**Licensed Nurse Competency Checklist-Pain Management**

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**Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Title:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Hire Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| **Skill Area** | | **Evaluation**  **(Check One)** | | **Method of Evaluation**  **(Check One)**  D = Skills Demonstration  O = Performance Observation  W = Written Test  V = Verbal Test | | | | **Verification**  **(Initials/Date)** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Competency**  **Demonstrated/**  **Meets**  **Standards** | **Needs Additional Training** |
| **D** | **O** | **W** | **V** |
| **Evaluator complete Licensed Nurse Competency Checklist-Pain Management** | Demonstrates involvement of resident/resident representative in the development of the care plan and defining the approaches and goals |  |  |  |  |  |  |  |
| Observes for signs and symptoms of pain:   * Verbal * Non-verbal and, * Cognitively impaired residents who cannot verbalize their pain and for effectiveness of interventions for pain. |  |  |  |  |  |  |  |
| Demonstrates and utilizes non-pharmacologic and pharmaceutical interventions pain |  |  |  |  |  |  |  |
| Describes the pain scale used in facility |  |  |  |  |  |  |  |
| Describes the relationship to pain and function |  |  |  |  |  |  |  |
| Describes situations when pain should be anticipated and how to identify individualized interventions |  |  |  |  |  |  |  |
| Is able to verbalize common adverse consequences associated with pain medications   * Constipation * Unusual or slow respiratory rate * Drowsiness * Nausea * Confusion * Itching * Headache * Other |  |  |  |  |  |  |  |
| Is able to describe the following definitions:   * Adverse consequences * Medication Assisted Treatment * Opioid Use Disorder (OUD) |  |  |  |  |  |  |  |
| Is able to describe the appropriate use, risks, effects and consequences with the use of opioids for pain management |  |  |  |  |  |  |  |
| Is able to describe the side effects for which residents should be monitored for when taking opioids |  |  |  |  |  |  |  |
| Is able to identify facility protocol for prn pain medication administration documentation and follow up (Characteristics of pain, location, frequency, duration, etc.), selection of medication options and the protocol for evaluating results of medication |  |  |  |  |  |  |  |
| Describes protocol for resident refusal of care or medications for pain management |  |  |  |  |  |  |  |
| Demonstrates proper MDS 3.0 Coding for Sections (if applicable):   * Section J |  |  |  |  |  |  |  |
| Monitors for the emergence or presence of adverse events related to pain medication and/or interventions. |  |  |  |  |  |  |  |
| Verbalizes understanding of Federal Requirements of Participation as it relates to pain management:   * Dignity(F550); * Right to be informed and make treatment decisions (F552); * Right to refuse (F578); * Advance Directives CA (F561); * Notification of change (F580); * Accommodation of needs, call system (Environment task & F558); * Be provided by qualified persons (F659); * Pressure ulcer (F686); * Nutrition (F692); * Hydration (F692); * Sufficient and Competent Staffing (Task & F725); * Unnecessary Medications (F757); * Infection Control (Task & F880); * Medical director (F841); * Resident Records (F842); and * QA&A QAPI (Task F868); |  |  |  |  |  |  |  |
| Licensed nurse demonstrates documentation responsibilities:   * Assessment Process including pain assessment * History of addiction, treatment for OUD * Inclusion of therapy in pain assessment * RAI Process * Care Plan Development, Implementation and Revisions * Communication * Etc. |  |  |  |  |  |  |  |
| Maintains or modifies approaches for persistent pain |  |  |  |  |  |  |  |
| Verbalizes facility policy and procedure in the event of an opioid overdose |  |  |  |  |  |  |  |
| Demonstrates ability to coordinate the resident’s care and monitor the outcomes with hospice if applicable |  |  |  |  |  |  |  |
| **Other (Describe)** |  |  |  |  |  |  |  |  |
| **Other (Describe)** |  |  |  |  |  |  |  |  |

**\*I certify that I have received orientation in the above-mentioned areas.**

**\*Employee:**

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**Initials**  **Signature**  **Date**

**Evaluator/Trainer:**

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**Initials Signature Date**

***(PLACE IN EMPLOYMENT FILE)***

**References:**

* Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17) Advance Copy 6/29/22: <https://www.cms.gov/files/document/appendix-pp-guidance-surveyor-long-term-care-facilities.pdf>
* LTC Survey Pathways (Download) Critical Element Pathways, Pain Recognition and Management Critical Element Pathway, CMS-20076, 5/2017: <https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes.html>