

Published for Joint Commission-accredited organizations and interested health care professionals, *R³ Report* provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also may provide a rationale, *R³ Report* goes into more depth, providing a rationale statement for each element of performance (EP). The references provide the evidence that supports the requirement. *R³ Report* may be reproduced if credited to The Joint Commission. Sign up for [email](#) delivery.

Pain assessment and management standards for hospitals

Effective Jan. 1, 2018, new and revised pain assessment and management standards will be applicable to all Joint Commission-accredited hospitals. These standards — in the Leadership (LD); Medical Staff (MS); Provision of Care, Treatment, and Services (PC); and Performance Improvement (PI) chapters of the hospital accreditation manual — are designed to improve the quality and safety of care provided by Joint Commission-accredited hospitals. The new and revised standards accomplish this by requiring hospitals to:

- Identify pain assessment and pain management, including safe opioid prescribing, as an organizational priority (LD.04.03.13).
- Actively involve the organized medical staff in leadership roles in organization performance improvement activities to improve quality of care, treatment, and services and patient safety (MS.05.01.01).
- Assess and manage the patient’s pain and minimize the risks associated with treatment (PC.01.02.07).
- Collect data to monitor its performance (PI.01.01.01).
- Compile and analyze data (PI.02.01.01).

Engagement with stakeholders, customers, and experts

As part of a national effort to address the opioid crisis and increase the quality and safety of patients, The Joint Commission began a project to revise its pain assessment and management standards in 2016. In addition to an extensive literature review and public field review, research undertaken included the following:

- A [technical advisory panel \(TAP\)](#) representing members of leading health care organizations to discuss innovative, high-quality, safe initiatives in the field of pain assessment and management.
- Learning visits at hospitals to research leading practices in pain assessment and management and the safe use of opioids.
- A [standards review panel \(SRP\)](#) to review draft pain assessment and management standards. These representatives from organizations or professional associations provided a “boots on the ground” point of view and insights into the practical application of the proposed standards.

The prepublication version of the [pain assessment and management standards](#) will be available online until the end of 2017. After Jan. 1, 2018, access the standards in the E-dition or standards manual.

Leadership

LD.04.03.13: Pain assessment and pain management, including safe opioid prescribing, is identified as an organizational priority for the hospital.

Requirement	EP 1: The hospital has a leader or leadership team that is responsible for pain management and safe opioid prescribing and develops and monitors performance improvement activities. (See also PI.02.01.01, EP 19)
Rationale	Leadership engagement in the oversight of pain management supports safe and effective practice and sustainable improvements across the various disciplines and departments involved in pain assessment, pain management and opioid prescribing.

Reference*	<ul style="list-style-type: none"> • Kaplan HC, et al. The Model for Understanding Success in Quality (MUSIQ): Building a Theory of Context in Healthcare Quality Improvement. <i>BMJ Quality & Safety</i>, 2012;21(1):13-20. • Quality Improvement. U.S. Department of Health and Human Services Health Resources and Services Administration. April 2011. • Chassin MR and Loeb JM. High-Reliability Health Care: Getting There from Here. <i>The Milbank Quarterly</i>, 2013;91(3):459-90
Requirement	EP 2: The hospital provides nonpharmacologic pain treatment modalities.
Rationale	While evidence for some nonpharmacologic modalities is mixed and/or limited, they may serve as a complementary approach for pain management and potentially reduce the need for opioid medications in some circumstances. The hospital should promote nonpharmacologic modalities by ensuring that patient preferences are discussed and, at a minimum, providing some nonpharmacologic treatment options relevant to their patient population. When a patient's preference for a safe nonpharmacologic therapy cannot be provided, hospitals should educate the patient on where the treatment may be accessed post-discharge. Nonpharmacologic strategies include, but are not limited to: physical modalities (for example, acupuncture therapy, chiropractic therapy, osteopathic manipulative treatment, massage therapy, and physical therapy), relaxation therapy, and cognitive behavioral therapy.
Reference*	<ul style="list-style-type: none"> • Sullivan D, et al. Exploring Opioid-Sparing Multimodal Analgesia Options in Trauma: A Nursing Perspective. <i>Journal of Trauma Nursing</i>, 2016;23(6):361-375. • Chou R, et al. Management of Postoperative Pain: A Clinical Practice Guideline from the American Pain Society, the American Society of Regional Anesthesia and Pain Medicine, and the American Society of Anesthesiologists' Committee on Regional Anesthesia, Executive Committee, and Administration Council. <i>The Journal of Pain</i>, 2016;17(2):131-157. • Gelinac C, et al. Patients and ICU Nurses' Perspective of Non-Pharmacological Interventions for Pain Management. <i>Nursing in Critical Care</i>, 2013;18(6):307-18. • Skolasky RL, et al. Health Behavior Change Counseling in Surgery for Degenerative Lumbar Spinal Stenosis. Part I: Improvement in Rehabilitation Engagement and Functional Outcomes. <i>Archives of Physical Medicine and Rehabilitation</i>, 2015;96(7):1200-07. • Rubinstein SM, et al. Spinal Manipulative Therapy for Acute Low-back Pain. <i>Cochrane Database of Systematic Reviews</i>, 2012. • Task Force on the Low Back Pain Clinical Practice Guidelines. American Osteopathic Association Guidelines for Osteopathic Manipulative Treatment (OMT) for Patients with Low Back Pain. <i>Journal of American Osteopathic Association</i>, 2016;116(8):536-49. • Walker BF, et al. Combined Chiropractic Interventions for Low-Back Pain. <i>Cochrane Database of Systematic Reviews</i>, 2010. • Wu MS, et al. The Efficacy of Acupuncture in Post-Operative Pain Management: A Systematic Review and Meta-analysis. <i>PLOS One</i>, 2016.
Requirement	EP3: The hospital provides staff and licensed independent practitioners with educational resources and programs to improve pain assessment, pain management, and the safe use of opioid medications based on the identified needs of its patient population.
Rationale	The technical advisory panel for The Joint Commission's pain standards review project recommended that organizations have readily available educational resources that staff and licensed independent practitioners can use to review pain assessment and pain management principles based on their specific specialty or even a specific clinical situation that they may encounter. The panel did not think that relying solely on staff and licensed independent practitioners to attend lectures would be valuable because engagement and retention of the material is likely to be low.

Reference*	<ul style="list-style-type: none"> Forsetlund L, et al. Continuing education meetings and workshops: Effects on professional practice and health care outcomes. <i>Cochrane Database of Systematic Reviews</i>, 2009;(2):CD003030. <p>Resources:</p> <ul style="list-style-type: none"> Opioid-Induced Ventilatory Impairment video (APSF) SAFE Opioid Prescribing: Strategies. Assessment. Fundamentals. Education. (ACP)
Requirement	EP 4: The hospital provides information to staff and licensed independent practitioners on available services for consultation and referral of patients with complex pain management needs.
Rationale	Many patients have complex pain management needs, including the opioid-addicted patient undergoing major surgery, the patient who is at high risk for adverse events (e.g., sleep apnea) and who requires treatment with opioids, or a patient whose pain management needs exceed the expertise of the patient's attending licensed independent practitioner. Access to pain specialists by consultation or referral reflects best practice in addressing patients with complex pain management needs.
Reference*	See the section above on "Engagement with stakeholders, customers, and experts."
Requirement	EP 5: The hospital identifies opioid treatment programs that can be used for patient referrals.
Rationale	When clinicians encounter patients who are addicted to opioids, they need readily accessible and accurate information to refer patients for treatment. It is often difficult for individual clinicians or departments to keep up with changing provider availability in the community, and hospital leadership should be responsible for identifying community resources. To help health care organizations do this, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) has a directory of opioid treatment programs.
Reference*	See the section above on "Engagement with stakeholders, customers, and experts." Resources:
	<ul style="list-style-type: none"> U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) directory of opioid treatment programs
Requirement	EP 6: The hospital facilitates practitioner and pharmacist access to the Prescription Drug Monitoring Program databases. Note: This element of performance is applicable in any state that has a Prescription Drug Monitoring Program database, whether querying is voluntary or is mandated by state regulations for all patients prescribed opioids.
Rationale	Prescription Drug Monitoring Programs (PDMPs) aggregate prescribing and dispensing data submitted by pharmacies and dispensing practitioners and are an effective tool for reducing prescription drug abuse and diversion. An example of facilitating access to PDMPs would be creating a link on the home page of the hospital's electronic health record (EHR) to all relevant PDMPs in the geographic areas served by the hospital. The Joint Commission did not mandate that organization's use PDMPs prior to prescribing an opioid because of the limitations of using current databases in many locations. However, some states (e.g., Massachusetts) now require use of PDMPs prior to prescribing an opioid; hospitals will be surveyed to assess compliance with state law.
Reference*	<ul style="list-style-type: none"> Patrick SW, et al. Implementation Of Prescription Drug Monitoring Programs Associated With Reduction In Opioid-Related Death Rates. <i>Health Affairs</i>, 2016;35(7):1324-32. Haffajee RL, et al. Mandatory Use of Prescription Drug Monitoring Programs. <i>Journal of the American Medical Association</i>; 2015;313(9):891-92.
	EP 7: Hospital leadership works with its clinical staff to identify and acquire the equipment needed to monitor patients who are at high risk for adverse outcomes from opioid treatment.

Rationale	The most dangerous adverse effect of opioid analgesics is respiratory depression, and monitoring for respiratory depression is sometimes appropriate. However, there are no controlled trials of monitoring to help determine the optimal strategy. Therefore, this decision should be left to the treating clinical team. The leadership team should work with clinician leaders to ensure equipment is available to monitor patients deemed highest risk (e.g., patients with sleep apnea, those receiving continuous intravenous opioids, or those on supplemental oxygen).
Reference*	<ul style="list-style-type: none"> • The Joint Commission. Safe use of opioids in hospitals. <i>Sentinel Event Alert</i>, 2012;49. • Frederickson TW, et al. Reducing Adverse Drug Events Related to Opioids Implementation Guide. Philadelphia: Society of Hospital Medicine, 2015. • Jarzyna D, et al. American Society for Pain Management Nursing Guidelines on Monitoring for Opioid-Induced Sedation and Respiratory Depression. <i>Pain Management Nursing: Official Journal of the American Society of Pain Management Nurses</i>, American Society for Pain Management Nursing, 2011;12(3):118-45.

Medical Staff

MD.05.01.01: The organized medical staff has a leadership role in organization performance improvement activities to improve quality of care, treatment, and services and patient safety.

Requirement	EP 18: The medical staff is actively involved in pain assessment, pain management, and safe opioid prescribing through the following: <ul style="list-style-type: none"> - Participating in the establishment of protocols and quality metrics - Reviewing performance improvement data
Rationale	Medical staff involvement in establishing protocols and reviewing performance improvement data improves the overall safety and quality of care.
Reference*	<ul style="list-style-type: none"> • Sutter ME, et al. The Changing Use of Intravenous Opioids in an Emergency Department. <i>Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health</i>, 2015;16(7). • Quality Improvement. U.S. Department of Health and Human Services Health Resources and Services Administration. April 2011.

Provision of Care, Treatment, and Services

PC.01.02.07: The hospital assesses and manages the patient's pain and minimizes the risks associated with treatment.

Requirement	EP 1: The hospital has defined criteria to screen, assess, and reassess pain that are consistent with the patient's age, condition, and ability to understand.
Rationale	An accurate screening and assessment is required for satisfactory pain management, and the hospital is responsible for ensuring that appropriate screening and assessment tools are readily available and used appropriately. The tools required to adequately assess pain may differ depending on a patient's age, condition, and ability to understand. For example, adult intensive care unit (ICU) patients who are unable to self-report and pediatric patients require the use of alternative assessment tools.
Reference*	<ul style="list-style-type: none"> • Gelinas C, et al. Patients and ICU Nurses' Perspective of Non-Pharmacological Interventions for Pain Management. <i>Nursing in Critical Care</i>, 2013;18(6):307-18. • Vael A and Whitted K. An Educational Intervention to Improve Pain Assessment in Preverbal Children. <i>Pediatric Nursing</i>, 2014;40(6):301-06.
Requirement	EP 2: The hospital screens patients for pain during emergency department visits and at the time of admission.
Rationale	The misidentification and under-treatment of pain continues to occur in hospitals. When a patient presents to the hospital for other medical issues, pain may be

	overlooked or missed. Screening patients for pain or the risk of pain at the time of admission will help to improve pain identification and treatment.
Reference*	<ul style="list-style-type: none"> McFarland DC, et al. Predictors of Patient Satisfaction with Inpatient Hospital Pain Management across the United States: A National Study. <i>Journal of Hospital Medicine</i>, 2016;11(7):498-501. Pierik JGJ, et al. Painful Discrimination in the Emergency Department: Risk Factors for Underassessment of Patient's Pain by Nurses. <i>Journal of Emergency Nursing</i>, 2017;43(3):228-238.
Requirement	EP 3: The hospital treats the patient's pain or refers the patient for treatment. Note: Treatment strategies for pain may include nonpharmacologic, pharmacologic, or a combination of approaches.
Rationale	Referrals may be required for patients who present with complex pain management needs, such as the opioid-addicted patient, the patient who is at high risk for adverse events and who requires treatment with opioids, or a patient whose pain management needs exceed the expertise of the patient's attending licensed independent practitioner.
Reference*	<ul style="list-style-type: none"> Glowacki D. Effective Pain Management and Improvements in Patients' Outcomes and Satisfaction. <i>Critical Care Nurse</i>, 2015;35(3):33-43.
Requirement	EP 4: The hospital develops a pain treatment plan based on evidence-based practices and the patient's clinical condition, past medical history, and pain management goals.
Rationale	Pain management strategies should reflect a patient-centered approach. The patient's right to pain management (see Standard RI.01.01.01, EP8) is an essential aspect of quality and safety. During screenings (and assessment as indicated) the patient's identified needs and pain management goals are discussed.
Reference*	<ul style="list-style-type: none"> Stacey D, et al. Decision Aids for People Facing Health Treatment or Screening Decisions. <i>The Cochrane Database of Systematic Reviews</i>, 2014;1:CD001431. Kramer MHH, et al. The Changing Face of Internal Medicine: Patient Centred Care. <i>European Journal of Internal Medicine</i>, 2014;25(2):125-27. The Joint Commission. <i>Comprehensive Accreditation Manual for Hospitals: Patient Rights</i> chapter. January 2017.
Requirement	EP 5: The hospital involves patients in the pain management treatment planning process through the following: <ul style="list-style-type: none"> - Developing realistic expectations and measurable goals that are understood by the patient for the degree, duration, and reduction of pain - Discussing the objectives used to evaluate treatment progress (for example, relief of pain and improved physical and psychosocial function) - Providing education on pain management, treatment options, and safe use of opioid and nonopioid medications when prescribed
Rationale	Patient involvement in planning pain management involves information sharing and collaboration between the patient and provider to arrive at realistic expectations and clear goals. Numerous patient factors may cause undertreatment or overtreatment of pain, such as pain expectations, knowledge of pain and its treatment, and underreporting of pain. Patient involvement in the pain management planning process allows the provider to clarify the objectives of the process, and guide patients in a manner that increases the likelihood of treatment adherence.
Reference*	<ul style="list-style-type: none"> Moseley GL and Butler DS. Fifteen Years of Explaining Pain: The Past, Present, and Future. <i>The Journal of Pain</i>, 2015;16(9):807-13 Paschkis Z and Potter ML. Acute Pain Management for Inpatients with Opioid Use Disorder. <i>American Journal of Nursing</i>, 2015;115(9):24-32; quiz 33, 46. Oliver J, et al. American Society for Pain Management Nursing Position Statement: Pain Management in Patients with Substance Use Disorders. <i>Journal of Addictions Nursing</i>, 2012;23(3):210-22. Schiavenato M and Craig KD. Pain Assessment as a Social Transaction: Beyond the 'Gold Standard.' <i>The Clinical Journal of Pain</i>, 2010;26(8):667-76.

Requirement	EP 6: The hospital monitors patients identified as being high risk for adverse outcomes related to opioid treatment. (See also LD.04.03.13, EP 7)
Rationale	The most dangerous adverse effect of opioid analgesics is respiratory depression, and monitoring for respiratory depression is sometimes appropriate. However, there are no controlled trials of monitoring to help determine the optimal strategy. Therefore, this decision should be left to the treating clinical team. The leadership team should work with clinician leaders to ensure equipment is available to monitor patients deemed highest risk (e.g., patients with sleep apnea, those receiving continuous intravenous opioids, or those on supplemental oxygen)
Reference*	<ul style="list-style-type: none"> • The Joint Commission. Safe use of opioids in hospitals. <i>Sentinel Event Alert</i>, 2012;49. • Frederickson TW, et al. Reducing Adverse Drug Events Related to Opioids Implementation Guide. Philadelphia: Society of Hospital Medicine, 2015. • Jarzyna D, et al. American Society for Pain Management Nursing Guidelines on Monitoring for Opioid-Induced Sedation and Respiratory Depression. <i>Pain Management Nursing: Official Journal of the American Society of Pain Management Nurses</i>, American Society for Pain Management Nursing, 2011;12(3):118-45.
Requirement	EP 7: The hospital reassesses and responds to the patient's pain through the following: <ul style="list-style-type: none"> - Evaluation and documentation of response(s) to pain intervention(s) - Progress toward pain management goals including functional ability (for example, ability to take a deep breath, turn in bed, walk with improved pain control) - Side effects of treatment - Risk factors for adverse events caused by the treatment
Rationale	Reassessment should be completed in a timely manner to determine if the intervention is working or if the patient is experiencing adverse effects. Using numerical pain scales alone to monitor patients' pain is inadequate. The Joint Commission's technical advisory panel stressed the importance of assessing how pain affects function and the ability to make progress towards treatment goals. For example, immediately after major abdominal surgery the goal of pain control may be the patient's ability to take a breath without excessive pain. Over the next few days, the goal of pain control may be the ability to sit up in bed or walk to the bathroom without limitation due to pain.
Reference*	<ul style="list-style-type: none"> • Ballantyne JC and Sullivan MD. Intensity of Chronic Pain — The Wrong Metric? <i>The New England Journal of Medicine</i>, 2015;373 (22):2098-99.
Requirement	EP 8: The hospital educates the patient and family on discharge plans related to pain management including the following: <ul style="list-style-type: none"> - Pain management plan of care - Side effects of pain management treatment - Activities of daily living, including the home environment, that might exacerbate pain or reduce effectiveness of the pain management plan of care, as well as strategies to address these issues - Safe use, storage, and disposal of opioids when prescribed
Rationale	During the discharge process, patients and families need education on the importance of how to manage the patient's pain at home. Unmanaged pain may cause a patient to regress in their recovery process or have uncontrolled pain at home leading to a readmission to the hospital. It is necessary to have a discussion with patients and their families regarding their home environment and activities of daily living that may increase the need for pain management. When a patient is being discharged with an opioid, medication education on safe use, including when and how much medication to take, should be included in the discharge plan. Opioid disposal education is also critical in order to both reduce diversion and decrease the risk of accidental exposure to someone other than the person for whom the opioid was prescribed.

Reference*	<ul style="list-style-type: none"> • Glowacki D. 2015. Effective Pain Management and Improvements in Patients' Outcomes and Satisfaction. <i>Critical Care Nurse</i>, 2015;35(3):33-43. • Jack BW, et al. A Reengineered Hospital Discharge Program to Decrease Rehospitalization: A Randomized Trial. <i>Annals of Internal Medicine</i>, 2009;150(3):178-87.
Resources	<ul style="list-style-type: none"> • U.S. Food and Drug Administration: How to Dispose of Unused Medicines. FDA Consumer Health Information. 2013.

Performance Improvement

PI.01.01.01: The hospital collects data to monitor its performance.

Requirement	EP 56: The hospital collects data on pain assessment and pain management including types of interventions and effectiveness.
Rationale	The collection and analysis of pain assessment and pain management data, including the timing of reassessments, types of interventions and effectiveness, are important in identifying areas that need change to increase safety and quality for patients. For example, data collection on the timing of reassessments may indicate a need for policy or procedure change if patient pain management needs are not being met.
Reference*	<ul style="list-style-type: none"> • Frederickson TW, et al. Reducing Adverse Drug Events Related to Opioids Implementation Guide. Philadelphia: Society of Hospital Medicine, 2015.

PI.02.01.01: The hospital compiles and analyzes data.

Requirement	EP 18: The hospital analyzes data collected on pain assessment and pain management to identify areas that need change to increase safety and quality for patients.
Rationale	The collection and analysis of pain assessment and pain management data, including the timing of reassessments, types of interventions and effectiveness, are important in identifying areas that need change to increase safety and quality for patients. For example, hospitals that have monitored the use of naloxone are able to determine areas and staff that require specific education and training related to opioid use.
Reference*	<ul style="list-style-type: none"> • Frederickson TW, et al. Reducing Adverse Drug Events Related to Opioids Implementation Guide. Philadelphia: Society of Hospital Medicine, 2015.
Requirement	EP 19: The hospital monitors the use of opioids to determine if they are being used safely (for example, the tracking of adverse events such as respiratory depression, naloxone use, and the duration and dose of opioid prescriptions).
Rationale	Monitoring the use of opioids within the hospital is critical to identifying safety and quality events. In the learning visits conducted by The Joint Commission, hospitals that tracked the use of naloxone were able to significantly reduce adverse events related to opioid use, and were able to identify areas or units within the hospital that had issues, including identifying staff who require specific education and training related to opioid use.
Reference*	<ul style="list-style-type: none"> • Frederickson TW, et al. Reducing Adverse Drug Events Related to Opioids Implementation Guide. Philadelphia: Society of Hospital Medicine, 2015.

*Not a complete literature review.