Long-Term Care Survey Alert

Resident Assessment: Get A Jumpstart On Your Pain Assessments

The draft F309 survey guidance suggests using this approach.

If you're looking for a little memory aid to ensure staff performs a complete pain assessment, consider using a mnemonic. The **Centers for Medicare & Medicaid Services'** draft F309 survey guidance for pain management suggests doing a thorough pain history, including a detailed description or symptom analysis, such as the one below:

P: Palliative and/or provocative factors

Q: Quality of pain (burning, stabbing, aching, etc.) and impact on quality of life (e.g., functioning, sleep, appetite, and mood)

R: Region of body affected

R: Radiation (where it spreads from its origin)

S: Severity of pain (e.g., 0-10 scale; verbal descriptor scale)

T: Timing of pain (e.g., after meals, in the morning, frequency, duration, etc.)

T: Treatments tried

A: Associated symptoms (e.g., shortness of breath, chest pressure, inflammation, warmth, tenderness).

Also: The effectiveness of past efforts to relieve pain; and satisfaction with current pain management.