects of the care plan goals, interventions, and implementation have been reviewed and modified as necessary to promote the best outcome for the resident based on an accurate and current pain assessment. The following probes will guide the investigation of the quality of the monitoring and evaluation of the care plan related to pain or comfort.

6.1 Monitoring Techniques

Has an objective means of monitoring the resident’s condition been established in order to determine progress or a lack of progress within the given timetables?

For example, for each resident, the level of pain and functioning is recorded on a flow sheet each time staff provides care or the resident talks about or has nonverbal communication about pain. This information was reported to the charge nurse at each shift change.

6.2 Communication

6.2.1 Do members of direct care staff (i.e., nurse aides, LPNs, RNs, others with daily contact with the resident) communicate adequately with the interdisciplinary team when they observe changes in the resident or when interventions are not working or cannot be carried out?

6.2.2 Are pool staff and new staff informed and educated about the interventions in the care plan for maximizing the resident’s level of comfort and functioning?

6.3 Review and Modification of Care Plan

6.3.1 Has the care plan been reviewed at least quarterly or whenever needed?

6.3.2 Were the goals related to the comfort and functioning of the resident reviewed and modified as necessary within the timetable originally established?

For example, the review of the pain assessment data at two weeks showed that the resident was receiving the Morphine SR on a scheduled basis but was having pain of 5-6 level after four hours and was asking for morphine for break-through pain. The dose of Morphine sustain release was reassessed and increased.

6.3.3 Have the goals and timetables been carried forward to the next quarter even though the resident’s condition is not responding to the interventions?
For example, the care plan indicated that the resident’s pain was controlled by the use of scheduled pain medication. The notes indicate that Mr. G refused to take the prescribed medication for pain because it caused nausea and sedation. He has missed five PT sessions and his functioning is declining. No change in medication or other interventions were offered as alternatives.

6.3.4 If the resident has improved significantly, have the care plan goals and interventions been changed to accomplish even more improvement or to maintain stability at the current level?

6.4 Care Plan Change

When changes are made to the care plan, is staff who carry out the interventions informed promptly?

6.5 Change of Condition

Was a comprehensive assessment completed if a significant change in condition occurred?

For example, Mrs. N has a history of severe arthritis. She had become unsteady when she stands up. She had refused to ambulate, to attend activities or therapies. Her appetite has decreased resulting in a significant weight loss. The physician was notified of the change. An assessment was performed.

6.6 Notification to Physician

Is the physician informed promptly when the resident’s condition changes or when treatment methods are not working as expected?

For example, Mr. G’s Physical Therapy session is scheduled at 3:00 pm. His NSAID is given on an empty stomach and Mr. G complains of being “sick at my stomach.” He has refused to go to his therapy sessions because he is nauseated and afraid he will “throw up.” The physician was informed and an assessment done regarding the symptoms and potential GI side effects of the analgesic. Another analgesic was ordered.

Key Question #6: Is there a problem with the monitoring and evaluation of the outcomes of the care and services provided for this resident related to pain/comfort?

7. Conclusions

Standard: The resident’s pain and comfort were correctly assessed, reasonable interventions were planned, the plan was implemented, and the effectiveness evaluated.

7.1 Problem Identification

As a result of your investigation of pain for THIS resident, were problems identified?
7.2 Step in the Care Process

If the standard was not met, where in the process of care was there a problem?

- Assessment – Accuracy
- Assessment – Clinical Status
- Decision Making
- Care Planning
- Implementation
- Monitoring and Evaluation

7.3 Causes and Factors

Did poor pain control lead to or cause the resident to lose functioning or quality of life? Did poor care exacerbate the problem or fail to improve the condition? Did inadequate staffing contribute to the inadequate management of this resident's pain?

7.4 Magnitude

Were the quality problems described for this resident related to pain of sufficient magnitude to conclude that there was a quality of care problem for the facility?

<table>
<thead>
<tr>
<th>Examples of problems that WERE NOT serious enough to be considered a facility problem:</th>
<th>Examples of problems that WERE serious enough to be considered a facility problem:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A nurse aide misunderstood the directions for ambulation aids for the resident. The nurse aide left a cane at the bedside and the walker near the bathroom. The resident used the cane to get to the walker and did not experience any pain when going to the bathroom. The nurse was informed and educated the nurse aide on the proper placement of the ambulation aids.</td>
<td>The resident needed a walker to ambulate to the bathroom without pain and did not have a walker near the bed. As a result, she had several episodes of incontinence because of not wanting to be in pain. This situation further led to the development of a stage one pressure sore.</td>
</tr>
<tr>
<td>A resident did not get their pain medication before PT. When PT found out about the medication not being administered, they rescheduled the therapy for 1 hour later to allow the pain medication to be give and take effect. PT talked to nursing who ensured that the medication was given 1 hour before therapies were scheduled.</td>
<td>The resident was scheduled to get a pain medication before PT and did not get the medication on several occasions. This resulted in the resident not participating in the therapy sessions and led to the loss of ROM.</td>
</tr>
<tr>
<td>The resident care plan indicated that a pain assessment was to be completed and documented each shift. While the pain assessment was completed each shift, it was not always documented. The resident did not experience pain during this time since the routinely scheduled medication was meeting the goal.</td>
<td>One resident attempted suicide because of the pain.</td>
</tr>
</tbody>
</table>
7.5 Related QIs and Clinical Links

As a result of the investigation of pain and this resident, did you identify other quality problems for either this or other residents? Were the problems related to other QIs that were flagged on the Facility Level Report? Were the other problems clinically linked to pain? (See Clinical Links Table in Appendix K.)

Examples:

- Verbally and/or physically abusive behaviors
- Development of pressure sores, or contractures
- Loss of ADL functioning
- Decreased participation in activities
- Urinary or fecal incontinence
- Development of a fecal impaction

7.6 Recommendations and Follow-up

- List recommendations for a plan of improvement, the need for referrals, or the need for further investigation related to the unwanted pain of this resident.
- List any other problems found as a result of the investigation of pain. Refer to the sampled resident identifiers for the specific details of the problem.
- List recommendations for further investigation, a plan of improvement, or referrals, etc., concerning additional problems for this resident.
Investigation of a Facility Level Quality of Care/Quality of Life Problem

Standard: Even though there may have been problems with the care of individual residents related to pain or comfort, there was not a consistent problem across the sample, nor were any of the quality problems serious enough that there was a potential for more than minimal harm or that actual harm occurred.

Key Question #1: Was there a pattern of inaccuracy with this quality indicator?

Key Question #2: Considering the entire sample, do you believe that there is a facility-wide problem with pain or comfort?

Examples of quality problems with the Prevalence of Pain based on the entire sample:

- In 5 of 5 residents with dementia, all agitation is treated with antipsychotic medication and acetaminophen. No attempt was made by staff to determine if pain is present or the location.
- In 6 of 10 cases, the care plan was not revised to maximize the resident’s comfort even though the residents had experienced pain more than once and the assessment for each showed patterns of causal relationships.

Examples of the care plan not being modified based on new information about the resident:

- Aides noted that 2 residents had less pain if they used a walker instead of a cane;
- 1 resident with arthritis in hands could no longer tie shoes, therefore OT had recommended that they change to use Velcro not lace shoes; and
- 3 residents wanted to participate in activities regularly but had pain on movement and activities had requested that the staff give an analgesic before scheduled activities.
- In 4 of 6 residents on long-acting opioids, PRN medication was not given for breakthrough pain.
- In 3 of 5 residents, pain medications were not administered on a routine basis prior to PT session; it became apparent that pain was decreasing their functioning and participation in the therapies program.

Key Question #3: Can the problem(s) related to pain be isolated to a specific area of the care process?

- Assessment – 5 residents who were to have pain assessments completed and documented each shift did not have this occur consistently on the night shift. This resulted in problems with sleep during the night, pain during morning care and loss of functioning by the residents.
- Care Planning – In 5 of the 6 residents with cancer, the physicians were reluctant to increase the dose or frequency of the narcotic medication because they were afraid of “addiction” or other problems. The Medical Director was not consulted to work with the physicians on their concerns.
Specific Quality Indicator Guide – Prevalence of Pain

- Implementation – In 3 of 4 cases, the staff did not identify the source of pain and its nature when it occurred and use the pain medication appropriate for the type of pain, e.g., nitroglycerin for chest pain, NSAID for arthritis pain.
- Monitoring/Evaluation – In 4 of 5 cases, new pain was not assessed at the time of occurrence, was not reported to the physician and was treated with existing analgesics.

Recommendations and Follow-up

- List recommendations for a plan of improvement, the need for referrals, the need for further investigation, etc., related to pain or comfort.
- List any other problems found as a result of the investigation of pain.
- List recommendations for further investigation, a plan of improvement, or referrals, etc., concerning these additional problems.
Appendices

Appendix A: Risks Associated with Inadequate Pain Control

The complications of inadequate pain control are very serious and can have permanent effects on the resident. Each of these potential complications need to be assessed on a regular basis and should be integrated into the resident’s care plan.

General Risks
- Decreased appetite, food and fluid intake—nutritional decline and dehydration
- Increased irritability, increased difficulty in providing care, increased aggressive behavior toward staff and other residents
- Decrease in mobility; impaired ambulation, gait disturbances, slowed rehabilitation
- Decrease participation in activities/social isolation
- Decrease self-esteem (isolation)
- Sleep disturbance
- Deconditioning

Physical and Functional Risks/Complications of Immobility
- Circulatory stasis—thrombosis and embolism, dilation of blood vessels in the abdomen, postural hypotension
- Impaired digestion—constipation, flatulence
- Loss of independence in ADLs
- Lymphatic disturbances—edema due to accumulation of fluid in the tissues
- Musculoskeletal damage—muscle weakness, joint stiffness, contractures, foot drop
- Loss of bone and muscle atrophy—increase catabolic activity is accelerated—leads to protein deficiency and negative nitrogen balance, also decalcification and demineralization of the bone, i.e., increase calcium level in the blood (renal calculi) and a loss from the bone (pathological fractures)
- Pain/discomfort—increased or new areas because of immobility, contractures forming, etc.
- Respiratory insufficiency, infections, hypostatic pneumonia
- Tissue breakdown—pressure ulcers, fungal rashes
- Urinary incontinence and urinary tract infections

Risks of Social Isolation
- Cognitive Loss
- Decline in Mood State
- Increase in Behavior Symptoms
Appendix B: Initial Pain Assessment

An initial assessment should occur with each new pain that is reported. The focus of the assessment is the identification of the cause of the pain and developing a pain management plan. This is different than the subsequent assessments that take place once a pain has been identified and assessed.

The initial evaluation of pain should include:
- Detailed history, including assessment of pain intensity and character
- Physical examination, emphasizing the neurological examination
- Psycho-social assessment

Attention to detail is important. A misdiagnosis can lead to needless pain and suffering and/or increased morbidity.

History

A pain assessment should include a detailed description of the pain. If more than one type of pain is present, a different assessment should be performed for each type of pain present. When the resident is cognitively alert, the following questions can be used.

Basic Assessment of Pain Intensity and Character

- **Pattern of pain**
  - When did it start?
  - How often does it occur?
  - Has the intensity or frequency changed?
  - What is the best/worst it gets?

- **Location of pain**
  - Where is the pain located?
  - Is there more than one location?

- **Description of pain** (will give clues as to the probable cause and potential treatments for pain)
  - How would you describe the pain (burning, hot, dull, sharp, steady, intermittent, infrequent, stays in one place, moves around)?

- **What improves or aggravates the pain or the conditions that cause pain**
  - What makes it better?
  - What makes it worse?
  - Is this true for all sites of the pain?

- **Treatment(s) rendered**
  - What has been tried that alleviates the pain?
  - How long does it take to get relief?
  - How long does the relief last?
  - What has been tried that has not been effective?
  - What has been tried that made the pain worse?
Specific Quality Indicator Guide – Prevalence of Pain

- **Effect pain has on daily routine/quality of life**
  - How does the pain affect residents’ ability to function - perform activities of daily living, level of independence, ability to participate in the resident’s choice of activities?
  - How does it affect the quality of the resident’s life?
  - How does the resident express pain to staff? To family?
  - (Family interview should also be done.)

The remainder of the history should address the organ system(s) with which the pain is associated to determine potential causes of the pain.

**Psychosocial Assessment**

- Knowledge of and understanding of the diagnosis causing the pain
- The meaning of the pain to the resident and family
- Significant past instances of pain and their effect on the resident
- The resident’s usual coping responses to stress or pain
- The resident’s knowledge of, curiosity about, preferences for, and expectations about pain management methods
- The resident’s concerns about using controlled substances, opioids, anxiolytics, or stimulants (as appropriate for type and severity of pain)
- Changes in mood that have occurred as a result of the pain (e.g., depression, anxiety, irritability/aggression)

**Physical and Neurological Assessment**

- Examine the site of pain and evaluate common referral patterns
- Perform a pertinent neurologic examination
  - Head and neck pain - cranial nerve and fundoscopic evaluation
  - Back and neck pain - motor and sensory function in limbs; rectal and urinary sphincter function

**Diagnostic evaluation**

Should be performed based on the results of the history and physical to determine the cause of the pain.
Appendix C: Ongoing Assessment of Pain

Pain should be assessed and documented:

- At regular intervals after starting the pain management plan (each time a pain medication or intervention is administered).
- With each new report of pain
- At a suitable interval after each pharmacologic or nonpharmacologic intervention, such as 1 hour after oral administration.
- When using the happy/sad face pain scale, have pain indicators under the faces i.e. sharp pain, dull pain, steady pain, etc., so that the resident knows you are asking about pain and not depression.

It is important to ask the resident about the pain and not rely on behavior and/or vital signs. Discrepancies between verbal reports and behavior should be noted.

- The resident may report pain at a level of 2 while tachycardia, splinting, and sweating are present or the resident may appear to be in no pain, smiling and engaging in activity.
  - The resident may believe that the presence of pain represents progression of the underlying condition or have negative consequences associated with it, e.g., the need for surgery or pending death.
  - The resident may not traditionally voluntarily talk about or behave as if pain is present, either because of cultural traditions, gender, and/or general philosophy of life.
  - The resident may be engaging in distraction tactics to decrease the attention and focus on the pain. This may be done as a natural coping strategy or one that has been taught as part of the pain management interventions.
- The resident may report very high levels of pain all the time, no matter what intervention and behavior is; the resident may believe that medication will only be given if a high level of pain is reported.
- Do not just write down the pain scale number but look at this number and determine if the intervention is achieving the goal set in the plan of care.

Residents should be taught to report changes in pain or new onset of pain so that an appropriate reassessment can be performed and changes in the treatment plan initiated, if appropriate.
Appendix D: Pain Assessment when Cognitive Impairment Is Present

Although pain assessment is more of a challenge when the resident is not cognitively alert and capable of verbally describing pain, it is still possible to collect information from the resident. Information will be from different sources and not contain the same wealth of information.

**Verbal Cues**

If mild cognitive impairment is present, the response to questions may be unreliable over time. A question about the presence of pain at this very moment may be reliable. Questions about pain in the past or comparison of pain now to past experiences may be unreliable because of the lack of memory, or misleading if the resident makes up information because the resident is aware of the memory loss and is trying to cover it up.

When moderate/severe cognitive impairment is present, the resident is not usually able to connect the physical experience with language. The resident may not even be able to understand internally what is happening, pain may be present as well as fear because the pain cannot be understood or gotten rid of. It may still be possible to obtain information if the resident is verbal at all. The nature of the words may provide a clue to whether pain is present; the phrases used may describe something that would be unpleasant. For example, a hands on examination may result in no verbal response or the resident continues a flow of nonsensical language that is not threatening or negative in nature until an area of pain is located. Touching the abdomen lightly may start the resident talking about “trains running through.”

**Observation**

Staff will need to rely on the power of observation and actively seek observations from all those who may have information to offer.
- Direct care staff need to be interviewed on all shifts
- Other staff who work around or with the resident should be interviewed.
- Resident’s representatives need to be interviewed

Staff may observe:
- Signs of illness, e.g, cough, sneezing, difficulty breathing, splinting, limping, rubbing an elbow or knee, change in usual habits, such as: no longer drinks the coffee, doesn’t want the favorite foods anymore; going to the bathroom more often or not going at all or in small amounts
- Signs of a problem present such as dark or red urine, foul smell to urine, urine on the floor, stool smeared in the bathroom, stool on the fingers, green mucus on the bedding or in the sink.

**Physical Assessment**

This would start with a review of signs, symptoms gathered from all sources and a review of the resident’s medical history for potential causes for the pain: past fractures, arthritis, cancer or other painful diseases, headaches, depression, etc.; review the record of bowel movements.

It may not be possible to perform a traditional physical assessment. An abbreviated exam can be performed, focusing on the major parts of the body that may cause pain.

A hands-on, simple examination is recommended:
- With the resident in a private area, sitting up or lying down if possible.
- The nurse should lightly touch the different body parts and ask the resident “Does this hurt?”
• Touch the parts of the body as you perform a simple review of systems to locate the source of pain, such as the head, face, ears, neck, each arm, chest, back, abdomen, legs, feet.
• Watch for facial expression, movement away from your hand, attempts to make you move your hand from the area, or changes in the conversation or words used. They may not use words about pain but may describe a sensation that would be painful, e.g., “like a railroad train running through.”

Look for:
• Sensory organs for signs of infection or swelling, tenderness to touch
• Skin for cuts, bruises, rash, pressure ulcers
• Lung sounds for possible infections, wheezing
• Abdomen – epigastric area for possible gastritis, general area for bowels- possible obstruction, constipation
• Suprapubic area – for tenderness, fullness
• ROM for pain on movement

If the behavior change is new and the assessment is not productive, increase observations during the shift and obtain vital signs. Either the behavior will resolve or more specific information will develop.

If there are no local signs of infection or injury, vital signs have not changed and are not abnormal, review the known medical conditions.
• If cardiac disease is present, consider a trial of one dose of nitroglycerin and observe the resident to see if it seems to help. If it does, notify the physician.
• If cardiac disease is not present, and the behavior is nonspecific or local (such as a resident with a history of arthritis rubbing a knee and no signs of injury or infection are present), consider a one time dose of a mild analgesic to see if it resolves the behavior that has alerted the staff to a potential problem, such as agitation or rubbing a part, such as a knee or arm or chest.
• If the behavior change has been more cognitive, such as an increase in confusion or a decrease in alertness, if vital signs are abnormal or signs of infection or injury are evident, contact the physician regarding the need for further medical assessment or tests and for treatment options. It is important that all interventions and their results are documented.

Episode(s) which staff suspect are related to pain, especially uncontrolled pain or new pain, should be brought to the attention of the physician and the team for further assessment and discussion.

**Pain Assessment Tool for Cognitively Impaired Persons**
An assessment tool for the cognitively impaired would focus on observations of abnormal activity. It may be general changes or the resident may have specific reactions or responses to different types of pain. Each tool would need to be individualized based on the observations of the staff and their assessment of the findings.
<table>
<thead>
<tr>
<th>BREATHING</th>
<th>VOCALIZATION</th>
<th>MOOD/BEHAVIOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Noisy</td>
<td>Grunting</td>
<td>Irritable</td>
</tr>
<tr>
<td>Gasping</td>
<td>Moans/groans</td>
<td>Striking out</td>
</tr>
<tr>
<td>Loud</td>
<td>Crying</td>
<td>Biting</td>
</tr>
<tr>
<td>Very deep</td>
<td>Constant muttering</td>
<td>Hitting/kicking</td>
</tr>
<tr>
<td>Very shallow</td>
<td>Disturbing sounds</td>
<td>Scratching</td>
</tr>
<tr>
<td>Labored</td>
<td>Yelling/swearing</td>
<td>Squirming/constant motion</td>
</tr>
<tr>
<td>Slow</td>
<td>No sounds/speech</td>
<td>Pushing/shoving</td>
</tr>
<tr>
<td>Rapid</td>
<td></td>
<td>Other behaviors</td>
</tr>
<tr>
<td>Also note if holds breath or breathing stops; if so, for how long</td>
<td>For each observation, consider frequency, volume, pitch &amp; rate</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EYES</th>
<th>FACE</th>
<th>BODY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wide open</td>
<td>Wrinkled forehead</td>
<td>Tense/rigid</td>
</tr>
<tr>
<td>Narrowed/slits</td>
<td>Sad</td>
<td>Thrashing</td>
</tr>
<tr>
<td>Closed</td>
<td>Crying</td>
<td>Wringing hands</td>
</tr>
<tr>
<td>Glazed</td>
<td>Worried</td>
<td>Fidgeting</td>
</tr>
<tr>
<td>Tearing</td>
<td>Scared</td>
<td>Constant movement</td>
</tr>
<tr>
<td>Excessive blinking</td>
<td>Anxious</td>
<td>Rocking</td>
</tr>
<tr>
<td>Rapid eye movements</td>
<td>Hurt</td>
<td>Clenched fist</td>
</tr>
<tr>
<td>No focus or following</td>
<td>Clenched mouth</td>
<td>Reaching/grabbing out</td>
</tr>
<tr>
<td></td>
<td>Grinding teeth</td>
<td>Guarding body part</td>
</tr>
<tr>
<td></td>
<td>Looks worried, fearful</td>
<td>Clenched teeth</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Curled up</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Knees pulled up tightly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of movement</td>
</tr>
</tbody>
</table>
Appendix E: Non-Drug Pain Interventions

The general approach to pain, including pain due to cancer, is:

- Residents should remain active and to participate in self-care when possible.
- When long-term bedrest occurs, the resident should be repositioned on a scheduled basis and activity and passive range of motion provided.
- Psychosocial interventions should be introduced as early as possible into the treatment plan, at the level appropriate for the resident’s cognitive ability. This allows the resident time to learn and practice the skills while they have sufficient strength and energy.
- Education about the ability to control pain effectively and myths about pain and pain control should be addressed as part of the treatment plan.
- Psychosocial and physical interventions are to be used as supplements to the use of pain medication. They are not a substitute for management with pain medication.

Psychosocial Interventions

These interventions have been demonstrated in research studies to be effective in pain management.

Relaxation/Imagery

- The goals are to achieve mental relaxation, which alleviates anxiety, and physical relaxation, which reduces skeletal muscle tension.
- Examples of techniques: slow rhythmic breathing, remembering peaceful past experiences, meditation, progressive muscle relaxation, and music assisted relaxation. Guided imagery may be tailored to the individual and the specific body parts for relaxation or pain reduction.
- Once learned, they do not require staff time to perform. Staff may prompt the resident to try one of the things learned when pain occurs.
- They are useful with brief pain such as with procedures and when the resident is fatigued or stressed.

Distraction and Reframing

- Distraction refers to focusing attention on something other than the pain or the negative feelings associated with it (anxiety, fear).
- Distraction Tools - it may be done with internal distraction (singing to oneself, counting, reciting poetry or saying prayers) or with external resources such as music, TV, talking, listening to someone read or other stimuli to take their mind off of the pain.
- Reframing - this is a technique which teaches the resident to replace negative thoughts and images with positive ones. Example - if preoccupied with the fear of pain, replacing that with the positive thought - “I have had similar pain and it has gotten better.”
- Reframing helps the resident gain a sense of control over the situation.

Education on interventions for pain relief

There is much misinformation about pain control, use of opioids, and expectations about pain control. Identification of the resident’s thoughts, past experience, expectations and concerns can significantly reduce anxiety, which reduces the negative experience of having pain.

Many benefit from peer support in support groups.
Religious counseling
Especially when the pain is due to cancer or to a life-threatening condition, issues of spirituality are often raised.

Biofeedback
This technique teaches the resident to relax the muscles in the area of pain. It requires the resident to have the cognitive ability to understand the instructions, learn the techniques and practice them independently once learned. It may be appropriate depending on the cause of the pain and the resident’s level of cognitive functioning.

Psychotherapy
For grief/depression aspects of the underlying condition and the presence of pain.

Physical Interventions
Cutaneous stimulation (items 1-4 below) is recommended for pain associated with muscle tension or muscle spasm. Sometimes the pain will increase briefly after the application of the technique before the pain is relieved.

Superficial heat (carefully applied to avoid burns). Examples include hot packs, heating pads, heat lamp, etc.

Cold—Ice, Icepacks,
- Cold is used to reduce inflammation, edema soon after injury, burning perineal pain, and muscle spasms when superficial heat has been ineffective.
- It should be applied for about 15 minutes.
- It should not be used on tissue damaged by radiation therapy or when the following are present: peripheral vascular disease, Raynaud's, or other vascular or connective tissue disease.

Massage/Vibrators—this is a comfort measure to help with relaxation and general aches and pains especially associated with immobility.

Exercise—this includes active and passive ROM and strengthening exercises
- During acute pain, only self-administered ROM should be done.
- Exercise helps mobilize stiff joints, helps restore coordination and balance and enhances resident comfort.

Repositioning—for correct body alignment, to prevent pressure ulcers, and overall comfort.

Immobilization—this may be used for acute pain and to stabilize fractures or otherwise compromised limbs, joints, or both.
- Supportive devices may be helpful in achieving the goal of immobilization and maintain optimal body alignment.

TENS—is a counterstimulation technique with the goal of inhibiting pain transmission. Results of its effectiveness are variable but some residents and some types of pain obtain relief from TENS.

Acupuncture—or acupressure to reduce pain sensation.
Appendix F: General Information about Pain Management

A pain assessment flow sheet should be used on any resident who expresses pain at a moderate level of intensity. (4 or more on a scale of 1-10; 2 or more on a scale of 0-5; 2 or more on a scale of 0-3).

Treatment needs to be tailored to the type and source of the pain.

For example, The resident is having a tingling, burning pain. This is suggestive of a neuropathic type pain that may be more responsive to antidepressants or anticonvulsants than to traditional pain medication.

Drugs for pain are used according to the World Health Organization Step-Ladder approach. This approach suggests that for:

- **Mild pain**—Acetaminophen (Tylenol), NSAID (Aspirin, Ibuprofen, Naproxen, etc.)
- **Moderate Pain**—Narcotic combination (Tylenol #3, Percocet), Tramadol
- **Severe Pain**—Narcotic analgesic (Morphine, Oxycodone, Duragesic)

For persistent pain, use the oral route whenever possible.

Residents who have intermittent pain may have PRN orders. Residents with persistent pain should have routine orders, around the clock (every 6 hours, every 8 hours, etc., vs. three or four times a day).

Residents with long acting or sustained release medications should also have an order for a short acting medication for "break-through" pain (pain not controlled by scheduling the analgesic for use at specific times in a 24 hour period).

For example, resident with Time release Morphine (MS Contin) has an order for Morphine Sulfate Immediate Release for break through pain. If this order is used routinely, reassess the dose of the sustained release preparation.

Only one combination analgesic medication is used on a resident at one time. This is to prevent duplication of ingredients. Example: Darvocet N, Percocet, Vicodan all have acetaminophen in them. Acetaminophen can cause liver damage if used in high concentrations (3000-4000mg) over time.

Only one opioid is used for continuous moderate to severe pain. Use MS Contin with Morphine Sulfate Immediate Release for “break-through pain.” Side effects are additive, therefore there is little reason to use Morphine and Oxycodone or Propoxephene on a resident.

Short acting opioids (morphine, codeine, oxycodone, not in time release forms) are given at intervals of not more than every 4 hours, for continuous persistent pain.
Consider the use of a stimulant laxative with or without a stool softener (Senokot, etc.) along with narcotic analgesics. The narcotic medications cause constipation. If the laxative is used along with the narcotic and increased as the narcotic dose increases, additional pain from constipation/impaction may be prevented. Stimulant laxatives seem to work better than stool softening, bulk producing and osmotic laxatives.
Appendix G: Pharmacologic Interventions for Pain Control

Medication therapy — These are general recommendations. It is important for the team to work closely with the consulting pharmacist and physician to identify and use the medications appropriate for the individual resident. Recommendations are specific for an Adult over 50kg (110 lb) in weight.

For MILD pain
- Aspirin, Ibuprofen, Naproxen, and other NSAIDs—have an analgesic ceiling at which point you do not get more analgesic effect by increasing the dose. Increasing the dose beyond that point does increase the chance of serious side effects. Example Aspirin should not be used at more than 4000 mg a day. There is not clear benefit of one of these medications over the others except with the new COX 2 inhibitors (Celebrex, Vioxx). In people with GI concerns, these may be a better choice.
- Acetaminophen—has an analgesic ceiling and should not be used at more than 4000 mg a day. Irreversible liver damage can occur with these doses over time.
- Propoxyphene (Darvon)—most studies show this narcotic is no more effective than Aspirin or Acetaminophen. It also has the narcotic side effects of euphoria, constipation, sedation, etc. It is usually used in combination with acetaminophen 650 mg (Darvocet, Wygesic, etc.), which limits the dose that can be given to 6/day.

For MODERATE pain
- Combinations of Codeine (Tylenol #3, 4), Hydrocodone (Vicodan, Lortab, Lorcet) Oxycodone (Percocet, Percodan Tylox), and Tramadol.
- In combination with Aspirin and Acetaminophen, this limits the dose that could be given to 4000mg/day of these two drugs.

For SEVERE pain—Short acting drugs
- Morphine, Hydromorphone, Oxycodone, Meperidine(only in short term acute pain)
- These medications have an onset of 15-30 min, peak effect in 60-90 minutes and duration of action of 2hr(Meperidine)—4hr (for others).

For SEVERE pain—long acting drugs
- MS Contin or Oramorph SR, Oxycontin, Transdermal Fentanyl Patch.
- The oral medications have a duration of action of 8-12 hours, the patch takes about 24 hours to get to peak effect and lasts for 48-72 hrs.
# Specific Quality Indicator Guide – Prevalence of Pain

## PAIN MEDICATIONS: SUMMARY AND COMPARISON

<table>
<thead>
<tr>
<th>Medication</th>
<th>Approximate Equialalgesic Oral Dose</th>
<th>Approximate Equialalgesic Parenteral Dose</th>
<th>Maximum Daily Dose</th>
<th>Dosing Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MILD PAIN</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acetaminophen (APAP)</td>
<td>NA</td>
<td>NA</td>
<td>4000mg</td>
<td>Every 4 hrs</td>
</tr>
<tr>
<td>Aspirin (ASA)</td>
<td>NA</td>
<td>NA</td>
<td>4000mg</td>
<td>Every 4 hrs</td>
</tr>
<tr>
<td>NSAIDs Ibuprofen Naproxen, etc.</td>
<td>NA</td>
<td>NA</td>
<td>See each drug</td>
<td>See each drug</td>
</tr>
<tr>
<td>Celecoxib</td>
<td>NA</td>
<td>NA</td>
<td>400 mg</td>
<td>Daily or twice a day</td>
</tr>
<tr>
<td>Rofecoxib</td>
<td>NA</td>
<td>NA</td>
<td>50 mg</td>
<td>Per day</td>
</tr>
<tr>
<td>Choline magnesium trisalicylate</td>
<td></td>
<td></td>
<td>3000mg</td>
<td>Every 8 hrs</td>
</tr>
<tr>
<td>Salsalate</td>
<td>NA</td>
<td>NA</td>
<td>3000 mg</td>
<td>Every 12 hrs</td>
</tr>
<tr>
<td>Propoxyphene +APAP</td>
<td>NA</td>
<td>NA</td>
<td>4000mg APAP</td>
<td>Every 12 hrs</td>
</tr>
<tr>
<td><strong>MODERATE PAIN</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Codeine (+APAP)</td>
<td>(180-200mg Codeine)</td>
<td>130mg Codeine only</td>
<td>4000mg APAP</td>
<td>Every 4 hrs</td>
</tr>
<tr>
<td>Oxycodone + APAP</td>
<td>(30mg Oxycodone)</td>
<td>NA</td>
<td>4000mg APAP</td>
<td>Every 4 hrs</td>
</tr>
<tr>
<td>Hydrocodone +APAP</td>
<td>(30mg Hydrocodone)</td>
<td>NA</td>
<td>4000mg APAP</td>
<td>Every 4 hrs</td>
</tr>
<tr>
<td><strong>SEVERE PAIN</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morphine IR</td>
<td>30mg</td>
<td>10mg</td>
<td>None</td>
<td>Every 4 hrs</td>
</tr>
<tr>
<td>Morphine SR</td>
<td>90-120mg</td>
<td></td>
<td></td>
<td>Every 8-12 hrs</td>
</tr>
<tr>
<td>Oxycodone IR</td>
<td>30mg</td>
<td>NA</td>
<td>None</td>
<td>Every 4 hrs</td>
</tr>
<tr>
<td>Oxycodone SR</td>
<td>90-120mg</td>
<td></td>
<td></td>
<td>Every 8-12 hrs</td>
</tr>
<tr>
<td>Hydromorphone (Dilaudid)</td>
<td>7.5mg</td>
<td>1.5mg</td>
<td>None</td>
<td>Every 4 hrs</td>
</tr>
<tr>
<td>Levorphanol Levo-dromoran</td>
<td>4mg</td>
<td>2mg</td>
<td>None</td>
<td>Every 4 hrs</td>
</tr>
<tr>
<td>Meperidine</td>
<td>300mg (not as effective orally)</td>
<td>100mg</td>
<td>None</td>
<td>Every 2-3 hrs</td>
</tr>
<tr>
<td>Duragesic (Fentanyl)</td>
<td>25micrograms = 45-120mg MS/24hr</td>
<td>A 60mg dose of MS in 24 hrs about = 25-50mcg patch</td>
<td>None</td>
<td>Every 48-72 hrs</td>
</tr>
</tbody>
</table>

NOTE: In the hospice type situation, there is no ceiling for the narcotic medication. The goal is pain relief. It is important to remember the factors considered are first, the therapeutic goal based on the overall condition of the resident and the prognosis; then the dose of the medication and the potential side effects.

## OTHER MEDICATIONS (ADJUVANT MEDICATIONS)

<table>
<thead>
<tr>
<th>Class of drugs</th>
<th>Use to treat</th>
<th>Examples and comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressants</td>
<td>neuropathic pain (burning, tingling, shooting pain)</td>
<td>TCAs (Tricyclic Antidepressants): Desipramine, Nortriptyline (less anticholinergic effects) and Amitriptyline. SSRIs Fluoxetine, Sertraline, Paroxetine have been shown to reduce pain for some conditions but the effect was not as stong as with TCSAs. There is not as much literature to support the use of these medications.</td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>neuropathic pain</td>
<td>Gabapentin (Neurontin), lamotrigine (Lamictal) and Carbamazepine (Tegretol)</td>
</tr>
<tr>
<td>Alpha adrenergic agonist</td>
<td>neuropathic pain</td>
<td>Clonidine, Prazosin, are used in also. Hypotension and slow heart rate limit the use of these drugs.</td>
</tr>
<tr>
<td>Corticosteroids</td>
<td>tumors or inflammation in a confined area (bone, skull, etc.)</td>
<td>Dexamethasone, Prednisone</td>
</tr>
<tr>
<td>Others</td>
<td>neuropathic pain</td>
<td>Capsaicin cream (Zostrix); Mesiletene (Mexitil); Tramadol (Ultram)</td>
</tr>
</tbody>
</table>

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Appendix H: Side Effects of Pharmacologic Interventions

- Constipation—Can be treated with combination stimulant/stool softener
- Nausea—Usually resolves in 2-3 days; if not, use an anti-emetic
- Sedation/confusion/euphoria—Usually resolves in 1-2 days
- Respiratory Depression—Rare with oral short acting opioids. Tolerance develops rapidly.
- Tolerance—This is the need to increase the dose to get the same analgesic effect. Uncommon.
- Physical Dependence—withdrawal reaction if drug is discontinued or antagonist is given.
- Psychological Dependence (Addiction)—The craving of medication for recreational uses.

This is rare when the medication is being used to treat pain. Most residents are in pain and seeking relief when they ask for pain medication. In the hospice setting, there is no ceiling for the narcotic medication. The goal is pain relief. It is important to remember the factors considered are first, the therapeutic goal based on the overall condition of the resident and the prognosis; then the dose of the medication and the potential side effects.
Appendix I: Tool – Pain Scales

Examples of pain scales for quantifying pain as it is occurring: a visual analog scale; a word descriptor scale; a graphic scale; and a verbal scale. Adapted from AGS Panel on Chronic Pain in Older Persons: “The management of chronic pain in older persons.” *Journal of the American Geriatrics Society* 46:635-651, 1998.
### Appendix J: Clinical Links Among MDS-Based Quality Indicator Domains and Quality Indicators

<table>
<thead>
<tr>
<th>ACCIDENTS (New Fractures, Falls)</th>
<th>BEHAVIORAL/EMOTIONAL PATTERNS (Behavioral Symptoms, Symptoms of Depression)</th>
<th>CLINICAL MANAGEMENT (Use of 9+ Medications)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bedfast Residents</td>
<td>Bedfast Residents</td>
<td>Bladder/Bowel Incontinence</td>
</tr>
<tr>
<td>Behavioral Symptoms</td>
<td>Cognitive Impairment</td>
<td>Cognitive Impairment</td>
</tr>
<tr>
<td>Bladder/Bowel Incontinence</td>
<td>Daily Physical Restraints</td>
<td>Daily Physical Restraints</td>
</tr>
<tr>
<td>Cognitive Impairment</td>
<td>Decline in Late Loss ADLs</td>
<td>Decline in Late Loss ADLs</td>
</tr>
<tr>
<td>Daily Physical Restraints</td>
<td>Dehydration</td>
<td>Dehydration</td>
</tr>
<tr>
<td>Decline in Late Loss ADLs</td>
<td>Fails</td>
<td>Falls</td>
</tr>
<tr>
<td>Dehydration</td>
<td>Fecal Impaction</td>
<td>Fecal Impaction</td>
</tr>
<tr>
<td>Pain</td>
<td>Little or No Activities</td>
<td>Pain</td>
</tr>
<tr>
<td>Psychotropic Drug Use (any)</td>
<td>New Fractures</td>
<td>Psychotropic Drug Use (any)</td>
</tr>
<tr>
<td>Use of 9+ Medications</td>
<td>Pain</td>
<td>Tube Feeding</td>
</tr>
<tr>
<td>Weight Loss</td>
<td>Psychotropic Drug Use (any)</td>
<td>Urinary Tract Infections</td>
</tr>
<tr>
<td></td>
<td>Use of 9+ Medications</td>
<td>Use of 9+ Medications</td>
</tr>
<tr>
<td></td>
<td>Weight Loss</td>
<td>Weight Loss</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COGNITIVE PATTERNS (Cognitive Impairment)</th>
<th>ELIMINATION/INCONTINENCE (Bladder/Bowel Incontinence, Indwelling Catheters, Fecal Impaction)</th>
<th>INFECTION CONTROL (Urinary Tract Infections)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Symptoms</td>
<td>Bedfast Residents</td>
<td>Bladder Residents</td>
</tr>
<tr>
<td>Bladder/Bowel Incontinence</td>
<td>Cognitive Impairment</td>
<td>Behavioral Symptoms</td>
</tr>
<tr>
<td>Daily Physical Restraints</td>
<td>Daily Physical Impairment</td>
<td>Bladder/Bowel Incontinence</td>
</tr>
<tr>
<td>Decline in Late Loss ADLs</td>
<td>Daily Physical Restraits</td>
<td>Cognitive Impairment</td>
</tr>
<tr>
<td>Dehydration</td>
<td>Decline in Late Loss ADLs</td>
<td>Daily Physical Restraits</td>
</tr>
<tr>
<td>Fecal Impaction</td>
<td>Dehydration</td>
<td>Decline in Late Loss ADLs</td>
</tr>
<tr>
<td>Little or No Activities</td>
<td>Fails</td>
<td>Dehydration</td>
</tr>
<tr>
<td>Pain</td>
<td>Fecal Impaction</td>
<td>Falls</td>
</tr>
<tr>
<td>Psychotropic Drug Use (any)</td>
<td>Pressure Ulcers</td>
<td>Indwelling Catheters</td>
</tr>
<tr>
<td>Symptoms of Depression</td>
<td>Psychotropic Drug Use (any)</td>
<td>Pain</td>
</tr>
<tr>
<td>Use of 9+ Medications</td>
<td>Symptoms of Depression</td>
<td>Symptoms of Depression</td>
</tr>
<tr>
<td>Weight Loss</td>
<td>Use of 9+ Medications</td>
<td>Use of 9+ Medications</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NUTRITION/EATING (Weight Loss, Tube Feeding, Dehydration)</th>
<th>PHYSICAL FUNCTIONING (Bedfast Residents, Decline in Late Loss ADLs, Decline in ROM)</th>
<th>PSYCHOTROPIC DRUG USE (Antipsychotic Use, Antianxiety/Hypnotic Use, Hypnotics)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bedfast Residents</td>
<td>Bladder/Bowel Incontinence</td>
<td>Behavioral Symptoms</td>
</tr>
<tr>
<td>Cognitive Impairment</td>
<td>Cognitive Impairment</td>
<td>Bladder/Bowel Incontinence</td>
</tr>
<tr>
<td>Daily Physical Restraints</td>
<td>Daily Physical Impairment</td>
<td>Cognitive Impairment</td>
</tr>
<tr>
<td>Decline in Late Loss ADLs</td>
<td>Daily Physical Restraints</td>
<td>Daily Physical Restraints</td>
</tr>
<tr>
<td>Dehydration</td>
<td>Decline in Late Loss ADLs</td>
<td>Decline in Late Loss ADLs</td>
</tr>
<tr>
<td>Fecal Impaction</td>
<td>Dehydration</td>
<td>Dehydration</td>
</tr>
<tr>
<td>Little or No Activities</td>
<td>Falls</td>
<td>Falls</td>
</tr>
<tr>
<td>New Fractures</td>
<td>Fecal Impaction</td>
<td>Fecal Impaction</td>
</tr>
<tr>
<td>Pressure Ulcers</td>
<td>Little or No Activities</td>
<td>Pain</td>
</tr>
<tr>
<td>Psychotropic Drug Use (any)</td>
<td>New Fractures</td>
<td>Symptoms of Depression</td>
</tr>
<tr>
<td>Symptoms of Depression</td>
<td>Pain</td>
<td>Use of 9+ Medications</td>
</tr>
<tr>
<td>Use of 9+ Medications</td>
<td>Psychotropic Drug Use (any)</td>
<td>Weight Loss</td>
</tr>
<tr>
<td>Weight Loss</td>
<td>Use of 9+ Medications</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>QUALITY OF LIFE (Daily Physical Restraints, Little of No Activities, Pain)</th>
<th>SKIN CARE (Stage 1-4 Pressure Ulcers)</th>
<th>PAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bedfast Residents</td>
<td>Bedfast Residents</td>
<td></td>
</tr>
<tr>
<td>Behavioral Symptoms</td>
<td>Bladder/Bowel Incontinence</td>
<td></td>
</tr>
<tr>
<td>Bladder/Bowel Incontinence</td>
<td>Cognitive Impairment</td>
<td></td>
</tr>
<tr>
<td>Cognitive Impairment</td>
<td>Daily Physical Restraints</td>
<td></td>
</tr>
<tr>
<td>Daily Physical Restraints</td>
<td>Decline in Late Loss ADLs</td>
<td></td>
</tr>
<tr>
<td>Decline in Late Loss ADLs</td>
<td>Decline in ROM</td>
<td></td>
</tr>
<tr>
<td>Dehydration</td>
<td>Dehydration</td>
<td></td>
</tr>
<tr>
<td>Falls</td>
<td>Indwelling Catheters</td>
<td></td>
</tr>
<tr>
<td>Fecal Impaction</td>
<td>New Fractures</td>
<td></td>
</tr>
<tr>
<td>Little or No Activities</td>
<td>Pain</td>
<td></td>
</tr>
<tr>
<td>New Fractures</td>
<td>Psychotropic Drug Use (any)</td>
<td></td>
</tr>
<tr>
<td>Pressure Ulcers</td>
<td>Symptoms of Depression</td>
<td></td>
</tr>
<tr>
<td>Psychotropic Drug Use (any)</td>
<td>Tube Feeding</td>
<td></td>
</tr>
<tr>
<td>Symptoms of Depression</td>
<td>Use of 9+ Medications</td>
<td></td>
</tr>
<tr>
<td>Use of 9+ Medications</td>
<td>Weight Loss</td>
<td></td>
</tr>
<tr>
<td>Weight Loss</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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References

This following list includes the articles or materials that were used to prepare this guide, however, it is not intended to be a complete list of references for this care area.


Fisher, Susan; Burgio, Louis; and others. Pain Assessment and Management in Cognitively Impaired Nursing Home Residents; Association of Certified Nursing Assistant Pain Report, Minimum Data Set Pain Report, and Analgesic Medication Use. JAGS 50: January 2002,152-156.


Kovach, Christine; Weissman, David; Griffie, Julie and others. Assessment and Treatment of Discomfort for People with Late-Stage Dementia. Journal of Pain and Symptom Management Vol 18 No. 6 December 1999, 412-419.
Krulwitch, Harry; London, Marla; Skakel, Victoria and others. Assessment of Pain in Cognitively Impaired Older Adults: A Comparison of Pain Assessment Tools and Their Use by Nonprofessional Caregivers. JAGS. 2000 Dec; 48(12):1607-1611.


**Suggested Websites**

Additional web-based resources on the prevention and treatment in this care area are listed below and, if applicable, linked. CHSRA does not endorse or condone the contents of the external sites and has no control over their content or availability. Pages at the links are subject to change at anytime, and CHSRA is not alerted to such change.

American Pain Society: [www.ampainsoc.org](http://www.ampainsoc.org)

American Geriatrics Society: [www.americangeriatrics.org](http://www.americangeriatrics.org)
(See JAGS guideline for the Management of Persistent Pain in Older Adults, JAGS 50:S250-224, 2002)

(See clinical information—National Guideline Clearing House)

Wisconsin Cancer Pain Initiative: [http://www.wisc.edu/wcpi/](http://www.wisc.edu/wcpi/)
Additional Reading

The following citations are provided as "information only." The journal articles have not been reviewed for content or accuracy by CHSRA staff. A literature search was conducted in August/September 2002 to identify recently published related articles. Abstracts for many of the cited articles may be viewed at the National Institute of Medicine's Medline database at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi.


LTC Quality Indicator Data Collection Tool — Individual Resident

Resident: ____________________________  QI Studied: ____________________________
Resident’s unit/wing/building: ____________________________  Reviewer’s Name: ____________________________
Date of MDS in Resident Report: ____________________________  Date of Review: ____________________________

**REVIEW OF THE CARE PROCESS***

<table>
<thead>
<tr>
<th>1. ASSESSMENT – ACCURACY</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>RESIDENT LEVEL STANDARD #1:</td>
<td></td>
</tr>
<tr>
<td>The MDS accurately reflects the status of this resident during the assessment period.</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>1.1 MDS date matches MDS date on the Resident Report.</td>
<td></td>
</tr>
<tr>
<td>1.2 All MDS items are present to match the QI definition.</td>
<td></td>
</tr>
<tr>
<td>1.3 Corroborating evidence is present (e.g., medical records review and/or interviews).</td>
<td></td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. ASSESSMENT – CLINICAL STATUS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>RESIDENT LEVEL STANDARD #2:</td>
<td></td>
</tr>
<tr>
<td>The interdisciplinary team has obtained assessment information for the resident regarding the condition identified in this QI. This includes assessing (1) the cause and contributing factors; (2) the need for further testing; (3) the impact of the condition on the resident’s quality of life, quality of care, and functional ability; and (4) other risk factors.</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>2.1 Relevant assessment protocols/tools have been used correctly.</td>
<td></td>
</tr>
<tr>
<td>2.2 The staff who collected the information was familiar with the resident’s condition.</td>
<td></td>
</tr>
<tr>
<td>2.3 Other team members (i.e., other disciplines/departments) have performed an assessment of the condition identified in this QI, its cause(s) and risk factor(s), based on their area of expertise.</td>
<td></td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
</tr>
</tbody>
</table>
3. DECISION-MAKING (See Section 3 of the specific QI Guide for the full investigative protocol and examples)

RESIDENT LEVEL STANDARD #3: The interdisciplinary team used the assessment information to make sound decisions about the care needs of the resident relative to the condition identified in this QI.

3.1 The decision-making process pulled together all pertinent information identified by team members, including risk and causal factors.
3.2 The resident/representative’s choices were honored in the decision-making process.
3.3 The interdisciplinary team’s discussion or conclusions were documented in the record.
3.4 When the steps in the interdisciplinary team’s decision-making process are retraced, it is reasonable to conclude that the team made the right decision to proceed or not proceed to the next step, care planning.

Notes:

4. CARE PLANNING (See Section 4 of the specific QI Guide for the full investigative protocol and examples)

RESIDENT LEVEL STANDARD #4: The interdisciplinary team, including the resident/representative, has specifically addressed the condition identified in this QI in the care plan to maintain the resident’s highest level of functioning and to prevent future adverse episodes.

4.1 The problem(s) are stated in functional/behavioral terms, describing the resident’s specific problem.
4.2 Goals are measurable, realistic and relevant to the resident. A baseline has been established for comparison.
4.3 A reasonable time frame has been established for the accomplishment or review of the goal.
4.4 The interventions are specified in the care plan and are specific, realistic and relevant to the resident.
4.5 The care plan matches the conclusions of the assessment (i.e., the pertinent risk and causal factors are addressed).
4.6 The care plan relies on expertise and information from staff most familiar with the resident, including CNAs and staff from all shifts.
4.7 The care plan reflects current standards of professional practice.
4.8 The resident/representative participated in planning interventions for treatment of the existing condition and prevention of future occurrences. Sufficient information was available to make informed decisions about treatment.
4.9 If the resident/representative refused treatment, the comprehensive assessment and the care plan reflect all efforts to find alternative means to address the condition.

Notes:
### 5. IMPLEMENTATION

**RESIDENT LEVEL STANDARD #5**: Staff is knowledgeable about the care plan and is providing care and services to treat the condition identified in this QI and to prevent future occurrences as described in the care plan.

- **5.1** It is clear from the care plan which staff/shifts are responsible for carrying out the specific interventions.
- **5.2** The interventions in the care plan have been adequately communicated to the interdisciplinary team and direct care staff, including float and pool staff.
- **5.3** Nurse aides and other staff have received adequate training and supervision.
- **5.4** Adequate equipment and resources are available to provide the care needed.
- **5.5** Staff has sufficient time to provide the interventions needed.
- **5.6** Implementation efforts have been documented. If care was not provided, or if it was not provided in the manner described in the care plan, there is a reasonable explanation.

**Notes:**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

### 6. MONITORING AND EVALUATION

**RESIDENT LEVEL STANDARD #6**: Staff has responded to changes in the resident’s condition identified in this QI since the care plan was implemented. The effects of the care plan, goals, interventions, and implementation have been reviewed and modified as necessary to promote the best outcome for the resident based on an accurate and current assessment.

- **6.1** Objective means of monitoring treatment, risk factors, and/or prevention of future episodes have been established.
- **6.2** Direct care staff communicates adequately when changes are observed in the resident’s condition or when interventions are not working as expected or cannot be carried out.
- **6.3** The care plan has been reviewed and modified within the time frames established, or as necessary based on the resident’s response, or at least quarterly.
- **6.4** Changes made to the care plan have been communicated to staff and carried out promptly.
- **6.5** A comprehensive assessment was promptly completed if a significant change in condition occurred.
- **6.6** The physician was promptly informed if the resident’s condition changed or treatment methods did not work.

**Notes:**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

*For complete Quality Indicator guides to help you investigate potential quality of care and/or quality of life problems, refer to the Specific Quality Indicator Guides, published by the Center for Health Systems Research and Analysis (CHRSA) as part of the Provider Initiative Project (PIP).

The individual Quality Indicator guides offer detailed information and relevant examples for the investigation of resident level quality problems within the steps of the care process (assessment, decision-making, care planning, implementation, monitoring and evaluation), as well as for the investigation of facility level quality problems. In addition, guide appendices provide a conceptual framework for the investigation of a specific Quality Indicator, clinical and functional assessment techniques, complications and risks associated with the problem, potential interventions, and relevant medication information, where applicable.

**For further information contact:**

Center for Health Systems Research and Analysis (CHRSA), University of Wisconsin–Madison,
610 Walnut Street, 11th Floor WARF Building, Madison, WI 53726; Toll-free: 888-300-8098; Phone: 608-263-5722; Fax: 608-263-4523
email: helpdesk@chsra.wisc.edu
7. Conclusions Based on Your Review of the Care for This Resident Relative to This QI:

<table>
<thead>
<tr>
<th>Resident Key Question 7.1—Is There a Problem?</th>
<th>Resident Key Question 7.2—If So, Where in the Care Process Was the Problem Identified?</th>
<th>Resident Key Question 7.4—Did the Problem Affect the Entire Facility?</th>
<th>Resident Key Question 7.5—Were Other Quality Problems Identified?</th>
<th>Resident Key Question 7.3—What Causes or Factors Contributed to the Problem?</th>
<th>7.6 Recommendations and Follow up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does there appear to be a problem(s) with the care of this resident?</td>
<td>Can the problem(s) with the care of this resident be isolated to one or more specific step(s) in the care process?</td>
<td>Was the quality problem(s) for this resident of sufficient magnitude to conclude that the facility has a quality of care problem?</td>
<td>If so, list the additional quality problems:</td>
<td>List the causes or factors that contributed to the care problem(s) for this resident (e.g., a specific shift, unit or wing, department or function; staffing issues; adequacy of supervision or training; communication breakdown).</td>
<td>List your recommendations for this resident for a plan of improvement, referrals needed, or further investigation relative to this QI.</td>
</tr>
<tr>
<td>□ Yes</td>
<td>□ Yes</td>
<td>□ Yes</td>
<td>□ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ No</td>
<td>□ No</td>
<td>□ No</td>
<td>□ No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If “Yes,” identify the step(s) not met:

- Assessment – Accuracy
- Assessment – Clinical Status
- Decision Making
- Care Planning
- Implementation
- Monitoring and Evaluation

Comments:

Were the causes or contributing factors (1) related, (2) unrelated, or (3) attributable to a single root cause? Explain.
Complete the resident level questions first. Enter the answers from the individual resident data collection sheets directly on this form below, and then proceed to answer the facility level questions.

### REVIEW OF THE CARE PROCESS

#### 1. ASSESSMENT – ACCURACY

<table>
<thead>
<tr>
<th>Resident Level Standard #1: The MDS accurately reflects the status of the resident during the assessment period.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Res. #1</td>
</tr>
<tr>
<td>☐ Yes</td>
</tr>
<tr>
<td>☐ No</td>
</tr>
</tbody>
</table>

**Facility Standard:** Based on the review of all residents for this QI, the MDS elements for this QI were accurate.

☐ Agree ☐ Disagree

**Comments:**

#### 2. ASSESSMENT – CLINICAL STATUS

<table>
<thead>
<tr>
<th>Resident Level Standard #2: For the condition identified in this QI, the interdisciplinary team assessed (1) the cause and contributing factors; (2) the need for further testing; (3) the impact of the condition on the resident’s quality of life, quality of care, and functional ability; and (4) other risk factors.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Res. #1</td>
</tr>
<tr>
<td>☐ Yes</td>
</tr>
<tr>
<td>☐ No</td>
</tr>
</tbody>
</table>

**Facility Standard:** Based on the review of all residents for this QI, the clinical assessment of this condition was appropriate.

☐ Agree ☐ Disagree

**Comments:**

#### 3. DECISION-MAKING

<table>
<thead>
<tr>
<th>Resident Level Standard #3: The interdisciplinary team used the assessment information to make sound decisions about the care needs of the resident relative to the condition identified in this QI.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Res. #1</td>
</tr>
<tr>
<td>☐ Yes</td>
</tr>
<tr>
<td>☐ No</td>
</tr>
</tbody>
</table>

**Facility Standard:** Based on the review of all residents for this QI, the decision-making step was appropriate.

☐ Agree ☐ Disagree

**Comments:**

#### 4. CARE PLANNING

<table>
<thead>
<tr>
<th>Resident Level Standard #4: The interdisciplinary team, including the resident/representative, has specifically addressed the condition identified in this QI in the care plan in order to maintain the resident’s highest level of functioning and to prevent future episodes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Res. #1</td>
</tr>
<tr>
<td>☐ Yes</td>
</tr>
<tr>
<td>☐ No</td>
</tr>
</tbody>
</table>

**Facility Standard:** Based on the review of all the residents for this QI, the care planning was appropriate.

☐ Agree ☐ Disagree

**Comments:**

#### 5. IMPLEMENTATION

<table>
<thead>
<tr>
<th>Resident Level Standard #5: Staff is knowledgeable about the care plan and is providing care and services to treat the condition identified in this QI and to prevent future occurrences as described in the care plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Res. #1</td>
</tr>
<tr>
<td>☐ Yes</td>
</tr>
<tr>
<td>☐ No</td>
</tr>
</tbody>
</table>

**Facility Standard:** Based on the review of all residents for this QI, implementation at the facility level was appropriate.

☐ Agree ☐ Disagree

**Comments:**

#### 6. MONITORING AND EVALUATION

<table>
<thead>
<tr>
<th>Resident Level Standard #6: Staff has responded to changes in the resident’s condition identified in this QI since the care plan was implemented. The effects of the care plan, goals, interventions, and implementation have been reviewed and modified as necessary to promote the best outcome for the resident based on an accurate and current assessment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Res. #1</td>
</tr>
<tr>
<td>☐ Yes</td>
</tr>
<tr>
<td>☐ No</td>
</tr>
</tbody>
</table>

**Facility Standard:** Based on the review of all residents for this QI, monitoring and evaluation of the resident’s response to care was appropriate.

☐ Agree ☐ Disagree

**Comments:**
## II. Conclusions Based on Your Review of the Care for These Residents Relative to This QI:

<table>
<thead>
<tr>
<th>Facility Key Question #1—Are There Problems?</th>
<th>Facility Key Question #4—Did the Problems Affect the Entire Facility?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Question: Does it appear there are quality problems with the care of these residents at the facility level?</td>
<td>Facility Question: Were the quality problems for all of these or even one of the residents of sufficient magnitude to conclude that the facility has a quality of care problem?</td>
</tr>
<tr>
<td>□ Yes</td>
<td>□ Yes</td>
</tr>
<tr>
<td>□ No</td>
<td>□ No</td>
</tr>
</tbody>
</table>

Comments:

<table>
<thead>
<tr>
<th>Facility Key Question #2—If So, Where in the Care Process Were the Problems Identified?</th>
<th>Facility Key Question #5—Are the Quality Problems Linked?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Question: Can the problem(s) with the care of this resident be isolated to one or more specific step(s) in the care process?</td>
<td>Facility Question: Were the quality problems clinically linked or attributable to a common cause?</td>
</tr>
<tr>
<td>□ Yes</td>
<td>□ Yes</td>
</tr>
<tr>
<td>□ No</td>
<td>□ No</td>
</tr>
</tbody>
</table>

If “Yes,” identify the step(s) not met:
- Assessment – Accuracy
- Assessment – Clinical Status
- Decision Making
- Care Planning
- Implementation
- Monitoring and Evaluation

Comments:

<table>
<thead>
<tr>
<th>Facility Key Question #3—What Causes or Factors Contributed to the Problems?</th>
<th>Recommendations and Follow up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Question: List the causes and factors that contributed to the care problems for these residents (e.g., a specific shift, unit or wing, department or function; staffing issues; adequacy of supervision or training; communication breakdown).</td>
<td>List your recommendations for a facility level plan of improvement, referrals needed, or further investigation relative to this QI.</td>
</tr>
</tbody>
</table>

Were the causes or contributing factors (1) related, (2) unrelated, or (3) attributable to a single root cause? Explain.