

Staff Assessment for Pain.

J0800. Indicators of Pain or Possible Pain in the last 5 days

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Check all that apply

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A. Non-verbal sounds (e.g., crying, whining, gasping, moaning, or groaning)

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B. Vocal complaints of pain (e.g., that hurts, ouch, stop)

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C. Facial expressions (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)

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D. Protective body movements or postures (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)

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Z. None of these signs observed or documented → If checked, skip to J1100, Shortness of Breath (dyspnea)

Item Rationale

Health-related Quality of Life

- Residents who cannot verbally communicate about their pain are at particularly high risk for under-detection and undertreatment of pain.
- Severe cognitive impairment may affect the ability of residents to verbally communicate, thus limiting the availability of self-reported information about pain. In this population, fewer complaints may not mean less pain.
- Individuals who are unable to verbally communicate may be more likely to use alternative methods of expression to communicate their pain.
- Even in this population some verbal complaints of pain may be made and should be taken seriously.

Planning for Care

- Consistent approach to observation improves the accuracy of pain assessment for residents who are unable to verbally communicate their pain.
- Particular attention should be paid to using the indicators of pain during activities when pain is most likely to be demonstrated (e.g., bathing, transferring, dressing, walking and potentially during eating).
- Staff must carefully monitor, track, and document any possible signs and symptoms of pain.
- Identification of these pain indicators can:
 - provide a basis for more comprehensive pain assessment,
 - provide a basis for determining appropriate treatment, and
 - provide a basis for ongoing monitoring of pain presence and treatment response.
- If pain indicators are present, assessment should identify aggravating/alleviating factors related to pain.

J0800: Indicators of Pain (cont.)

Steps for Assessment

1. **Review the medical record** for documentation of each indicator of pain listed in J0800 that occurred in the last 5 days. If the record documents the presence of any of the signs and symptoms listed, confirm your record review with the direct care staff on all shifts who work most closely with the resident during activities of daily living (ADL).
2. **Interview staff** because the medical record may fail to note all observable pain behaviors. For any indicators that were not noted as present in medical record review, interview direct care staff on all shifts who work with the resident during ADL. Ask directly about the presence of each indicator that was not noted as being present in the record.
3. **Observe resident** during care activities. If you observe additional indicators of pain in the last 5 days code the corresponding items.
 - Observations for pain indicators may be more sensitive if the resident is observed during ADL, or wound care.

Coding Instructions

Check all that apply in the last 5 days based on staff observation of pain indicators.

- If the medical record review and the interview with direct care providers and observation on all shifts provide no evidence of pain indicators, Check J0800Z, None of these **signs observed or documented**, and proceed to the **Shortness of Breath** item (J1100).
- **Check J0800A, nonverbal sounds:** included but not limited to if crying, whining, gasping, moaning, or groaning were observed or reported in the last 5 days.
- **Check J0800B, vocal complaints of pain:** included but not limited to if the resident was observed to or reported to have made vocal complaints of pain (e.g. "that hurts," "ouch," or "stop") in the last 5 days.
- **Check J0800C, facial expressions:** included but not limited to if grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw were observed or reported in the last 5 days.
- **Check J0800D, protective body movements or postures:** included but not limited to if bracing, guarding, rubbing or massaging a body part/area, or clutching or holding a body part during movement were observed or reported in the last 5 days.

DEFINITIONS

NON VERBAL SOUNDS

e.g., crying, whining, gasping, moaning, groaning or other audible indications associated with pain.

VOCAL COMPLAINTS OF PAIN

e.g., "That hurts," "ouch," "stop," etc.

FACIAL EXPRESSIONS THAT MAY BE INDICATORS OF PAIN

e.g., grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw, etc.

PROTECTIVE BODY MOVEMENTS OR POSTURES

e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement, etc.

J0800: Indicators of Pain (cont.)

- **Check J0800Z, none of these signs observed or documented:** if none of these signs were observed or reported in the last 5 days.

Coding Tips

- Behavior change, depressed mood, rejection of care and decreased activity participation may be related to pain. These behaviors and symptoms are identified in other sections and not reported here as pain screening items. However, the contribution of pain should be considered when following up on those symptoms and behaviors.

Examples

1. Resident P has advanced dementia and is unable to verbally communicate. A note in their medical record documents that they have been awake during the last night crying and rubbing their elbow. When you go to their room to interview the certified nurse aide (CNA) caring for them, you observe Resident P grimacing and clenching their teeth. The CNA reports that they have been moaning and said “ouch” when the CNA tried to move their arm.

Coding: Nonverbal Sounds item (J0800A); Vocal Complaints of Pain item (J0800B); Facial Expressions item (J0800C); and Protective Body Movements or Postures item (J0800D), would be **checked**.

Rationale: Resident P has demonstrated vocal complaints of pain (ouch), nonverbal sounds (crying and moaning), facial expression of pain (grimacing and clenched teeth), and protective body movements (rubbing their elbow).

2. Resident M has end-stage Parkinson’s disease and is unable to verbally communicate. There is no documentation of pain in their medical record in the last 5 days. The CNAs caring for them report that on some mornings they moan and wince when their arms and legs are moved during morning care. During direct observation, you note that Resident M cries and attempts to pull their hand away when the CNA tries to open the contracted hand to wash it.

Coding: Nonverbal Sounds items (J0800A); Facial Expressions item (J0800C); and Protective Body Movements or Postures item (J0800D), would be **checked**.

Rationale: Resident M has demonstrated nonverbal sounds (crying, moaning); facial expression of pain (wince), and protective body movements (attempt to withdraw).

3. Resident E has been unable to verbally communicate following a massive cerebrovascular accident (CVA) several months ago and has a Stage 3 pressure ulcer. There is no documentation of pain in their medical record. The CNA who cares for them reports that they do not seem to have any pain. You observe the resident during their pressure ulcer dressing change. During the treatment, you observe groaning, facial grimaces, and a wrinkled forehead.

Coding: Nonverbal Sounds item (J0800A), and Facial Expressions item (J0800C), would be **checked**.

Rationale: The resident has demonstrated nonverbal sounds (groaning) and facial expression of pain (wrinkled forehead and grimacing).

J0800: Indicators of Pain (cont.)

Examples (cont.)

4. Resident S is in a persistent vegetative state following a traumatic brain injury. They are unable to verbally communicate. There is no documentation of pain in their medical record in the last 5 days. The CNA reports that they appear comfortable whenever the CNA cares for them. You observe the CNA providing morning care and transferring them from bed to chair. No pain indicators are observed at any time.

Coding: None of These Signs Observed or Documented item (J0800Z), would be **checked**.

Rationale: All steps for the assessment have been followed and no pain indicators have been documented, reported or directly observed.