

COMPREHENSIVE PAIN ASSESSMENT FORM — COGNITIVELY INTACT

F272(b) *Comprehensive Assessments*
 F309 *Quality of Care*

Why — Pain can place the resident at risk for illness, accident, or decline
How — Ask the resident about pain symptoms. A resident may not want to complain, so it is important to observe for indicators to identify actual symptoms versus what the resident might classify as "old age". Consult family and staff members who work closely with the resident.

F279 *Interdisciplinary Care Plans*
 F280
 F282
How — Involve the resident, resident's family (or other representative) in the team's discussions in order to provide information, get suggestions, confirm agreement, or clarify reasons for developing specific goals and approaches to care.
Why — To develop quantifiable objectives for the highest level of functioning the resident may be expected to attain, based in the comprehensive assessment.

Resident Name _____ ID # _____ Room # _____

Assessment Date _____ Time _____ Physician _____

Current Diagnosis(es): Refer to Cumulative Diagnoses Sheet Refer to MDS Section I, Disease Diagnoses

Refer to Resident Medical Record Face Sheet Other: _____

Reason for Assessment: MDS Admission MDS Significant Change MDS Readmission MDS Quarterly

MDS Annual New Condition 5th Vital Sign Routine Monitoring

Mental Status: Alert Confused Comatose

MMSE (Mini Mental State Examination) Score: _____ Date: _____ Depression Scale Score: _____ Date: _____

CPS Score: _____ Date: _____ (This section will be customized for the tool your facility uses.)

If not available, please mark N/A:

Intensity of Pain: Scale Used (This will be customized to the pain scales your facility decides to use.)

Numerical 0-10 (circle the correct rating) Numerical 0-5 (circle the correct rating)

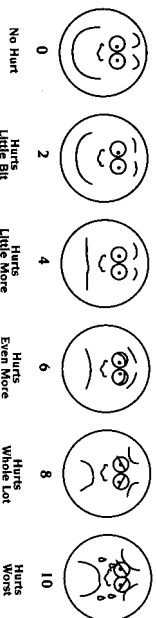
0 1 2 3 4 5 6 7 8 9 10
 ↑

0 1 2 3 4 5
 ↑

No pain Moderate Worst possible
 pain pain

No pain Moderate Worst possible
 pain pain

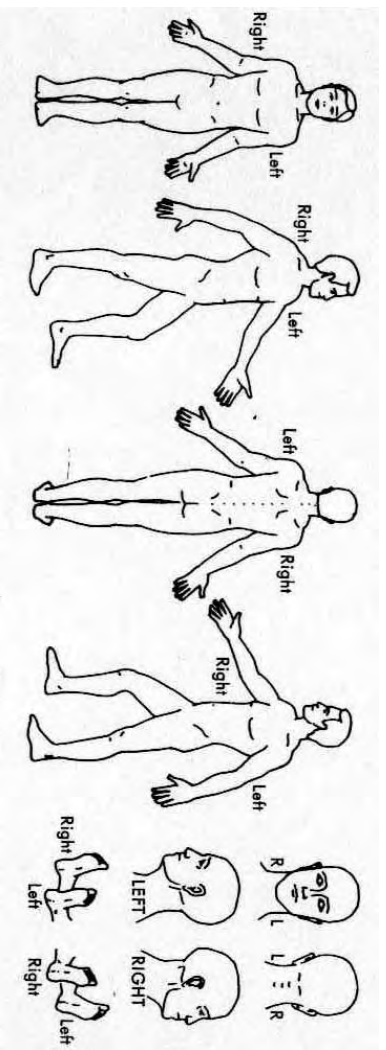
Faces (circle the correct rating)



From Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P.: Wong's Essentials of Pediatric Nursing, 6/e, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.

Location: (Resident or nurse mark drawing) Mark on the areas where you feel pain. If you feel more than one sensation in the same area, mark over that area with all the symbols that apply. Make sure you show all affected areas.

- O Aching
- / Burning
- # Cramping
- = Crushing
- ◆ Dull
- * Numbness
- + Pins/needles
- Sharp
- ↓ Stabbing
- ↯ Throbbing



History of Pain

Onset of Pain: New (within the last 7 days) Recent (within the last 3 mos.) More distant (> 3 mos.)
Type/Frequency of Pain: Constant Intermittent Other, describe: _____

Description of Pain: Aching Burning Cramping Crushing Dull Numbness Pins & Needles
 Sharp Shooting Throbbing Other, describe: _____

Change in Pattern of Pain: Has the discomfort changed in description or intensity the last 7 days? Yes No
 If yes, describe the change: _____

Causes/Increases in Pain: Movement Coughing Cold Heat Fatigue Anxiety Other, describe: _____

What Relieves the Pain: Cold Eating Exercise Heat Medication Massage Relaxation Rest
 Repositioning Other, describe: _____

Manner of expressing pain: (per resident or by observation) Facial expressions Guarding Moaning
 Readily describes pain Restlessness Rubbing area Other, describe: _____

Effects of Pain: (Note decreased function) Using the following scale, rate how the pain has had an effect in each area in the past 24 hours: 0 (no effect) 2 (mild effect) 5 (moderate effect) 10 (severe effect)

Accompanying Symptoms (e.g., nausea) _____ Sleep Disturbance _____ Appetite Change _____
 Physical Activity Change _____ Mood/Behavior _____ Concentration _____
 Relationship with Others _____ Other (describe): _____

Worst Pain in the Last 24 hours: 0 1 2 3 4 5 6 7 8 9 10
 ↑ ↓ ↑ ↓ ↑
 No pain Moderate Worst possible
 pain pain pain

In the past 24 hours, how much have the medications or treatments eased your pain?
 0 No relief 2 Mild relief 5 Moderate relief 8 Relief 10 Complete relief

Information provided by: (Check all that apply) resident family significant others staff

Plan for Addressing Pain: Initiate pain management flow sheet Call physician/NP/PA-C Refer to pain team

Rehab referral (PT, OT, ST) Non-med intervention Medications prescribed Spiritual counseling
 Staff education/communication

Comments: _____

Resident's Pain Control Goal	Resident's Pain Intensity Goal
<input type="checkbox"/> Sleep comfortably <input type="checkbox"/> Comfort at rest <input type="checkbox"/> Comfort with movement <input type="checkbox"/> Total pain control	<input type="checkbox"/> Stay alert <input type="checkbox"/> Perform activities <input type="checkbox"/> Other: _____ 1 2 3 4 5 6 7 8 9 10 (Circle the correct rating) (Will customize to Numerical 0-5 or 0-10)

Signature/Title of person completing assessment: _____ Date: _____

Resident _____ ID# _____
Room # _____ Physician _____

Pain Management Flow Sheet

Date/Time	Location of Pain (refer to pain assessment, if applicable)	Current Intensity Scale used	Precipitating/ Aggravating Factor(s)	Non-Med Intervention	Medication/Dose (See MAR for details, e.g., route, frequency)	Date	Follow-up Monitoring of Effective Intervention Intensity of Pain		Arousal Scale	Initials
							30 min.	2 hours		

Pain Scale Codes
 N = Numerical
 F = Faces
 (Will customize for pain scales used)

NON-MED INTERVENTION CODES

A. Rehab services 1 = Safety assessment 2 = Immobilization of joints 3 = Strength & endurance 4 = Other pain management techniques such as ultrasound & transcutaneous electrical nerve stimulation (TENS)	B. Physical modalities 1 = Heat 2 = Ice 3 = Massage	C. Relaxation & distraction techniques 1 = Individual 2 = Group 3 = 1:1 activities	D. Psychological & social support 1 = Family visits 2 = Spiritual counseling 3 = Other
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SUGGESTED AROUSAL SCALE

1 = Wide awake
 2 = Drowsy
 3 = Dozing intermittently
 4 = Only awakens when aroused
 5 = Asleep at the time of assessment

Comments:

Initials	Signature/Title	Initials	Signature/Title	Initials	Signature/Title	Initials	Signature/Title
Initials	Signature/Title	Initials	Signature/Title	Initials	Signature/Title	Initials	Signature/Title

Resident _____ ID# _____

Room # _____ Physician _____
 (or a facility label can be placed here)

Pain Management Interdisciplinary Team Summary

Physician and IDT should discuss physician's findings and develop interventions

Problem related to: <i>(check those that apply)</i>	Defining Characteristics <i>(check those that apply)</i>	Goals <i>(check those that apply)</i>	Interventions <i>(check those that apply)</i>	Responsible Discipline	
<input type="checkbox"/> Chronic physical disability <input type="checkbox"/> Chronic psychological disability <input type="checkbox"/> Musculoskeletal impairment <input type="checkbox"/> Circulatory impairment <input type="checkbox"/> Skin or tissue impairment <input type="checkbox"/> Neurological impairment <input type="checkbox"/> Advanced disease process <input type="checkbox"/> Age Diagnosis/medical history of: <i>(circle the correct Dx/Hx)</i> Diabetes ASHD (Arteriosclerotic Heart Disease) PVD (Peripheral Vascular Disease) Arthritis Hip Fracture Osteoporosis Pathological Bone Fx Other Fractures Multiple Sclerosis Depression Other: _____	<input type="checkbox"/> Resident self report of pain, discomfort, fatigue <input type="checkbox"/> Observed non-verbal behavior cues of pain <input type="checkbox"/> Physical and social withdrawal <input type="checkbox"/> Altered ability to continue previous activities <input type="checkbox"/> Anorexia <input type="checkbox"/> Weight changes <input type="checkbox"/> Changes in sleep patterns <input type="checkbox"/> Facial mask of pain <input type="checkbox"/> Guarded movement <input type="checkbox"/> Limited range of motion <input type="checkbox"/> Limited ability to perform ADLs <input type="checkbox"/> Limited ability to transfer and ambulate <input type="checkbox"/> Gait disturbance <input type="checkbox"/> Falls <input type="checkbox"/> Deconditioning <input type="checkbox"/> Slow rehabilitation <input type="checkbox"/> Cognitive dysfunction (impaired memory) <input type="checkbox"/> Incontinence <input type="checkbox"/> Constipation	Resident will: <input type="checkbox"/> Verbalize or acknowledge pain when questioned by staff <input type="checkbox"/> Indicate location of pain when questioned by staff <input type="checkbox"/> Establish a pain goal of tolerable limits on a standardized pain scale <input type="checkbox"/> Alert staff of need for PRN analgesic to maintain comfort <input type="checkbox"/> Express relief or decreased discomfort 20-30 minutes after analgesic use <input type="checkbox"/> Alert staff of need for non-medication interventions to improve/maintain comfort <input type="checkbox"/> Report or exhibit increased ROM 20-30 minutes after analgesic use <input type="checkbox"/> Demonstrate muscle relaxation when experiencing increased discomfort <input type="checkbox"/> Verbalize frustrations & feelings regarding disease process <input type="checkbox"/> Express loss of intimacy and companionship <input type="checkbox"/> Participate in activity programs or leisure activities <input type="checkbox"/> Have 3-4 hours of uninterrupted sleep at night <input type="checkbox"/> Will have decreased or resolved indicators of discomfort (crying, acting out, restlessness, insomnia, etc.)	<input type="checkbox"/> 5th vital sign monitoring <input type="checkbox"/> Complete pain assessment <input type="checkbox"/> Monitor elements of pain: Frequency Intensity Location <input type="checkbox"/> Standardized pain scale used <input type="checkbox"/> Assess resident 20-30 minutes after medication administration for effectiveness <input type="checkbox"/> Record response to medications and adjust medication as necessary <input type="checkbox"/> Offer support and reassurance that pain relief will be provided quickly and to the maximum extent possible <input type="checkbox"/> Educate resident/significant others about pain/pain relief measures <input type="checkbox"/> Utilize pain management flow sheet <input type="checkbox"/> Teach and perform non-medication interventions and evaluate effect (circle those that apply) Positioning Massage Cold/heat Relaxation Diversion Exercise Deep breathing TENS Music Elevation of extremities Immobilization	<input type="checkbox"/> Collaborate with physician/PA-C/NP if pain control measures currently ordered are ineffective <input type="checkbox"/> Teach, coach, and monitor adjuvant therapy (distraction imagery, relaxation) <input type="checkbox"/> Document pain rating before/after interventions <input type="checkbox"/> Monitor sleep pattern, adjust medications and non-medication interventions to allow 3-4 hours uninterrupted sleep <input type="checkbox"/> Assess GI status and tolerance to medications; implement bowel program to prevent constipation <input type="checkbox"/> Assess changes in pain that may indicate new problem <input type="checkbox"/> 1:1 visits to provide therapeutic intervention <input type="checkbox"/> 1:1 visits to encourage spiritual resources <input type="checkbox"/> Volunteer visits <input type="checkbox"/> 1:1 visits to identify food preferences and comfort foods <input type="checkbox"/> Involve family in initial pain assessment <input type="checkbox"/> Document historical behavior to express pain <input type="checkbox"/> Around the clock (ATC) dosing of medications <input type="checkbox"/> Medicate before planned activities/exercises	

Date	Initials	Signature/Title	Date	Initials	Signature/Title

RESPONSIBLE DISCIPLINES

- | | |
|---|---|
| CH = Chaplain
DT = Dietary
PR = Physician/Mid-Level Practitioner
OT = Occupational Therapy
FAM = Family | NS = Nursing Services
PT = Physical Therapy
ST = Speech Therapy
RT = Recreational Therapy/Activities
SS = Social Services |
|---|---|

Resident _____ ID# _____

Room # _____ Physician _____
(or a facility label can be placed here)

