Ontario

Pain Management
Inspection Guide

This Inspection Guide provides ***guidance*** to the inspector during the initial planning of an inspection. Not all sections will be applicable in every situation and the inspector may need to adjust the inspection based on information collected.

PROFILE FOR RESIDENT

- Name, room number, home area
- Date of birth, date of admission, date of discharge (if applicable)
- Diagnoses
- Other resident information, as applicable: Physician, SDM, Advanced Directives, Activities of Daily Living, and RAI-MDS Outcome Scores, e.g., CPS, Pain (0-3, higher score = increased severity)

CLINICAL RECORD REVIEW (ELECTRONIC AND HARD COPY)

ASSESSMENTS

- RAI-MDS - Section J (Pain Frequency & Intensity), Section O (Medications/Analgesics)
- Pain management assessments, including for cognitively impaired residents (software generated, PAINAD)
- Assessments are consistent and complement each other.
- Consultations – pain specialist, Therapies (PT/OT, restorative), Skin and Wound
- Documentation of care (flow sheets, tasks)

PLAN OF CARE

- Plan of care focus based on assessments – Pain focus, goals and interventions, medical and non-pharmaceutical
- Evidence of revisions if changes and/or ineffective

MEDICATION ADMINISTRATION RECORD (MAR)

- Pain medication ordered - routine and PRN (review administration record, given as prescribed)
- Evidence of physician reviews – (Three Month Medication Review and orders)

- Evidence of medication changes as per assessments

TREATMENT ADMINISTRATION RECORD (TAR)

- Pain treatments ordered - routine and PRN (review administration record, given as prescribed)
- Evidence of physician reviews – (Three Month Medication Review and orders)
- Evidence of treatment changes as per assessments

PROGRESS NOTES

- Effectiveness of medications – routine and PRN - alternatives trialed if ineffective
- Entries related to pain, pain management, physician involvement, resident/SDM involvement
- Entries related to referrals, consultative notes (internal and external)

OBSERVATIONS

- Conduct observations at varying times, e.g., before care, after care, during programs, resting, and dining
- Observe what the resident is doing, e.g., signs of pain-facial grimacing, moaning, irritability, rubbing a specific area, restless, and verbalizations
- Observe for interventions implemented as per the plan of care, e.g., administration of medications and treatments (including non-pharmacological), assistive aids, transferring, and care provided

INTERVIEWS

RESIDENT/SDM

- Discuss if experiences pain, request details, e.g., where located, severity.
- Discuss measures implemented for pain management and what care is provided to them to assist with their pain and the effectiveness; explore if any concerns.

DIRECT CARE STAFF

Care Aids, PSW, RPN, RN

- Discuss how staff are made aware of a resident's care needs and preferences and how made aware of changes, e.g., plan of care, shift reports etc.
- Discuss what education and training received (including additional training) on pain management, e.g., policies, evidence-based assessments utilized, approaches, additional supports available (specialists), pain committee, etc.
- Confirm their familiarity of the resident and their plan of care.
- Confirm the staff members awareness of the resident's change in condition, assessments completed, and the strategies/interventions implemented.
- Explore if there are approaches and tools used in the monitoring of the resident's condition and care provided – where documented.
- Explore if there were identified concerns with the resident's pain management.
- Discuss the involvement of the physician, SDM, other disciplines and/or external resources – referral process and use of additional resources.

OTHER STAFF

Program Lead, Physician, NP, specialty consultations, PT/OT, restorative, activation

- Discuss their role in the pain management program.
- Discuss the residents pain management, e.g., assessments, orders, care provided, monitoring, follow up completed.

MANAGEMENT

Director of Care, Administrator/Delegate

- Discuss the Pain Management program – who is involved, and processes to be implemented.
- Discuss contents of staffs training on pain management, the policy and the evaluation of the program.
- Discuss the legislative areas of concern, if identified.

OTHER RECORD REVIEW

- CI report, if applicable – internal investigation notes
- Complaint log – pertaining to resident or pain management
- Relevant policies – Pain Management Program, Medications, Plan of Care
- Staff education and training records for pain management
- Annual evaluation for Pain Management Program

FOR FURTHER GUIDANCE

Please refer to policies, guidance documents, and job aids available in the eInspectors' Handbook.