

Ten Ways to Improve Your Pain QM Score

- 1 Understand the quality measure (QM).**

This measure is the percentage of long-stay residents with at least one episode of moderate/severe pain or horrible, excruciating pain of any frequency in the last five-day look-back period on the most recent Minimum Data Set (MDS) assessment.
- 2 Pain is everyone's responsibility.**

Educate everyone (all staff, residents, family, volunteers, etc.) to consider that every resident is at risk for pain, to recognize pain and to know the process for reporting residents who are in potential pain to the nurse.
- 3 Start an interdisciplinary pain team.**

The team should include a member from every department at every level to facilitate a comprehensive, aggressive pain management program. In your daily stand-up meetings, review any residents with moderate or worse pain within the past twenty-four hours and consider care plan adjustments.
- 4 Make pain the fifth vital sign.**

Screen for pain daily, upon admission, with every MDS and with any change in behavior or condition. Be sure to ask questions using various synonyms for pain such as discomfort and aching. Include questions about any factors preventing the resident from moving about as he or she would like. Pain should be monitored on a **shiftly** basis throughout the nursing home stay.
- 5 Use a consistent pain assessment scale.**

The scale should address location, intensity, duration, what improves and worsens pain and response to any treatment. The pain assessment scale should be appropriate for the cognitive functioning of the resident and used consistently by all staff. Document and communicate your findings consistently to all team members.
- 6 Know the residents.**

Observe and document baseline behaviors in every resident with special emphasis on people with cognitive impairments, as they may need a validated, behavior-based pain assessment/monitor scale.
- 7 Review PRN pain medication usage.**

Each resident's *Pro Re Nata* (PRN) pain medication usage should be monitored. Change to a regularly scheduled medication when there is a pattern of consistent PRN pain medication usage. PRN pain medication usage should be documented at least monthly by either nursing or pharmacy professionals.
- 8 Prevent or reduce pain by giving pain medication before an activity, therapy, treatments (e.g., wound care) or after a fall.**

Remember: Coding for pain on the MDS should not be automatic when meds are given to prevent pain. If pain is mild or absent at the time of the MDS assessment, rate the pain at that level.
- 9 Use pharmacological and non-pharmacological pain treatments for each resident.**

Non-pharmacological treatments such as range-of-motion exercise, heat therapy, whirlpool, art/music therapy, aroma therapy, distraction, etc., may reduce the dosage or frequency of pharmacological treatments. Delivery of some non-pharmacological interventions for pain management may be shared by other interdisciplinary team members with the added benefit of improving quality of life activities.
- 10 Consult physician, resident, family and staff.**

All team members need to be consulted in pain management with care planning, monitoring, evaluating and documenting the effects of the pain management interventions. On a monthly basis, monitor your QM pain values and communicate these with all staff. Administration should let staff know they care by being aware and supportive of pain management initiatives.

Percent of Residents Who Self-Report Moderate to Severe Pain (Long Stay) Quality Measure Cheat Sheet

MDS Target Assessment Used:

- Most recent three months of long stay period (>101 days in facility episode)
- Reason for assessment: Admission, quarterly, annual or significant change in status

MDS Prior Assessment Used:

- Latest assessment that is 46-165 days before target assessment
- Reason for assessment: Admission, quarterly, annual or significant change in status

Numerator:

A resident will trigger this measure if on their most recent Minimum Data Set (MDS) 3.0 Target Assessment the resident reports ONE of the following in the five-day look-back period:

- Almost constant or frequent pain **and** at least one episode of moderate to severe pain (pain frequency)
- OR**
- Resident reports very severe/horrible pain of any frequency (pain intensity)

Denominator:

All residents with a target assessment after exclusions are applied

Exclusions:

- The target assessment is an admission, a prospective payment system (PPS) five-day assessment or a PPS readmission/return assessment
- Resident is not included in the numerator if any of the following conditions are true:
 - Pain assessment interview not completed
 - Pain presence item was not completed
 - Pain frequency item was not completed
 - Pain intensity item was not completed

Note: If a long-stay resident is unable to participate in the pain assessment interview, then the resident will NOT trigger the quality measure.

Covariates: This quality measure is risk-adjusted using the following elements.

(See Quality Measures User's Manual)

- Indicator of independence or modified independence in daily decision making on the prior assessment
- Impaired cognitive skills for daily decision making
- Summary score on BIMS or
- Covariant values are missing because no prior assessment is available.

Comparing Your Practice Pain Management – Long-Stay Residents

Name of Facility: _____

Date Reviewed: ____/____/20____

- DIRECTIONS:**
1. Enter the resident's clinical record identification number or initials.
 2. Review the clinical record for evidence of each practice.
 3. Enter a "Y" if the best practice is used and an "N" if it is not used. (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.

	Clinical Record										TALLY		%
	1	2	3	4	5	6	7	8	9	10	# Yes	Total #	
Enter Resident's Clinical Record ID # or Initials													
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 is indicated in screening process, comprehensive pain assessment is completed and includes evaluation of pain intensity, character, frequency, location, duration, aggravating and alleviating factors, medical history, analgesic history, ADL performance and psychosocial function													
3. If pain is 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 is present, care plan includes a comfort goal defined by resident/family member													
5. If pain is 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 (e.g., bathing), resident is receiving regularly scheduled analgesics													
7. If pain is present, care plan includes non-pharmacological as well as pharmacological interventions													
8. When analgesic is administered or non-pharmacological treatment is initiated, effectiveness of intervention and resident comfort level is evaluated at appropriate intervals													
9. Care plan includes interventions to ameliorate actual/potential untoward side effects from analgesics													
10. If pharmacological/non-pharmacological interventions are ineffective, communication with physician for change is documented													
11. All residents are monitored shiftily for the presence of pain													