

## PERSISTENT PAIN PATHWAY - DATA RETRIEVAL WORKSHEET

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

Person Completing Worksheet: \_\_\_\_\_

### I. Components of Assessment for Persistent Pain in New Nursing Home

**Admissions.** Many persons newly admitted to long-term care have been suffering from persistent pain for years. Thorough, initial assessment is key to identification of pain, potential sources, risk and contributing factors, and successful management.

*Review home/ pain management policies and procedures. Complete this worksheet using **resident/family interview, staff interview, direct resident observation, observations of environment and direct care delivery, and record review** for type of data retrieval.*

Type of Data Retrieval	Monitoring Criteria	Y/N	NA	Incomplete Record	Comments
Interview, Record Review	1. Resident/family interviewed about presence of pain/discomfort and associated pain behaviors.				
Record Review, Interview	2. Diagnoses reviewed and considered for persistent pain potential. a. Examples: arthritis, DJD, cancer, previous fractures, post-herpetic neuralgias, post-stroke syndrome, diabetic neuropathies, etc. (Commonly more than one source of pain.)				
Interview, Record Review	3. Medication history is completed - OTC prescription, herbal, home remedies.				
Interview, Observation	4. Physical assessment is completed for indications of persistent pain including pain scale (see general assessment guidelines).				
Observation	5. Behavior is observed for potential indicators of persistent pain.				
Record Review, Interview, Observation	6. MDS Items that indicate or may indicate pain are reviewed by interdisciplinary team. a. Pain items, MDS 3.0 Section J b. Potential pain indicators from other MDS 3.0 sections <ul style="list-style-type: none"> <li>• Resident mood interview, symptoms present(D0200)</li> <li>• Resident mood interview behaviors (D0500)</li> </ul>				

	<ul style="list-style-type: none"> <li>• Behavioral symptom presence (E0200)</li> <li>• Wandering presence and frequency (E0900)</li> <li>• Change in behavior or other symptoms (E1100)</li> <li>• Activities of daily living assistance (G0110)</li> <li>• Functional limitations in ROM (G0400)</li> <li>• Active diagnoses (I)</li> <li>• Fall history on admission (J1700)</li> <li>• Falls since admission or prior assessment (J1800)</li> <li>• Weight loss (K0300)</li> <li>• Oral/Dental status (L0200)</li> <li>• Skin conditions (M)</li> <li>• Medications received (N0400)</li> <li>• Special treatments and procedures (O0100)</li> </ul>				
Record Review, Interview, Observation	7. Interdisciplinary pain care plan is developed for resident based on findings from: <ol style="list-style-type: none"> <li>a. Assessment</li> <li>b. Observations</li> <li>c. History/Record review</li> <li>d. CAA triggers</li> <li>e. Resident/family/staff interviews</li> </ol>				
Record Review	8. Care plan is shared with resident and all involved in care.				
Record Review	9. Ongoing evaluation for effectiveness.				

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**II. Components of Assessment for Persistent Pain - Existing Residents.** Over the course of a residents stay in long term care many changes take place that may bring about new or worsening pain, or periodic acute exacerbations of persistent pain. Pain symptoms can also be missed and attributed to other disease processes for some residents. This occurs many times when a resident has been on a long standing pain medication that is no longer effective. The resident in long-term care should be routinely assessed for pain and treatment efficacy. Pain should be a part of each routine assessment, with the RAI process and with any of the following indications.

*Review home/ pain management policies and procedures. Complete this worksheet using resident/family interview, staff interview, direct resident observation, observations of the environment and direct care delivery, and record review.*

Type of Data Retrieval	Monitoring Criteria	Y/N	NA	Incomplete	Comments
Interview, Observation	1. Resident or caregiver verbalizations about new or worsening pain.				
Record Review	2. Existing or new diagnoses indicate potential for persistent pain.				
Record Review	3. Changes in MDS items that indicate pain. a. Pain items - see previous list b. Potential indicators - see previous list				
Observation, Interview	4. Changes in resident routines, behaviors, mood.				
Observation	5. Observed behaviors that may indicate pain.				
Interview, Observation	6. Physical assessment indications of persistent pain including pain scale.				
Record Review	7. Monthly MAR review for the following which may indicate increasing or unrecognized pain. a. Increased use of pain medications and/or pain interventions. b. Increased use of prn antipsychotics, anti-anxiety meds, sleep meds.				
	8. Interdisciplinary pain care plan is				

	developed for resident based on: a. Assessment b. Observations c. History/record review f. CAA triggers g. Resident/staff/family interviews				
Interview	9. Care plan is shared with resident and all involved in care.				
Interview, Observation, Record Review	10. Ongoing evaluation for effectiveness.				

### Persistent Pain Pathway - Data Retrieval Worksheet I and II

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Minner, D, Marek, K (2005). Evidence based assessment and treatment of persistent pain in the community dwelling elderly receiving home health services: a pathway. *Home Health Care Management and Practice*, 17(4), 293-301.

Rantz, M, Vinz Miller, T, Popejoy, L, & Zwygart-Stauffacher, M. (2003) Outcome-Based Quality Improvement for Long-Term Care: Using MDS Process and Outcome Measures. [2<sup>nd</sup> Ed] Thomson Delmar Learning Center: Clifton Park, NY.

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