Pain Assessment, Management and Treatment: Medical Record Review

Q.I. Category	Quality Indicator	Eligibility for scoring (N for each indicator)	Criteria Needed to Pass Indicator	% Pass	% Fail
Screening and Assessment of Chronic Pain	1. **ALL** NH residents should be screened for chronic pain with documentation in the primary care provider's note during the initial evaluation period and at least quarterly	All residents whose admission occurred up to 12 months prior to medical record abstraction	Any documentation of a pain assessment (type, intensity, location of pain), or "no distress" or "comfortable" in the admission H & P[a] or 1st progress note and once each quarter.		
	2. **IF** a NH resident has pain on MDS screen or is diagnosed with chronic pain, **THEN** the resident should be evaluated for depression by a PCP[b] within 1 month.	All residents with MDS documented pain on the most recent assessment	Any documentation of mood by PCP or licensed mental health provider, or documentation of a standardized depression assessment by other staff during the abstraction period.		
	3. **IF** a NH resident has a positive MDS screen for pain, **THEN** a quantitative pain assessment using a standard pain scale should be used (with its use not precluded but modified for cognitive impairment).	All residents with MDS documented pain on the most recent assessment	Any standard pain scale used by Licensed Nurse to document pain (zero to 10 scale, pain thermometer, faces rated scale etc.)		
	4. **IF** a NH resident has a newly reported painful condition, **THEN** a targeted H & P should be done by the PCP and documented within 1 month.	All residents with a new positive MDS pain screen during the abstraction period or initiation of pain management during the abstraction period.	Documentation of onset/duration, location, quality/severity of pain, response to prior treatment, and examination of the painful area by PCP.		

[a] H & P= History and Physical Examination [b] PCP = Primary Care Physician

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Appropriate Use of Medication for Treatment of Chronic Pain	5. **IF** a NH resident has been prescribed a non-steroidal anti-inflammatory drug (NSAID) for the treatment of chronic pain, **THEN** the medical record should indicate whether s/he has a history of peptic ulcer disease, and if a positive history is present, justification of NSAID use in place of alternative therapy should be prescribed.	Any resident with an order for a non-COX 2 inhibitor NSAID.	Any PCP documentation documentation describing the presence or absence of history of peptic ulcer disease. If a positive history is documented, then any PCP statement that defends use of NSAID in place of alternative therapy.		
	6. **IF** a NH resident over age 75 is being treated with a non-COX-2 inhibitor NSAID, and has any of the following: history of peptic ulcer disease, history of gastrointestinal bleed, or current warfarin use **THEN**, s/he should be offered treatment with misoprostol or a proton pump inhibitor.	Any resident on a non-COX 2 inhibitor NSAID (whose medical record documents high risk status (history of peptic ulcer disease, gastrointestinal bleed, or current warfarin use.	Documentation of PCP order for Misoprostol or proton pump inhibitor		
	7. **IF** a NH resident with chronic pain is treated with opiods, **THEN** s/he should be offered a bowel regimen or the medical record should document the potential for constipation and/or explain why bowel treatment is not needed.	Any resident with an order for opiods	PCP order for stimulant laxative or note indicating that it is not indicated. (order for colace alone or order for MoM prn only is not sufficient)		
	8. **IF** a NH resident requires analgesia, **THEN** merperidene should not be used.	Any resident with a positive MDS pain screen at any time during the abstraction period.	No order for or use of Merperidene during the abstraction period.		
Q.I. Category	Quality Indicator	Eligibility for scoring (N for each indicator)	Criteria Needed to Pass Indicator	No./% Pass	No./% Fail

Documenting Response to Treatment	9. **IF** a NH resident is treated for a chronic painful condition, **THEN** s/he should be assessed for a response within 3 months	Any resident treated with pain medication for at least 3 months prior to medical record review.	Any PCP documentation of response to treatment such as: symptoms (sx) improved, sx worse, no change in sx, any mention of medication side effects.		
Treatment Of Osteoarthritis	10. **IF** an ambulatory NH resident is newly diagnosed with symptomatic osteoarthritis (OA) of the knee, has no contraindication to exercise, and is physically and mentally able to exercise, **THEN** a directed or supervised strengthening program should be prescribed within 1 month of diagnosis.	Any resident with an admission diagnosis of OA if admitted during the medical record abstraction period, or for residents admitted prior to abstraction period, new diagnosis of OA documented during the abstraction period.	Any order for lower extremity strengthening or ambulation with Physical Therapist or Restorative Nursing Assistant documented after the date of OA diagnosis.		
	11. **IF** oral pharmacologic therapy is initiated to treat symptomatic osteoarthritis, **THEN** acetaminophen should be the first drug used.	Any resident with original order for OA treatment in the medical record.	Documentation that acetaminophen was used as initial treatment for OA.		
	12. **IF** oral pharmacologic therapy for symptomatic osteoarthritis, is changed from acetaminophen, to a different agent, **THEN** there should be evidence that that the resident has had a trial of maximum dose acetaminophen (suitable for age/ comorbidities).	Any resident with OA whose treatment was changed from acetaminophen to a different medication or had another medication added to acetaminophen.	Documentation that resident received 4 Gm/day of acetaminophen without acceptable pain relief or note indicating that dose tried was the maximal recommended dose for resident.		