

Systems Investigative Audit – Pain Management

Purpose: To evaluate the decision-making process and adequacy of the facility's process in the management of pain.

- NOTE: The following audit criteria are broad and are based on having a policy in place that mandates screening, assessment/reassessment, continuous monitoring and resident-specific care planned interventions for pain management.
- Select a current clinical practice guideline or utilize the Facility Assessment Checklist for Pain Management to guide a more detailed facility audit.

Criteria:

1. Resident was screened for pain, or risk of pain, within 24 hours of admission.
2. If pain was identified, a full assessment of the causes and characteristics of the pain was completed.
3. Pain medication was ordered within 24 hours of pain identification.
4. A pain management care plan was in place within 48 hours of admission.
 - Specific non-pharmacologic interventions were identified on the care plan to be used routinely as adjunct to the pain medication
 - Identified risk factors for pain were addressed on the care plan (e.g., contractures, limited movement, depression, etc.)
 - An aggressive bowel management program was initiated for the resident on routine pain medication
5. Each resident with pain (or at risk for pain) was monitored, and a pain scale score recorded, using a research-based, 0-10 pain monitoring scale determined to be appropriate for that resident (e.g., Numbers, Faces or Verbal descriptor scales for the cognitively intact or the PainAD for the cognitively impaired).
 - At least every 24 hours (including the resident identified as at risk for pain)
 - Before giving a prn pain medication
 - Within 30-60 minutes after giving a prn pain medication
 - With each complaint of pain
6. A comprehensive reassessment of the resident's pain was done and the care plan was evaluated and revised for:
 - Pain that is not controlled to the goal established by the resident
 - Increasing doses of prn pain medications or onset of new pain
 - Any change in condition
 - Each readmission
 - Each MDS
7. If the resident received prn pain medication at least daily, consideration was given to changing the medication to a scheduled medication with an additional medication or dosage ordered to cover break-through pain.
8. Documentation reflected that monitoring and care plan interventions were implemented as indicated.
9. Responsibility and accountability was assigned for oversight of each phase of the pain management plan: screening, assessment/reassessment, monitoring and care plan development/implementation.
10. A pain management policy and protocol was in place, updated and communicated to all staff according to current CPGs.
11. The QA/CQI committee had processes in place and routinely tracked pain management efficacy.
12. Education was provided to all staff, residents and families on all areas of pain management on an ongoing basis.
 - All staff were taught indicators of pain
 - Appropriate non-pharmacologic interventions for pain management were taught to all direct care staff.
 - Up-to-date pain management materials were made available to all staff.
 - Educational brochures/literature were provided for residents and families.

Reviewer: _____

Date of Review: _____

	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Comments
1. Resident was screened for pain or risk of pain within 24 hours of admission.							
2. A full pain assessment was completed if pain was identified.							
3. Pain medication was ordered within 24 hours of pain identification.							
4. Pain care plan in place within 48 hours of admission. All elements addressed.							
5. Pain was monitored using appropriate scale and pain scale score recorded as indicated.							
6. Pain was reassessed and care plan revised as indicated.							
7. Frequent prn pain meds were changed to scheduled dosing as appropriate. <ul style="list-style-type: none"> • Additional medication or dosage was ordered for breakthrough pain. 							
8. Pain monitoring and care plan interventions were implemented as indicated.							
9. Accountability was evidenced by those responsible for each phase of the pain mgmt process.							
10. Pain management policy/protocols are current and followed consistently.							
11. QA/CQI committee tracks efficacy of pain management routinely.							
12. Appropriate education provided to all staff, residents and family.							

Comparing your practice Pain Management – Chronic Care Residents

Name of Facility: _____

Date Reviewed: ____/____/20____

- DIRECTIONS:**
1. Enter the resident's clinical record number or initials.
 2. Review the clinical record for evidence of each practice.
 3. Enter a "Y" if it is identified and an "N" if it is not identified. (Reviewers may have N/A for some records.)
 4. Tally the Number of "Y" s identified for each Best Practice, divide by the total number of applicable records reviewed to determine the percent.

Enter Resident's Clinical Record ID # or Initials	Clinical Record										TALLY		%
	1	2	3	4	5	6	7	8	9	10	# Yes	Total #	
	1. Resident screened for pain using appropriate validated tool: on admission, at readmission, with change in condition (i.e., after fall), and at each MDS assessment.												
2. If pain indicated in screening process, comprehensive pain assessment that includes evaluation of pain intensity, character, frequency, location, duration, aggravating and alleviating factors, medical history, analgesic history, ADL performance and psychosocial function was completed.													
3. If pain present, resident received pain treatment appropriate for cause, type, and intensity of pain based on clinically accepted guidelines (i.e., WHO Three-Step Analgesia Ladder, AMDA or AGS).													
4. If pain present, the care plan includes a comfort goal defined by resident/family member.													
5. If pain present, orders for pain medication were received within 24 hours of identification of resident's pain.													
6. If pain is present daily or aggravated by regularly occurring activities (i.e., bath), resident is receiving regularly scheduled analgesics.													
7. If pain present, care plan includes non-pharmacological, as well as pharmacological interventions.													
8. When analgesic administered or non-pharmacological treatment initiated, effectiveness of intervention and resident comfort level evaluated at appropriate intervals.													
9. Care plan includes interventions to ameliorate actual/potential untoward effects from analgesics.													
10. If pharmacological/non-pharmacological interventions ineffective, communication with physician for change documented.													