**Nursing Assistant Competency Checklist-Pain Management**

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

| **Skill Area** | **Evaluation****(Check One)** | **Method of Evaluation****(Check One)**D = Skills DemonstrationO = Performance ObservationW = Written TestV = Verbal Test | **Verification** **(Initials/Date)** |
| --- | --- | --- | --- |
| **Competency****Demonstrated/****Meets** **Standards** | **Needs Additional Training** |
| **D** | **O** | **W** | **V** |
| **Evaluator complete Nursing Assistant Competency Checklist-Pain Management** | Monitors the resident for any complaints, or exhibits any signs or symptoms of pain |  |  |  |  |  |  |  |
| Understands verbal and non-verbal indicators of pain |  |  |  |  |  |  |  |
| Communicates to nurseif there is a report from the resident, family, or other staff that the resident is experiencing pain  |  |  |  |  |  |  |  |
| Participates/shares information for revisions to the care plan if the interventions did not work |  |  |  |  |  |  |  |
| Verbalizes the importance of allowing time as indicated in the care plan for pain medication prior to interventions that are identified:* ADL care
* Restorative Nursing procedures
* Etc.
 |  |  |  |  |  |  |  |
| Demonstrate /verbalizes reporting the resident’s complaints and signs or symptoms of pain |  |  |  |  |  |  |  |
| Verbalizes how to observe for non-verbal indicators of pain for residents unable to verbalize or if cognitively impaired. |  |  |  |  |  |  |  |
| Knows the non-pharmacologic interventions that are on the resident’s care plan for pain/discomfort and demonstrates their use |  |  |  |  |  |  |  |
| Demonstrates / verbalizesunderstanding of resident preference. |  |  |  |  |  |  |  |
| Nursing Assistant demonstrates documentation responsibilities:* Care Plan Interventions
* Etc.
 |  |  |  |  |  |  |  |
| **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:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

**Initials Signature Date**

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

**References:**

Centers for Medicare and Medicaid Services (CMS) State Operations Manual, Appendix PP-Guidance to Surveyors for Long Term Care Facilities. (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf>

Centers for Medicare and Medicaid Services (CMS) Pain Management Critical Element Pathway, Form CMS 20076: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html>