

**PAIN MANAGEMENT  
CHART REVIEW**

Medical Record # \_\_\_\_\_

Date of Review \_\_\_\_\_

1. Diagnoses related to pain \_\_\_\_\_
2. List all regular scheduled and PRN meds used for pain control
- | medication | dose/route | frequency | date ordered or dosage changed | if PRNs # of doses in last 30 days |
|------------|------------|-----------|--------------------------------|------------------------------------|
|            |            |           |                                |                                    |
|            |            |           |                                |                                    |
|            |            |           |                                |                                    |

3. Follow up documentation of PRNs complete      yes \_\_\_\_\_ no \_\_\_\_\_
4. Were PRNs effective      yes \_\_\_\_\_ no \_\_\_\_\_  
if no, was plan of care changed      yes \_\_\_\_\_ no \_\_\_\_\_
5. Any increases in # of PRNs used      yes \_\_\_\_\_ no \_\_\_\_\_  
if yes, was plan of care changed      yes \_\_\_\_\_ no \_\_\_\_\_
6. Any consistent (almost daily) uses/trends for PRN use noted      yes \_\_\_\_\_ no \_\_\_\_\_  
if yes, was plan of care changed      yes \_\_\_\_\_ no \_\_\_\_\_
7. Any contraindicated meds ordered      yes \_\_\_\_\_ no \_\_\_\_\_  
if yes, was plan of care changed      yes \_\_\_\_\_ no \_\_\_\_\_  
physician response \_\_\_\_\_

8. Comprehensive pain assessment current      yes \_\_\_\_\_ no \_\_\_\_\_
9. Does comprehensive pain assessment match pain section of MDS      yes \_\_\_\_\_ no \_\_\_\_\_  
if no, explain \_\_\_\_\_

10. Does the care plan address:
- |                                    |                    |
|------------------------------------|--------------------|
| goal as defined by the resident    | yes _____ no _____ |
| non-pharmacological approaches     | yes _____ no _____ |
| if chronic pain, routine meds used | yes _____ no _____ |
| to keep resident mobile            | yes _____ no _____ |
| positioning needs                  | yes _____ no _____ |
| evaluating response to pain meds   | yes _____ no _____ |
| reassessment of pain               | yes _____ no _____ |
| education to resident/family of    |                    |
| pain management/tx plan            | yes _____ no _____ |
| education to resident/family of    |                    |
| potential side effects of meds     | yes _____ no _____ |

11. List all corrective actions taken to address areas of concern identified through this audit \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Signature and Date Completed \_\_\_\_\_

