CHAPTER 12

FEDERAL INDICATORS AFFECTING THE DRUG REGIMEN REVIEW
OVERVIEW OF FEDERAL INDICATORS USED IN PERFORMING A DRUG REGIMEN REVIEW

I. Omnibus Budget Reconciliation Act (OBRA 1990) includes the “Nursing Home Standards Reform Act”. These laws are still in effect and are addressed by CMS through the Federal Interpretive Guidelines. These guidelines have evolved over the years each time raising the contributions and responsibilities of the Consultant Pharmacist

1. 1974 – Drug Regimen Review was mandated
2. 1982 – The Initial Federal Indicators were created
3. 1992 – The Unnecessary Drug were created
4. 1999 – The Quality Indicators & Beers Criteria were created
5. 2006 – Major re-write of the MRR and Unnecessary Medication Guidelines

II. Summary Of Federal Indicators Affecting The Drug Regimen Review

1. F329 – Drug Therapy Guidelines for Unnecessary Medications
2. F428 – Drug Therapy Guidelines for Medication Regimen Review
3. F425 – Pharmacy Services (if services are affecting the intended outcome)
4. F309 – Quality of Care (Pain management)

III. Unnecessary Medications (Ftag 329)

1. General. Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:
   (i) In excessive dose (including duplicate therapy); or
   (ii) For excessive duration; or
   (iii) Without adequate monitoring; or
   (iv) Without adequate indications for its use; or
   (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
   (vi) Any combinations of the reasons above.

2. Antipsychotic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that:
   (i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and
   (ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

INTENT: §483.25(l) Unnecessary drugs The intent of this requirement is that each resident’s entire drug/medication regimen be managed and monitored to achieve the following goals:
The medication regimen helps promote or maintain the resident’s highest practicable mental, physical, and psychosocial well-being, as identified by the resident and/or representative(s) in collaboration with the attending physician and facility staff;

- Each resident receives only those medications, in doses and for the duration clinically indicated to treat the resident’s assessed condition(s);
- Non-pharmacological interventions (such as behavioral interventions) are considered and used when indicated, instead of, or in addition to, medication;
- Clinically significant adverse consequences are minimized; and
- The potential contribution of the medication regimen to an unanticipated decline or newly emerging or worsening symptom is recognized and evaluated, and the regimen is modified when appropriate.

3. Monitoring for Efficacy and Adverse Consequences (Excerpts from F329)

The information gathered during the initial and ongoing evaluations is essential to:

- Incorporate into a comprehensive care plan that reflects appropriate medication related goals and parameters for monitoring the resident’s condition, including the likely medication effects and potential for adverse consequences. Examples of this information may include the FDA boxed warnings or adverse consequences that may be rare, but have sudden onset or that may be irreversible. If the facility has established protocols for monitoring specific medications and the protocols are accessible for staff use, the care plan may refer staff to these protocols;

- Optimize the therapeutic benefit of medication therapy and minimize or prevent potential adverse consequences;

- Establish parameters for evaluating the ongoing need for the medication; and

- Verify or differentiate the underlying diagnoses or other underlying causes of signs and symptoms.

The key objectives for monitoring the use of medications are to track progress towards the therapeutic goal(s) and to detect the emergence or presence of any adverse consequences.

4. Determining the frequency of monitoring (Excerpts from F329)

The frequency and duration of monitoring needed to identify therapeutic effectiveness and adverse consequences will depend on factors such as clinical standards of practice, facility policies and procedures, manufacturer’s specifications, and the resident’s clinical condition.

Monitoring involves three aspects:
- Periodic planned evaluation of progress toward the therapeutic goals;
- Continued vigilance for adverse consequences; and
- Evaluation of identified adverse consequences.
5. Duration (Excerpts from F329)

Many conditions require treatment for extended periods, while others may resolve and no longer require medication therapy.

6. Tapering of a Medication Dose/Gradual Dose Reduction (GDR) (Excerpts from F329)

The requirements underlying this guidance emphasize the importance of seeking an appropriate dose and duration for each medication and minimizing the risk of adverse consequences. The purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident.

7. F329 incorporates 9 common conditions and offers tools for monitoring and reference sources for standards of care. These conditions include:
   - Diabetes
   - Dementia (including Alzheimer’s)
   - Behavioral Symptoms associated with Dementia
   - Functional Decline
   - Delirium
   - Bipolar Disorder
   - Pain
   - Depression
   - Abnormal Movements

8. F329 reviews 70 common therapeutic classes of drugs used in geriatrics. This review includes:
   - The drugs indication
   - Methods for monitoring the drug
   - Common Drug Interactions
   - Adverse consequences of therapy
   - Identifies exemptions to the monitoring

9. The Use Of Antipsychotics (Ftag 329)

1. There must be a supporting diagnosis justifying the use of the antipsychotic

2. The facility must identify “target behaviors” (ex. striking out) that will be monitored every shift to determine if the drug is effective. This is most frequently done using a “Behavior Intervention Flow Record (see page 12.9)
   Ideally, target behaviors should decrease if the drug and dose are appropriate.
Antipsychotics (continued)

3. The dose of the antipsychotic should not exceed a daily maximum dose (defined in FTAG 329) unless the prescriber can justify the need for higher doses (based on objective data) and he/she addresses the risk vs benefit of the higher dose.

4. The patient must be monitored on a daily basis for non-movement side effects such as drowsiness, drooling, constipation etc.

5. The patient must be assessed at least every 6 months for movement side effects. The most common instrument used in LTC is the AIMS review (Abnormal involuntary movement scale). Movement disorders may include extrapyramidal symptoms (EPS) akathesia, dystonias and pseudo-parkinsonian movements) which may be an early indication of tardive dyskinesia.

*6. Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility must attempt a gradual dosage reduction (GDR) in two separate quarters (with at least one month between the attempts), unless clinically contraindicated.

*7. After the first year, a GDR must be attempted annually, unless clinically contraindicated.

*8. For any individual who is receiving an antipsychotic medication to treat behavioral symptoms related to dementia, the GDR may be considered clinically contraindicated if:

- The resident’s target symptoms returned or worsened after the most recent attempt at a GDR within the facility; and
- The physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident’s function or increase distressed behavior.

*9. For any individual who is receiving an antipsychotic medication to treat a psychiatric disorder other than behavioral symptoms related to dementia (for example, schizophrenia, bipolar mania, or depression with psychotic features), the GDR may be considered contraindicated, if:

- The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident’s function or cause psychiatric instability by exacerbating an underlying psychiatric disorder, or
The resident’s target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident’s function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.

10. In May 2013, CMS Updated FTag 329 and introduced the concept of "Individualized, person centered approaches that may help reduce potentially distressing or harmful behaviors and promote improved functional abilities and quality of life for residents"

1. These guidelines now clearly state that antipsychotic medications can only be used after all other causes of behavior - medical, emotional, environmental, etc - have been ruled out

2. This update reminds both prescribers and surveyors that antipsychotic medications commonly cause complications such as movement disorders, falls, hip fractures, cerebrovascular adverse events (CVAs and transient ischemic events) and increased the risk of death.

3. The Agency for Healthcare Research & Quality found that:
   1) EPS occurs in 1 out of every 10 patients receiving Olanzapine and 1 out of 20 receiving Risperisone.
   2) CVAs occur in 1 out of every 34 patients receiving Risperidone
   3) Cardiovascular adverse effects occur in 1 out of 53 patients taking Risperidone and 1 out of 48 patients on Olanzapine.
   4) 1 out of every 100 patients treated with an atypical antipsychotic died as a result of the result of this treatment within the 10-12 week trial.

4. There must now be clear evidence in the patient's chart that the facility has addressed with both the staff and the family potential approaches of addressing the behaviors without medication and the result of each approach.

5. Surveyors have also been trained to monitor patients who have been removed from the atypical antipsychotics who are now on alternative therapies (i.e. tranquilizers, mood stabilizers etc)

11. In December 2014 CMS established new goals for Antipsychotic Reductions

The National Partnership for the Treatment of Dementia has released data showing that the initial goal of a 15% reduction in antipsychotic use (set in 2012) for symptoms of dementia has been met. The national rate of reduction since the baseline of fourth quarter 2011 is 15.1%, with Hawaii, (31.4%) North Carolina (29.9%), Vermont (28.2%), and Georgia (28.1%) showing the highest rates of reduction. The Partnership has set now set goals of 25% reduction from baseline by the end of 2015 and 30% by the end of 2016.
10. Sedative Hypnotics (Ftag 329)

1. Evidence must exist that other possible reasons (caffeine use, depression, pain, noise etc) have been ruled out prior to using a hypnotic

2. For as long as a resident remains on a sedative/hypnotic that is used routinely during the previous quarter, the facility should attempt to taper the medication at least quarterly.

* 3 Before one can conclude that tapering is clinically contraindicated for the remainder of that year, tapering must have been attempted during the previous three quarters.

* 4. For the use of sedative/hypnotics, clinically contraindicated means that the physician has documented the clinical rationale for why any additional attempted tapering at that time would be likely to impair the resident’s function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.

* These are 2006 changes in the interpretive guidelines

11. Considerations Specific to Psychopharmacological Medications (Other Than Antipsychotics and Sedative/Hypnotics).

1. This includes: Anticonvulsants
   Tranquilizers
   Mood Stabilizers
   Psychoactive Drugs
   Anti-Alzheimers Drugs (Cholinesterase Inhibitors)

   (NOTE: Anticonvulsants & Mood stabilizers are only considered Psychopharmacologic medications if they are used for behaviors)

2. During the first year in which a resident is admitted on a psychopharmacological medication (other than an antipsychotic or a sedative/hypnotic), or after the facility has initiated such medication, the facility should attempt to taper the medication during at least two separate quarters (with at least one month between the attempts), unless clinically contraindicated.

3. After the first year, a tapering should be attempted annually, unless clinically contraindicated. The tapering may be considered clinically contraindicated, if:
• The resident’s target symptoms returned or worsened after the most recent attempt at a tapering within the facility; and
• The physician has documented the clinical rationale for why any additional attempted tapering at that time would be likely to impair the resident’s function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.

12. The Use Of Tranquilizers (Ftag 329)

1. There must be a supporting diagnosis for the use of all routine tranquilizer drugs. There should be evidence in the chart that environmental reasons for a patient’s anxiety or distress have been ruled out.

2. Long acting benzodiazepines (i.e. Chlordiazepoxide, Diazepam) should not be used in the elderly unless there is evidence that a short acting drug is ineffective

3. The dose of all benzodiazepines should not exceed the maximum daily dose as defined in F329 unless there is justification in the chart for a higher dose

* 4. During the first year in which a resident is admitted on a psychopharmacological medication (other than an antipsychotic or a sedative/hypnotic), or after the facility has initiated such medication, the facility should attempt to taper the medication during at least two separate quarters (with at least one month between the attempts), unless clinically contraindicated

* 5. After the first year, a tapering should be attempted annually, unless clinically contraindicated.

* 6. The tapering may be considered clinically contraindicated, if:
  • The resident’s target symptoms returned or worsened after the most recent attempt at a tapering within the facility; and
  • The physician has documented the clinical rationale for why any additional attempted tapering at that time would be likely to impair the resident’s function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.

7. The patient should be monitored every shift for side effects from the medication. This is most frequently done using a “Behavior Intervention Flow Record (see page 12.10)

8. Duplication of benzodiazepines should be avoided. The use of a daily tranquilizer and a benzodiazepine sleeper many be considered duplicate therapy
13. **Antidepressants (Ftag 329)**

1. There must be a supporting diagnosis for the use of an antidepressant drugs. There should be evidence in the chart that environmental reasons for a patient’s depression have been ruled out.

2. Older tri-cyclic antidepressants are not considered appropriate drugs in the elderly because of the high likelihood of anti-cholinergic side effects.

3. The federal guidelines do not require a “Behavior Intervention Flow Record (see page 12.10) be used to monitor antidepressant therapy. However, there should be evidence in the chart that the drug has improved the depression and side effects are not an issue.

4. Tri-cyclic antidepressants may be appropriate when used to treat neuropathic pain.

5. It may be appropriate to discontinue an antidepressant if the patient is stable and has not shown signs of depression in more than 6 months.

14. **Alzheimers Treatments**

1. These products may loose their effectiveness if they are discontinued during the course of therapy. Therefore, it may not be appropriate to attempt dosage reductions on these medication to prove effectiveness.

2. The consultant should have literature available during the survey (or in the patient’s chart) that would justify not attempting dosage reductions.

3. The prescriber should document in the chart why it is inappropriate to attempt dosage reductions

4. There may be a time when the dementia has progressed to the point to the drug is no longer providing benefit. When this happens, discontinuation may be appropriate.
1. §483.60(c) Drug Regimen Review

(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

(2) The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

2. INTENT (F428) 42 CFR 483.60(c)(1)(2) Medication Regimen Review

The intent of this requirement is that the facility maintains the resident’s highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy to the extent possible, by providing:

- A licensed pharmacist’s review of each resident’s regimen of medications at least monthly; or a more frequent review of the regimen depending upon the resident’s condition and the risks or adverse consequences related to current medication(s);

- The identification and reporting of irregularities to the attending physician and the director of nursing; and

- Action taken in response to the irregularities identified.

- The facility must have policies and procedures to obtain a consultant pharmacist review on any new admission or resident who experiences adverse effects BETWEEN scheduled consultant visits.

3. CMS Definitions 2006 (see F425 in Section II of this manual for a complete list of definitions)

1. Irregularity - refers to any event that is inconsistent with usual, proper, accepted, or right approaches to providing pharmaceutical services (see definition in F425), or that impedes or interferes with achieving the intended outcomes of those services.

2. Medication Regimen Review (MRR) - is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication. The review includes preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities, and collaborating with other members of the interdisciplinary team.
3. **Monitoring** - is the ongoing collection and analysis of information (such as observations and diagnostic test results) and comparison to baseline data in order to:

- Ascertain the individual’s response to treatment and care, including progress or lack of progress toward a therapeutic goal;
- Detect any complications or adverse consequences of the condition or of the treatments; and
- Support decisions about modifying, discontinuing, or continuing any interventions.

IV. **F425 – Pharmacy Services (if services are affecting the intended outcome)**

F425 (Pharmacy services) will be discussed in following chapters. In general, if the level of pharmacy services does not meet the needs of the resident the consultant pharmacist MUST address this deficiency in their monthly consultant reviews.

Examples:

- A pain medication has been ordered but has not been delivered by the pharmacy before the medication needs pain management
- A resident is admitted late in the evening and medications are unavailable in the facility for the morning med pass.
- The time between the drug being ordered and the scheduled time of delivery results in missed doses. This is especially true for Antibiotics and Pain Medications
- The Emergency Kit does not contain medications frequently ordered in the facility resulting in delays in initiating therapy

V. **F309 – Quality of Care (Pain management)**

1. **Synopsis of Regulation (Tag F309)** The resident must receive and the facility must provide the necessary care and services to attain or maintain his/her highest practicable level of physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

2. **Criteria for Compliance with F309 for a Resident with Pain or the Potential for Pain** For a resident with pain or the potential for pain (such as pain related to treatments), the facility is in compliance with F309 Quality of Care as it relates to the recognition and management of pain, if each resident has received and the facility has provided the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care i.e., the facility:

- Recognized and evaluated the resident who experienced pain to determine (to the extent possible) causes and characteristics of the pain, as well as factors influencing the pain;
• Developed and implemented interventions for pain management for a resident experiencing pain, consistent with the resident’s goals, risks, and current standards of practice; or has provided a clinically pertinent rationale why they did not do so;

• Recognized and provided measures to minimize or prevent pain for situations where pain could be anticipated;

• Monitored the effects of interventions and modified the approaches as indicated; and

• Communicated with the health care practitioner when a resident was having pain that was not adequately managed or was having a suspected or confirmed adverse consequence related to the treatment.

The expectation is the Consultant Pharmacist will be involved in the selection of pain medication and the assessment of therapy to ensure that the medication is controlling the pain.
SAMPLE POLICY & METHODS

AIMS TEST

POLICY:

It is the policy of this facility that all residents receiving antipsychotic drugs shall be monitored for extrapyramidal symptoms.

METHODS:

1. All residents admitted to this facility with orders for antipsychotic medications shall receive an AIMS test (abnormal involuntary movement scale test) within 7 days of admission.

2. All residents receiving initial orders of antipsychotic medications while in the facility shall receive an AIMS test within 7 days of the initial order.

3. All residents receiving antipsychotic medications shall receive AIMS test every six months while receiving these drugs.

4. All AIMS tests shall be conducted by the charge nurse or their designee. These tests shall include the name of the resident and the date the test was conducted.

5. All AIMS tests shall be reviewed by the physician, signed and dated.

6. Any significant change in ratings shall be identified and reported to the physician.

7. This test shall remain a part of the chart.
ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

INSTRUCTIONS: Complete examination procedure before making ratings. While conducting the examination, have resident sit in a firm chair without arms. For all MOVEMENT ratings (sections A, B and C) rate highest severity observed. Circle only one code for each evaluation.

SCORING CODES: 0 = None 1 = Minimal/Normal 2 = Mild 3 Moderate 4 = Severe

<table>
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<tr>
<th>ASSESSMENT DATES</th>
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<tr>
<td>0 1 2 3 4</td>
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<td>0 1 2 3 4</td>
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<td>0 1 2 3 4</td>
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SECTION A. FACIAL AND ORAL MOVEMENTS

1. MUSCLES OF FACIAL EXPRESSION
e.g., movements of forehead, eyebrows, periorbital area, cheeks; include frowning, blinking, smiling, grimacing
0 1 2 3 4 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4

2. LIPS AND PERIORAL AREA
e.g., puckering, pouting, smacking
0 1 2 3 4 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4

3. JAW
e.g., biting, clenching, chewing, mouth opening, lateral movement
0 1 2 3 4 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4

4. TONGUE
Rate only increase in movement both in and out of mouth, NOT inability to sustain movement.
0 1 2 3 4 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4

SECTION B. EXTREMITIES MOVEMENTS

5. UPPER (ARMS, WRISTS, HANDS, FINGERS)
Include choreic movements, (i.e., rapid, objectively purposeless, irregular, spontaneous, athetoid movements (i.e., slow, irregular, complex, serpentine). Do NOT include tremor (i.e., repetitive, regular, rhythmic)
0 1 2 3 4 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4

6. LOWER (LEGS, KNEES, ANKLES, TOES)
e.g., lateral knee movement, foot tapping, heel dropping, foot sculling, inversion and eversion of foot
0 1 2 3 4 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4

SECTION C. TRUNK MOVEMENTS

7. NECK, SHOULDERS, HIPS
e.g., rocking, twisting, sculling, pelvic gyrations
0 1 2 3 4 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4

SECTION D. GLOBAL JUDGMENTS

8. SEVERITY OF ABNORMAL MOVEMENTS
0 1 2 3 4 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4

9. INCAPACITATION DUE TO ABNORMAL MOVEMENTS
0 1 2 3 4 0 1 2 3 4 0 1 2 3 4 0 1 2 3 4

10. RESIDENT AWARENESS OF ABNORMAL MOVEMENTS
Rate only patient's report
0 = No awareness
1 = Aware, no distress
2 = Aware, mild distress
3 = Aware, moderate distress
4 = Aware, severe distress
0 = No awareness
1 = Aware, no distress
2 = Aware, mild distress
3 = Aware, moderate distress
4 = Aware, severe distress
0 = No awareness
1 = Aware, no distress
2 = Aware, mild distress
3 = Aware, moderate distress
4 = Aware, severe distress

SECTION E. DENTAL STATUS

11. CURRENT PROBLEMS WITH TEETH AND/OR DENTURES
0 = No
1 = Yes
0 = No
1 = Yes
0 = No
1 = Yes
0 = No
1 = Yes

12. DOES RESIDENT USUALLY WEAR DENTURES?
0 = No
1 = Yes
0 = No
1 = Yes
0 = No
1 = Yes

EVALUATOR SIGNATURES

<table>
<thead>
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<th>Signature/Title</th>
<th>Date</th>
<th>Signature/Title</th>
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NAME—Last First Middle Attending Physician Chart No.

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DYSKINESIA IDENTIFICATION SYSTEM - CONDENSED USER SCALE (DISCUS)

Facility

Current Psychotropics/ Anticholinergic and Total MG/Day
(Choose one per
Exam Date)

SCORING
0 - NOT PRESENT (movements not observable or some movements observed but not considered abnormal)
1 - MINIMAL (abnormal movements are difficult to detect, or movements are easy to detect but occur only once or twice in a short non-repetitive manner)
2 - MODERATE (abnormal movements occur intermittently and are easy to detect)
3 - SEVERE (abnormal movements occur almost constantly and are easy to detect)
N - NOT ASSESSED (an assessment for an item is not able to be made)

ASSESSMENT DISCUS Item and Score (enter Score Code for each Item)

FACE
1. Tics
2. Grimaces

EYES
3. Blinking

ORAL
4. Chewing/Licking Smacking
5. Flicker/Sucking/THRUSTING LOWER LIP

LINGUAL
6. Tongue Thrusting/
Tongue in Cheek
7. Tongue in Cheek
8. Tongue Tremor
9. Altered/Tongue
Lateral Tongue

HEAD/NECK/TRUNK
10. Retractio/Torticollis
11. Shoulder/Head Tilt

UPPER LIMB
12. Altered/ Myokymic
Flexor-Wrist-Arm
13. Pill Rolling

LOWER LIMB
14. Ankle Flexion/
Foot Tapping
15. Toe Movement

TOTAL SCORE

COMMENTS/OTHER

EVALUATION (see other side)

EXAM DATES

1. Greater than 90 days
neuroleptic exposure?
2. Scoring/intensity level met?
3. Other diagnostic condition?
(ex., specify)

PREPARE Signature and Title for item 1 - 4 (if different from physician):

L. Signature

NEXT EXAM DATE

PHYSICIAN'S SIGNATURE

DATE

This form is most often used in the ICF-DD facility)
<table>
<thead>
<tr>
<th>Behavior</th>
<th>Bitin'</th>
<th>Kicking</th>
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<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Intervention Codes</td>
<td>(to be filled in)</td>
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<tr>
<td>Outcome Codes</td>
<td>Improved</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Side Effects</td>
<td>(to be filled in)</td>
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</table>

### Monthly Flow Record

This monitoring form is to be used for the following conditions or any others as appropriate (check all):

- Anxiety Agent
- Antidepressant
- Antipsychotic
- Sedative/Hypnotic

**Facility:** OAK VIEW

**Physician:** Ath

**Allergies:** Pen, Dementia, CHE, Hypothyroidism, COPD

**Report No.:** 1216

**Date:** 3/1/14

**Nurse:** A. R.
SAMPLE POLICY & METHODS

BEDTIME SEDATIVE/HYPNOTIC MEDICATION

POLICY:

It is the policy of this facility that bedtime medications given for sleep shall be made available to our residents as ordered by the physician and shall not be administered inappropriately.

METHODS:

1. Unless otherwise ordered by the physician, **no sleep medication shall be given before the hour of 10 PM.**

2. Each sleeping medication administered shall clearly state the events that necessitated giving the medication after 10 PM including what non-medication interventions were utilized to aid the resident in going to sleep.

3. Orders from the physician for times prior to 10 PM shall clearly designate the time the medication should be given (i.e., 7:00 PM) or at the time requested by the resident.
Center for Clinical Standards and Quality/ Survey & Certification Group

Ref: S&C: 13-02-NH  
DATE: November 2, 2012

TO: State Survey Agency Directors

FROM: Director Survey and Certification Group

SUBJECT: Nursing Homes - Clarification of Guidance related to Medication Errors and Pharmacy Services

Memorandum Summary

We are providing clarification on three specific topics related to medication errors and pharmacy services:

• Medication Errors: Potential medication errors related to medication administration via feeding tube and administration timing for metered dose inhalers and proton pump inhibitors and survey implications.

• Medication Administration Practices: The practice of “borrowing” medications and issues related to diversion, control, reconciliation and disposal of medications, including Fentanyl patches.

• Medication Regimen Reviews for Stays under 30 days and/or Changes in Condition: The need for pharmacist medication regimen reviews when a resident experiences a change in condition and/or for residents admitted for less than 30 days.

Background

Medications are an integral part of the care provided to nursing home residents. They are administered to achieve positive outcomes, such as curing an illness, diagnosing a disease or a condition, modifying a disease process, reducing or eliminating symptoms, or preventing a disease or symptom. However, any medication or combination of medications may result in adverse consequences. Therefore residents must only receive medications when there are clear clinical indications and when the potential benefits outweigh the risks.

To improve the review of the requirements regarding medications and pharmacy services, the Centers for Medicare & Medicaid Services (CMS) implemented revised interpretive guidance for tag F329- Unnecessary medications and for Pharmacy services at F425, F428, and F431 on
December 18, 2006. Since the 2006 guidance release, we have received several requests for clarifications regarding:

• Medication errors;
• Medication administration practices; and
• Medication regimen reviews for stays under 30 days and changes in resident condition.

I. Medication errors

• Administration of Medications via a Feeding Tube (collectively refers to Nasoenteric i.e. nasogastric or nasointestinal, or Gastrostomy tubes)

Surveyors have identified problems regarding safe administration of medications via a feeding tube (such as incorrectly crushing time-released oral medications) or not flushing the tube before, in between and after administration of a medication. In accordance with F425- Pharmacy Services, the facility, in consultation with the pharmacist, must provide procedures for the accurate administration of all medications. The procedures must reflect current standards of practice, including but not limited to; types of medications that may be safely administered via a feeding tube; appropriate dosage forms; techniques to monitor and verify that the feeding tube is in the right location (e.g., stomach or small intestine, depending on the tube) before administering medications; preparing drugs for enteral administration, administering drugs separately, diluting drugs as appropriate, and flushing the feeding tube before, between, and after drug administration\(^1\); and that medications with known incompatibilities must not be given at the same time.

Survey Implications:

Refer to F322- Nasogastric Tubes, if placement of the feeding tube is not checked prior to medication administration. For a resident who requires fluid regulation, the physician’s order should include the amount of water to be used for the flushing and administration of medications.

For administering medications via tube feeding, the standard of practice\(^5\) is to administer each medication separately and flush the tubing between each medication. An exception would be if there is a physician’s order that specifies a different flush schedule for an individual resident, for example because of a fluid restriction. Failure to flush before and in between each medication administration is considered a single medication error and would be included in the calculation for medication errors exceeding 5 percent. If noncompliance with the administration of medication(s) via a feeding tube has been identified at F332- Medication Errors, additional requirements should be investigated such as F425- Pharmacy Services to assure that the facility has policies for administration of medications via feeding tube that meet current standards of practice.

Also consider F520 - Quality Assessment and Assurance (QAA), in order to determine whether the QAA committee monitors for safe medication administration practices including the administration of medications via feeding tubes in order to assure that facility policy and
standards of practice are implemented. The committee and the medical director and pharmacist are expected to be involved in the oversight of safe medication administration practices.

**• Metered Dose Inhalers (MDIs)**

Updates in asthma and chronic obstructive pulmonary disease (COPD) practice guidelines have prompted us to clarify the use of metered dose inhalers to administer medications, and more specifically the timing between puffs. If more than one (1) puff is required, (whether the same medication or a different medication), current guidelines, and/or manufacturer product information indicate there should be a waiting time of approximately one (1) minute between puffs except for short acting beta agonists such as albuterol, where a shorter wait time of 15-30 seconds is acceptable. Ensuring that a device is administered correctly is vital to optimizing inhalation therapy. Numerous educational resources on the storage and administration of various inhalation therapies (e.g., diskus, nebulizer, MDI) are available. Some examples include:

- http://www.aafa-md.org/thumbdrive.htm (under pharmacy file- handouts);
- You Tube Video: http://www.youtube.com/watch?v=Z_95ni8DJwU

**Survey Implications:**

If surveyors identify concerns related to the administration of medications at F332- Medication Errors, then additional requirements may also be considered and investigated such as F425-Pharmacy Services.

**• Proton Pump Inhibitors (PPI)**

This clarification provides surveyors directions for further investigation if they have identified concerns related to the circumstances and timing of PPI administration. Section 483.60(a), Pharmacy Services, requires the facility to establish procedures that assure the accurate administration of medications to meet the needs of each resident. The facility must have policies that address the timing for medications that are required to be administered with regard to food intake (for example, with food or on an empty stomach). PPIs, such as lansoprazole (Prevacid) and omeprazole (Prilosec), are routinely used in nursing home settings. For optimal therapeutic benefit, most PPIs should be administered on an empty stomach, ideally 30-60 minutes before meals. The rationale is that in order for the medication to provide the maximum benefit it needs to be present in the system before food activates the acid pumps so that the peak concentration of the PPI will coincide with maximal acid secretion. Some residents may report benefits of this medication being administered outside the 30-60 minutes prior to a meal and this needs to be determined and documented to justify the continued administration times.

As with any class of medication, it is important to identify the indication for use as well as continued need to ensure appropriate use. This is particularly important with new resident admissions, since many patients are placed on a PPI after an acute care stay, but may not require long-term therapy with these agents. The Food and Drug Administration requires adding information to the PPI prescription label as well as to the over the counter (OTC) PPIs. They
noted that patients who take higher doses and/or remain on PPIs longer (at least one year) were reported to have a higher incidence of hip, wrist or spine fractures.\textsuperscript{4a} This warning, as well as the increased risk for infections such as pneumonia and \textit{Clostridium difficile}, \textsuperscript{4b} reinforces the importance of evaluating each resident for continued medication use.

Survey Implications:

If concerns related to the administration of medications have been identified at F332- Medication Errors, then additional requirements may also be considered and investigated such as F281- Professional Standards of Quality, F329- Unnecessary Medications or F425- Pharmacy Services.

\textbf{II. Concerns regarding medication administration practices}

\textbf{A. “Borrowing Medications”}

Nurses have reported situations in which a medication is not available in the resident’s supply or in the facility’s emergency medication kit or supply. Nursing staff may then decide to “borrow” medications from another resident’s supply in order to relieve pain or ensure timely administration of an antibiotic or cardiac medication for the benefit of a resident. This practice of borrowing medications from other residents’ supplies is not consistent with professional standards and contributes to medication errors\textsuperscript{6}.

If permitted under State law, a contracted pharmacy provider may establish an emergency supply of medications in collaboration with the medical director and the director of nurses. The surveyor should investigate whether policies and procedures are in place for emergency kit use and if they are being implemented. The facility may use an automated medication distribution system and should have procedures for both routine and emergency use of medications.

\textbf{Survey Implications:}

The surveyor should interview staff responsible for medication administration in order to determine:

• How they assure each resident has a sufficient supply of their prescribed medications (for example, a resident who is on pain management to assure an adequate supply of medication is available to meet the resident’s needs). At a minimum the system is expected to include a process for the timely ordering and reordering of a medication;
• Who monitors to assure that the medications are delivered when ordered; and
• What they do if a resident’s prescribed medication is not available for administration.

If the staff borrows medications to administer to a resident due to the failure of the staff to order the medication and not following the facility’s system for reordering medications, refer to F281- Professional Standards of Quality.

In addition, interview the pharmacist, director of nurses, and/or medical director as appropriate in order to determine if they have a system in place to assure each resident has a sufficient supply
of their prescribed medications for timely administration and monitor that the system is followed. (See F425- Pharmacy Services)

Determine whether the nursing staff contacted the prescriber if an ordered medication was not available. Review the resident’s record for documentation regarding the notification and orders from the prescriber on how to address the non-availability of the medication. If the prescriber was not available, determine if the medical director was contacted for orders or further action (See F501-Medical Director, and F514 - Accuracy of medical record.)

Determine whether the QAA committee monitors to assure the timely provision and administration of each resident’s prescribed medications. (See F520 - Quality Assessment and Assurance).

**B. Fentanyl Patches**

Tag F431- Service Consultation requires a licensed pharmacist, who is employed by or provides services to a facility, to establish a system of records of receipt and disposition of all controlled medications. The system should enable periodic, accurate reconciliation and accounting of all controlled drugs. Fentanyl transdermal patches are a controlled substance commonly used in nursing homes for pain medication. These patches present a unique situation given the multiple boxed warnings, the potential for abuse, misuse and diversion, and the substantial amount of fentanyl remaining in the patch after use. The facility’s policies must address safe and secure storage, limited access and reconciliation of controlled substances in order to minimize loss or diversion, and provide for safe handling, distribution and disposition of the medications.

One benefit of the patch is the continuous delivery of fentanyl over 72 hours. This slow-release of fentanyl from the transdermal reservoir allows for more consistent pain control in patients with chronic pain. This unique delivery system, however, is not impervious to diversion, even after the fentanyl patch has been used, removed and/or disposed. One study determined that even after three days of use, 28 to 84.4% of the original fentanyl dose was still present in the patch. The study noted that the dose remaining in the patch was within the limits of a lethal fentanyl dose.7

The remaining fentanyl in a used patch is a potential vehicle of abuse and accidental overdose and warrants implementation of adequate disposal policies. Fentanyl products contain several boxed warnings related to potential abuse, misuse and diversion, and specifically, the contraindication of fentanyl transdermal patch use in individuals who are not opioid tolerant.

Staff should dispose of fentanyl patches in the same manner as wasting of any other controlled substances, particularly because the active ingredient is still accessible. Wasting must involve a secure and safe method, so diversion and/or accidental exposure are minimized. Tag F425 requires the facility’s procedures to address the disposition of all medications. This includes but is not limited to:

- Timely identification and removal of medications from the current supply of medications for disposition;
- Identification of storage method for medications awaiting final disposition;

12.22
• Control and accountability of medications awaiting final disposition;
• Documentation of actual disposition for both full dose and any other remaining partial dose; and
• A method of disposition consistent with applicable state and federal requirements, local ordinances, and standards of practice.

Survey Implications:

If surveyors identify misuse or diversion of a controlled substance, they should consider and investigate these requirements:

• F309 - Quality of care, for evidence and/or potential outcomes, such as unrelieved pain. For example, evidence that on a particular shift, or when a particular staff member is working, that the resident’s pain symptoms are not relieved to the extent possible but the pain symptoms are met to the extent possible on other shifts;
• F425 - Pharmacy Services, for policies for safeguarding and access, monitoring, administration, documentation, reconciliation and destruction of controlled substances;
• F431 - Pharmacy service consultation, for drug records and reconciliation of controlled drugs;
• F514 - Clinical Records, accuracy of medical record and for the documentation of the administration of the medication and outcomes; or
• F520 - Quality assessment and assurance, for how the QAA committee monitors the administration, reconciliation and disposition of controlled substances in the facility.

In addition, if the investigation identifies diversion of a resident’s medication, the surveyor must review for F224- Misappropriation of Resident’s Property. If it is determined that a resident’s medications were diverted for staff use, the State Agency must make referrals to appropriate agencies, such as local law enforcement; Drug Enforcement Administration; State Board of Nursing; State Board of Pharmacy; and possibly the State licensure Board for Nursing Home Administrators.

III. Medication Regimen Reviews for Stays under 30 days and Changes in Condition

Consultation (including medication regimen review) by the pharmacist can promote safe and effective medication use. The regulation at F428-Medication Regimen Review requires that a licensed pharmacist review each resident’s medication regimen at least once a month.

The facility is expected to have a proactive, systematic and effective approach to monitoring, reporting, and acting upon the effects, risks, and adverse consequences of medications. The pharmacist may need to conduct the medication regimen review more frequently (for example weekly), depending on the resident’s condition and the risks for adverse consequences related to current medications. The requirement for the medication regimen review applies to all residents, including residents receiving respite care, residents at the end of life or who have elected the hospice benefit, residents with an anticipated stay of less than 30 days, or residents who have experienced a change in condition. Complex residents generally benefit from a pharmacist’s review during the transition from hospital to skilled nursing facility. This review may prevent
errors due to drug-drug interactions, omissions, duplication of therapy or miscommunication during the transition from one team of care providers to another.

The current guidance at F425-Pharmacy Services provides examples of how the facility, in collaboration with the pharmacist and medical director, can establish procedures to address medication regimen reviews for residents whose anticipated stay is less than 30 days. According to the guidance, facility procedures are expected to address how and when the need for a consultation will be communicated, how the medication review will be handled if the pharmacist is off-site, how the results or report of the pharmacist’s findings will be communicated to the provider, the expectations for the provider’s response and follow up, and how and where this information will be documented.

**Survey Implications:**

Both the previous and the current guidance at F428-Medication Regimen Review have identified that the pharmacist may need to review a medication regimen more frequently, depending on the resident’s condition and the risk for adverse consequences associated with the medications. Efforts to prevent medication-related adverse consequences and to recognize existing or emerging complications are a significant focus of clinical care in nursing homes. If there is evidence the pharmacist should have conducted more frequent reviews, surveyors should consider consulting an advanced practitioner, pharmacist or physician at the State Survey Agency or Regional Office to review cases in which this practice may be considered deficient.

If non-compliance has been identified at F428, then additional requirements may also be considered and investigated such as F385-Physician Supervision; F329-Unnecessary Medications; or F501-Medical Director.

For questions on this memorandum, please contact alice.bonner@cms.hhs.gov.

**Effective Date:** Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

**References:**


4. a. FDA (Federal Drug Administration) drug safety communication: possible increased risk of fractures of the hip, wrist and spine with the use of proton pump inhibitors. 3/23/2011.
# STANDARDIZED MINI-MENTAL STATE EXAMINATION (SMMSE)

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>TIME ALLOWED</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. a. What year is this?</td>
<td>10 seconds</td>
<td>/1</td>
</tr>
<tr>
<td>1. b. Which season is this?</td>
<td>10 seconds</td>
<td>/1</td>
</tr>
<tr>
<td>1. c. What month is this?</td>
<td>10 seconds</td>
<td>/1</td>
</tr>
<tr>
<td>1. d. What is today’s date?</td>
<td>10 seconds</td>
<td>/1</td>
</tr>
<tr>
<td>1. e. What day of the week is this?</td>
<td>10 seconds</td>
<td>/1</td>
</tr>
<tr>
<td>2. a. What country are we in?</td>
<td>10 seconds</td>
<td>/1</td>
</tr>
<tr>
<td>2. b. What province are we in?</td>
<td>10 seconds</td>
<td>/1</td>
</tr>
<tr>
<td>2. c. What city/town are we in?</td>
<td>10 seconds</td>
<td>/1</td>
</tr>
<tr>
<td>2. d. IN HOME – What is the street address of this house?</td>
<td>10 seconds</td>
<td>/1</td>
</tr>
<tr>
<td>2. e. IN HOME – What room are we in? IN FACILITY – What floor are we on?</td>
<td>10 seconds</td>
<td>/1</td>
</tr>
<tr>
<td>3. SAY: I am going to name three objects. When I am finished, I want you to repeat them. Remember what they are because I am going to ask you to name them again in a few minutes. Say the following words slowly at 1-second intervals - ball/ car/ man</td>
<td>20 seconds</td>
<td>/3</td>
</tr>
<tr>
<td>4. Spell the word WORLD. Now spell it backwards.</td>
<td>30 seconds</td>
<td>/5</td>
</tr>
<tr>
<td>5. Now what were the three objects I asked you to remember?</td>
<td>10 seconds</td>
<td>/3</td>
</tr>
<tr>
<td>6. SHOW wristwatch. ASK: What is this called?</td>
<td>10 seconds</td>
<td>/1</td>
</tr>
<tr>
<td>7. SHOW pencil. ASK: What is this called?</td>
<td>10 seconds</td>
<td>/1</td>
</tr>
<tr>
<td>8. SAY: I would like you to repeat this phrase after me: No ifs, ands or buts.</td>
<td>10 seconds</td>
<td>/1</td>
</tr>
<tr>
<td>9. SAY: Read the words on the page and then do what it says. Then hand the person the sheet with CLOSE YOUR EYES on it. If the subject reads and does not close their eyes, repeat up to three times. Score only if subject closes eyes</td>
<td>10 seconds</td>
<td>/1</td>
</tr>
<tr>
<td>10. HAND the person a pencil and paper. SAY: Write any complete sentence on that piece of paper. (Note: The sentence must make sense. Ignore spelling errors)</td>
<td>30 seconds</td>
<td>/1</td>
</tr>
<tr>
<td>11. PLACE design, eraser and pencil in front of the person. SAY: Copy this design please.</td>
<td>1 minute</td>
<td>/1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. ASK the person if he is right or left-handed. Take a piece of paper and hold it up in front of the person. SAY: Take this paper in your right/left hand (whichever is non-dominant), fold the paper in half once with both hands and put the paper down on the floor. Score 1 point for each instruction executed correctly.</td>
<td>30 seconds</td>
<td>/1</td>
</tr>
<tr>
<td>Takes paper correctly in hand</td>
<td>/1</td>
<td></td>
</tr>
<tr>
<td>Folds it in half</td>
<td>/1</td>
<td></td>
</tr>
<tr>
<td>Puts it on the floor</td>
<td>/1</td>
<td></td>
</tr>
<tr>
<td>TOTAL TEST SCORE</td>
<td>/30</td>
<td></td>
</tr>
</tbody>
</table>

Note: This tool is provided for use in British Columbia with permission by Dr. William Molloy. This questionnaire should not be further modified or reproduced without the written consent of Dr. D. William Molloy.

Provided by the Alzheimer’s Drug Therapy Initiative for physician use.
### GLOBAL DETERIORATION SCALE (GDS)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Deficits in cognition and function</th>
<th>Usual care setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Subjectively and objectively normal</td>
<td>Independent</td>
</tr>
</tbody>
</table>
| 2     | - Subjective complaints of mild memory loss.  
      | - Objectively normal on testing.  
      | - No functional deficit | Independent |
| 3     | **Mild Cognitive Impairment (MCI)**  
      | - Earliest clear-cut deficits.  
      | - Functionally normal but co-workers may be aware of declining work performance.  
      | - Objective deficits on testing.  
      | - Denial may appear. | Independent |
| 4     | **Early dementia**  
      | - Clear-cut deficits on careful clinical interview. Difficulty performing complex tasks, e.g., handling finances, travelling.  
      | - Denial is common. Withdrawal from challenging situations. | Might live independently – perhaps with assistance from family or caregivers. |
| 5     | **Moderate dementia**  
      | - Can no longer survive without some assistance.  
      | - Unable to recall major relevant aspects of their current lives, e.g., an address or telephone number of many years, names of grandchildren, etc. Some disorientation to date, day of week, season, or to place. They require no assistance with toileting, eating, or dressing but may need help choosing appropriate clothing. | At home with live-in family member.  
      | In seniors’ residence with home support. Possibly in facility care, especially if behavioural problems or comorbid physical disabilities. |
| 6     | **Moderately severe dementia**  
      | - May occasionally forget name of spouse.  
      | - Largely unaware of recent experiences and events in their lives.  
      | - Will require assistance with basic ADLs. May be incontinent of urine.  
      | - Behavioural and psychological symptoms of dementia (BPSD) are common, e.g., delusions, repetitive behaviours, agitation. | Most often in Complex Care facility. |
| 7     | **Severe dementia**  
      | - Verbal abilities will be lost over the course of this stage.  
      | - Incontinent. Needs assistance with feeding.  
      | - Loses ability to walk. | Complex Care |


Provided by the Alzheimer’s Drug Therapy Initiative for physician use.
The Geriatric Depression Scale (GDS)

By: Sherry A. Greenberg, Ph.D(c), MSN, GNP-BC,
Hartford Institute for Geriatric Nursing, NYU College of Nursing

WHY: Depression is common in late life, affecting nearly 5 million of the 31 million Americans aged 65 and older with clinically significant depressive symptoms reaching 13% in older adults aged 80 and older (Blazer, 2009). Major depression is reported in 8-16% of community dwelling older adults, 5-10% of older medical outpatients seeing a primary care provider, 10-12% of medical-surgical hospitalized older adults with 23% more experiencing significant depressive symptoms (Blazer, 2009). Recognition in long-term care facilities is poor and not consistent amongst studies (Blazer, 2009).

Depression is not a natural part of aging. Depression is often reversible with prompt recognition and appropriate treatment. However, if left untreated, depression may result in the onset of physical, cognitive, functional, and social impairment, as well as decreased quality of life, delayed recovery from medical illness and surgery, increased health care utilization, and suicide.

BEST TOOL: While there are many instruments available to measure depression, the Geriatric Depression Scale (GDS), first created by Yesavage, et al., has been tested and used extensively with the older population. The GDS Long Form is a brief, 30-item questionnaire in which participants are asked to respond by answering yes or no in reference to how they felt over the past week. A Short Form GDS consisting of 15 questions was developed in 1986. Questions from the Long Form GDS which had the highest correlation with depressive symptoms in validation studies were selected for the short version. Of the 15 items, 10 indicated the presence of depression when answered positively, while the rest (questions numbers 1, 5, 7, 11, 13) indicated depression when answered negatively. Scores of 0-4 are considered normal, depending on age, education, and complaints; 5-8 indicate mild depression; 9-11 indicate moderate depression; and 12-15 indicate severe depression.

The Short Form is more easily used by physically ill and mildly to moderately demented patients who have short attention spans and/or feel easily fatigued. It takes about 5 to 7 minutes to complete.

TARGET POPULATION: The GDS may be used with healthy, medically ill and mild to moderately cognitively impaired older adults. It has been extensively used in community, acute and long-term care settings.

VALIDITY AND RELIABILITY: The GDS was found to have a 92% sensitivity and a 80% specificity when evaluated against diagnostic criteria. The validity and reliability of the tool have been supported through both clinical practice and research. In a validation study comparing the Long and Short Forms of the GDS for self-rating of symptoms of depression, both were successful in differentiating depressed from non-depressed adults with a high correlation (r = .84, p < .001) (Sheikh & Yesavage, 1986).

STRENGTHS AND LIMITATIONS: The GDS is not a substitute for a diagnostic interview by mental health professionals. It is a useful screening tool in the clinical setting to facilitate assessment of depression in older adults especially when baseline measurements are compared to subsequent scores. It does not assess for suicidality.

FOLLOW-UP: The presence of depression warrants prompt intervention and treatment. The GDS may be used to monitor depression over time in all clinical settings. Any positive score above 5 on the GDS Short Form should prompt an in-depth psychological assessment and evaluation for suicidality.

MORE ON THE TOPIC:
Best practice information on care of older adults: www.ConsultGeriSN.org

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Geriatric Depression Scale: Short Form

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? YES / NO
2. Have you dropped many of your activities and interests? YES / NO
3. Do you feel that your life is empty? YES / NO
4. Do you often get bored? YES / NO
5. Are you in good spirits most of the time? YES / NO
6. Are you afraid that something bad is going to happen to you? YES / NO
7. Do you feel happy most of the time? YES / NO
8. Do you often feel helpless? YES / NO
9. Do you prefer to stay at home, rather than going out and doing new things? YES / NO
10. Do you feel you have more problems with memory than most? YES / NO
11. Do you think it is wonderful to be alive now? YES / NO
12. Do you feel pretty worthless the way you are now? YES / NO
13. Do you feel full of energy? YES / NO
14. Do you feel that your situation is hopeless? YES / NO
15. Do you think that most people are better off than you are? YES / NO

Answers in **bold** indicate depression. Score 1 point for each bolded answer.

A score > 5 points is suggestive of depression.
A score ≥ 10 points is almost always indicative of depression.
A score > 5 points should warrant a follow-up comprehensive assessment.

Source: [http://www.stanford.edu/~yesavage/GDS.html](http://www.stanford.edu/~yesavage/GDS.html)
This scale is in the public domain.

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*The Hartford Institute for Geriatric Nursing would like to acknowledge the original author of this Try This, Lenore Konowicz, PhD, RN, CS, FAAN, who made significant contributions to the field of geropsychiatric nursing and passed away in 2007.*
# NPI-NH Neuropsychiatric Inventory – Nursing Home Version Worksheet

## G. Apathy/Indifference:
- **□ Yes** □ No □ N/A
- Frequency _____ Severity _______
- Occupational Disruptiveness _______
  - □ 1. Less spontaneous or active
  - □ 2. Less likely to initiate conversation
  - □ 3. Less affectionate, lacking emotions
  - □ 4. Contributes less to household chores
  - □ 5. Less interested in others
  - □ 6. Lost interest in friends or family
  - □ 7. Less enthusiastic about interests
  - □ 8. Other _______________________

## H. Disinhibition:
- **□ Yes** □ No □ N/A
- Frequency _____ Severity _______
- Occupational Disruptiveness _______
  - □ 1. Acts impulsively
  - □ 2. Excessively familiar with strangers
  - □ 3. Insensitive or hurtful remarks
  - □ 4. Crude or sexual remarks
  - □ 5. Talks openly of private matters
  - □ 6. Inappropriate touching of others
  - □ 7. Other _______________________

## I. Irritability/Lability:
- **□ Yes** □ No □ N/A
- Frequency _____ Severity _______
- Occupational Disruptiveness _______
  - □ 1. Bad temper, “flies off handle” easily
  - □ 2. Rapid changes in mood
  - □ 3. Sudden flashes of anger
  - □ 4. Impatient, trouble coping with delays
  - □ 5. Cranky, irritable
  - □ 6. Argues, difficult to get along with
  - □ 7. Other _______________________

## J. Aberrant Motor Behavior:
- **□ Yes** □ No □ N/A
- Frequency _____ Severity _______
- Occupational Disruptiveness _______
  - □ 1. Paces without purpose
  - □ 2. Opens or unpacks closets or drawers
  - □ 3. Repeatedly dresses and undresses
  - □ 4. Repetitive activities or “habits”
  - □ 5. Handling, picking, wrapping behavior
  - □ 6. Excessively fidgety
  - □ 7. Other _______________________

## K. Sleep and Nighttime Behavior Disorders:
- □ Yes □ No □ N/A
- Frequency _____ Severity _______
- Occupational Disruptiveness _______
  - □ 1. Difficulty falling asleep
  - □ 2. Up during the night
  - □ 3. Wanders, paces, inappropriate activity
  - □ 4. Awakens others at night
  - □ 5. Wakes and dresses to go out at night
  - □ 6. Early morning awakening
  - □ 7. Sleeps excessively during the day
  - □ 8. Other _______________________

## L. Appetite/Eating Changes:
- **□ Yes** □ No □ N/A
- Frequency _____ Severity _______
- Occupational Disruptiveness _______
  - □ 1. Loss of appetite
  - □ 2. Increased appetite
  - □ 3. Weight loss
  - □ 4. Weight gain
  - □ 5. Change in eating habits
  - □ 6. Change in food preferences
  - □ 7. Eating rituals
  - □ 8. Other _______________________

---

12.29
Appendix 2 -- Cornell Scale for Depression in Dementia (CSDD)

NAME ___________________ AGE _______ SEX _______ DATE _________

WING _______ ROOM _______ PHYSICIAN ____________ ASSESSER ____________

Ratings should be based on symptoms and signs occurring during the week before interview. No score should be given if symptoms result from physical disability or illness.

SCORING SYSTEM
a = Unable to evaluate 0 = Absent 1 = Mild to intermittent 2 = Severe

a 0 1 2 A. MOOD-RELATED SIGNS
1. Anxiety: anxious expression, rumination, worrying
2. Sadness: sad expression, sad voice, tearfulness
3. Lack of reaction to present events
4. Irritability: annoyed, short tempered

a 0 1 2 B. BEHAVIORAL DISTURBANCE
5. Agitation: restlessness, hand wringing, hair pulling
6. Retardation: slow movements, slow speech, slow reactions
7. Multiple physical complaints (score 0 if gastrointestinal symptoms only)
8. Loss of interest: less involved in usual activities (score only if change occurred acutely, i.e., in less than one month)

a 0 1 2 C. PHYSICAL SIGNS
9. Appetite loss: eating less than usual
10. Weight loss: (score 2 if greater than 5 pounds in one month)
11. Lack of energy: fatigues easily, unable to sustain activities

a 0 1 2 D. CYCLIC FUNCTIONS
12. Diurnal variation of mood: symptoms worse in the morning
13. Difficulty falling asleep: later than usual for this individual
14. Multiple awakenings during sleep
15. Early morning awakening: earlier than usual for this individual

a 0 1 2 E. IDEATIONAL DISTURBANCE
16. Suicidal: feels life is not worthy living
17. Poor self-esteem: self-blame, self-depreciation, feelings of failure
18. Pessimism: anticipation of the worst
19. Mood congruent delusions: delusions of poverty, illness or loss

SCORE _________ Score greater than 12 = Probable depression

Notes/Current Medications:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Instructions for use:
1. The same CNA (certified nursing assistant) should conduct the interview each time to assure consistency in response.
2. The assessment should be based on the patient’s normal weekly routine.
3. If uncertain of answers, questioning other caregivers may further define the answer.
4. Answer all questions by placing a check in the column under the appropriately numbered answer.
   (a = unable to evaluate, 0 = absent, 1 = mild to intermittent, 2 = severe)
5. Add the total score for all numbers checked for each question.
6. Place the total score in the "Score" box and record any subjective observation notes in the "Notes/Current Medications" section.
7. Scores totaling twelve (12) points or more indicate probable depression.
**INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCALE (IADL)**

M.P. Lawton & E.M. Brody

<table>
<thead>
<tr>
<th>A. Ability to use telephone</th>
<th>E. Laundry</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Operates telephone on own initiative; looks up and dials numbers, etc.</td>
<td>1</td>
</tr>
<tr>
<td>2. Dials a few well-known numbers</td>
<td>1</td>
</tr>
<tr>
<td>3. Answers telephone but does not dial</td>
<td>1</td>
</tr>
<tr>
<td>4. Does not use telephone at all.</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Shopping</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Takes care of all shopping needs independently</td>
</tr>
<tr>
<td>2. Shops independently for small purchases</td>
</tr>
<tr>
<td>3. Needs to be accompanied on any shopping trip</td>
</tr>
<tr>
<td>4. Completely unable to shop</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Food Preparation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Plans, prepares and serves adequate meals independently</td>
</tr>
<tr>
<td>2. Prepares adequate meals if supplied with ingredients</td>
</tr>
<tr>
<td>3. Heats, serves and prepares meals or prepares meals but does not maintain adequate diet</td>
</tr>
<tr>
<td>4. Needs to have meals prepared and served</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D. Housekeeping</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Maintains house alone or with occasional assistance (e.g. &quot;heavy work domestic help&quot;)</td>
</tr>
<tr>
<td>2. Performs light daily tasks such as dishwashing, bed making</td>
</tr>
<tr>
<td>3. Performs light daily tasks but cannot maintain acceptable level of cleanliness</td>
</tr>
<tr>
<td>4. Needs help with all home maintenance tasks</td>
</tr>
<tr>
<td>5. Does not participate in any housekeeping tasks</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>F. Mode of Transportation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Travels independently on public transportation or drives own car</td>
</tr>
<tr>
<td>2. Arranges own travel via taxi, but does not otherwise use public transportation</td>
</tr>
<tr>
<td>3. Travels on public transportation when accompanied by another</td>
</tr>
<tr>
<td>4. Travel limited to taxi or automobile with assistance of another</td>
</tr>
<tr>
<td>5. Does not travel at all</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>G. Responsibility for own medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is responsible for taking medication in correct dosage at correct time</td>
</tr>
<tr>
<td>2. Takes responsibility if medication is prepared in advance in separate dosage</td>
</tr>
<tr>
<td>3. Is not capable of dispensing own medication</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>H. Ability to Handle Finances</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Manages financial matters independently (budgets, writes checks, pays rent, bills go to bank, collects and keeps track of income)</td>
</tr>
<tr>
<td>2. Manages day-to-day purchases, but needs help with banking, major purchases, etc</td>
</tr>
<tr>
<td>3. Incapable if handling money</td>
</tr>
</tbody>
</table>


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Pain Assessment Scales

The National Initiative on Pain Control™ (NIPC™) has provided these diagnostic tools to assist you in assessing the severity and quality of pain experienced by your patients. We suggest that you produce multiple photocopies so that you may obtain written feedback to place in the patient’s history file.
Wong-Baker FACES Pain Rating Scale

No Hurt  Hurts Little Bit  Hurts Little More  Hurts Even More  Hurts Whole Lot  Hurts Worst

Explain to the person that each face is for a person who feels happy because he has no pain (hurt) or sad because he has some or a lot of pain. Face 0 is very happy because he doesn’t hurt at all. Face 1 hurts just a little bit. Face 2 hurts a little more. Face 3 hurts even more. Face 4 hurts a whole lot. Face 5 hurts as much as you can imagine, although you don’t have to be crying to feel this bad. Ask the person to choose the face that best describes how he is feeling.

Rating scale is recommended for persons age 3 years and older.

Brief word instructions: Point to each face using the words to describe the pain intensity. Ask the child to choose face that best describes own pain and record the appropriate number.

0–10 Numeric Pain Rating Scale

Where is Your Pain?

Please mark, on the drawings below, the areas where you feel pain. Write “E” if external or “I” if internal near the areas which you mark. Write “EI” if both external and internal.

Reprinted from Pain, Vol 1, Melzack R. The McGill Pain Questionnaire: major properties and scoring methods, 277-299. Copyright 1975, with permission from the International Association for the Study of Pain.
PAIN QUALITY ASSESSMENT SCALE® (PQAS®)

Instructions: There are different aspects and types of pain that patients experience and that we are interested in measuring. Pain can feel sharp, hot, cold, dull, and achy. Some pains may feel like they are very superficial (at skin-level), or they may feel like they are from deep inside your body. Pain can be described as unpleasant and also can have different time qualities.

The Pain Quality Assessment Scale helps us measure these and other different aspects of your pain. For one patient, a pain might feel extremely hot and burning, but not at all dull, while another patient may not experience any burning pain, but feel like their pain is very dull and achy. Therefore, we expect you to rate very high on some of the scales below and very low on others.

Please use the 20 rating scales below to rate how much of each different pain quality and type you may or may not have felt OVER THE PAST WEEK, ON AVERAGE.

<table>
<thead>
<tr>
<th>1. Please use the scale below to tell us how intense your pain has been over the past week, on average.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No pain: 0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Please use the scale below to tell us how sharp your pain has felt over the past week. Words used to describe sharp feelings include “like a knife,” “like a spike,” or “piercing.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not sharp: 0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Please use the scale below to tell us how hot your pain has felt over the past week. Words used to describe very hot pain include “burning” and “on fire.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not hot: 0</td>
</tr>
</tbody>
</table>

12.36
4. Please use the scale below to tell us how dull your pain has felt over the past week.

<table>
<thead>
<tr>
<th>Not dull</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The most dull sensation imaginable</td>
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</tbody>
</table>

5. Please use the scale below to tell us how cold your pain has felt over the past week. Words used to describe very cold pain include “like ice” and “freezing.”

<table>
<thead>
<tr>
<th>Not cold</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
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</tr>
<tr>
<td>The most cold sensation imaginable (“freezing”)</td>
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<td></td>
<td></td>
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</tbody>
</table>

6. Please use the scale below to tell us how sensitive your skin has been to light touch or clothing rubbing against it over the past week. Words used to describe sensitive skin include “like sunburned skin” and “raw skin.”

<table>
<thead>
<tr>
<th>Not sensitive</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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<td></td>
</tr>
<tr>
<td>The most sensitive sensation imaginable (“raw skin”)</td>
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</tbody>
</table>

7. Please use the scale below to tell us how tender your pain is when something has pressed against it over the past week. Another word used to describe tender pain is “like a bruise.”

<table>
<thead>
<tr>
<th>Not tender</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
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<td></td>
</tr>
<tr>
<td>The most tender sensation imaginable (“like a bruise”)</td>
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</tbody>
</table>

8. Please use the scale below to tell us how itchy your pain has felt over the past week. Words used to describe itchy pain include “like poison ivy” and “like a mosquito bite.”

<table>
<thead>
<tr>
<th>Not itchy</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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<td></td>
<td></td>
</tr>
<tr>
<td>The most itchy sensation imaginable (“like poison ivy”)</td>
<td></td>
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<td></td>
<td></td>
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</tr>
</tbody>
</table>

9. Please use the scale below to tell us how much your pain has felt like it has been shooting over the past week. Another word used to describe shooting pain is “zipping.”

<table>
<thead>
<tr>
<th>Not shooting</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The most shooting sensation imaginable (“zipping”)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Please use the scale below to tell us how numb your pain has felt over the past week. A phrase that can be used to describe numb pain is &quot;like it is asleep.&quot;</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Not numb</strong></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>The most numb</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>sensation imaginable</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>&quot;asleep&quot;</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11. Please use the scale below to tell us how much your pain sensations have felt electrical over the past week. Words used to describe electrical pain include &quot;shocks,&quot; &quot;lightning,&quot; and &quot;sparking.&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Not electrical</strong></td>
</tr>
<tr>
<td>The most electrical</td>
</tr>
<tr>
<td>sensation imaginable</td>
</tr>
<tr>
<td>&quot;shocks&quot;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12. Please use the scale below to tell us how tingling your pain has felt over the past week. Words used to describe tingling pain include &quot;like pins and needles&quot; and &quot;prickling.&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Not tingling</strong></td>
</tr>
<tr>
<td>The most tingling</td>
</tr>
<tr>
<td>sensation imaginable</td>
</tr>
<tr>
<td>&quot;pins and needles&quot;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13. Please use the scale below to tell us how cramping your pain has felt over the past week. Words used to describe cramping pain include &quot;squeezing&quot; and &quot;tight.&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Not cramping</strong></td>
</tr>
<tr>
<td>The most cramping</td>
</tr>
<tr>
<td>sensation imaginable</td>
</tr>
<tr>
<td>&quot;squeezing&quot;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>14. Please use the scale below to tell us how radiating your pain has felt over the past week. Another word used to describe radiating pain is &quot;spreading.&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Not radiating</strong></td>
</tr>
<tr>
<td>The most radiating</td>
</tr>
<tr>
<td>sensation imaginable</td>
</tr>
<tr>
<td>&quot;spreading&quot;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>15. Please use the scale below to tell us how throbbing your pain has felt over the past week. Another word used to describe throbbing pain is &quot;pounding.&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Not throbbing</strong></td>
</tr>
<tr>
<td>The most throbbing</td>
</tr>
<tr>
<td>sensation imaginable</td>
</tr>
<tr>
<td>&quot;pounding&quot;</td>
</tr>
</tbody>
</table>
16. Please use the scale below to tell us how aching your pain has felt over the past week. Another word used to describe aching pain is “like a toothache.”

<table>
<thead>
<tr>
<th>Not aching</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>The most aching sensation imaginable (“like a toothache”)</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

17. Please use the scale below to tell us how heavy your pain has felt over the past week. Other words used to describe heavy pain are “pressure” and “weighted down.”

<table>
<thead>
<tr>
<th>Not heavy</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>The most heavy sensation imaginable (“weighted down”)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tbody>
</table>

18. Now that you have told us the different types of pain sensations you have felt, we want you to tell us overall how unpleasant your pain has been to you over the past week. Words used to describe very unpleasant pain include “annoying,” “bothersome,” “miserable,” and “intolerable.” Remember, pain can have a low intensity but still feel extremely unpleasant, and some kinds of pain can have a high intensity but be very tolerable. With this scale, please tell us how unpleasant your pain feels.

<table>
<thead>
<tr>
<th>Not unpleasant</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>The most unpleasant sensation imaginable (“intolerable”)</td>
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</tbody>
</table>

19. We want you to give us an estimate of the severity of your deep versus surface pain over the past week. We want you to rate each location of pain separately. We realize that it can be difficult to make these estimates, and most likely it will be a “best guess,” but please give us your best estimate.

**HOW INTENSE IS YOUR DEEP PAIN?**

<table>
<thead>
<tr>
<th>No deep pain</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>The most intense deep pain sensation imaginable</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

**HOW INTENSE IS YOUR SURFACE PAIN?**

<table>
<thead>
<tr>
<th>No surface pain</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>The most intense surface pain sensation imaginable</td>
<td></td>
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</tbody>
</table>
20. Pain can also have different time qualities. For some people, the pain comes and goes and so they have some moments that are completely without pain; in other words the pain “comes and goes”. This is called intermittent pain. Others are never pain free, but their pain types and pain severity can vary from one moment to the next. This is called variable pain. For these people, the increases can be severe, so that they feel they have moments of very intense pain (“breakthrough” pain), but at other times they can feel lower levels of pain (“background” pain). Still, they are never pain free. Other people have pain that really does not change that much from one moment to another. This is called stable pain. Which of these best describes the time pattern of your pain (please select only one):

( ) I have intermittent pain (I feel pain sometimes but I am pain-free at other times).
( ) I have variable pain (“background” pain all the time, but also moments of more pain, or even severe “breakthrough” pain or varying types of pain).
( ) I have stable pain (constant pain that does not change very much from one moment to another, and no pain-free periods).