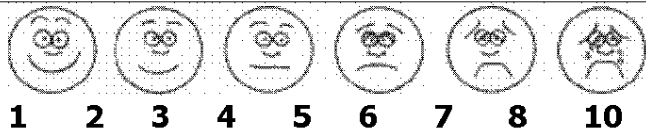
goldencare
Home Health Agency Inc.

Ongoing Pain Assessment

Pain Assessment Codes				
Pain Quality	**Pain Duration**	**Non-Verbal Behaviors**	**Pain Control Therapies/Treatments (PCT)**	**Side Effects**
A = Ache/dull N = Nagging H = Heavy/crushing S = Sharp/stabbing Th= Throbbing R = Radiating B = Burning T = Tingling C = Cramping O = Other	C = Continuous I = Intermittent O = Occasionally F = Frequently	G = Grimacing M = Moaning R = Restless C = Crying I = Irritability A = Anger T = Tense V = Change in vital signs O = Other N = None	Rx = Medication R = Repositioning MT = Music Therapy I = Ice H = Heat V = Visitors D = Diversion/Guided Imagery T = TENS Unit M = Massage S = Spiritual (prayer) O = Other	N = Nausea V = Vomiting S = Sleepy CF= Confusion C = Constipation UR = Urinary Retention MSD = Motor Sensory deficit HA = Headache J = Itching/rash R = Respiratory depression P = ↑Pain O = Other NO = None
Pain Location	**#1__________**	**#2__________**	**#3__________**	**# 4__________**
Pain Quality				
Pain Duration				
What triggers pain?				
Does one medication relieve pain better than another? If yes which one.				
Non-verbal behaviors				
Pain intensity before PCT (0-10)				
Pain intensity after PCT (0-10)				
Patient's goal for pain relief (0-10)				
Family's goal for pain relief (0-10)				
Current pain control therapies (PCT)				
Side effects of PCT				

Comments/Plans (e.g. for relief of side effects, improving pain management, pain barriers, family beliefs, concerns)

Reviewed Patient Pain Log ☐ **Yes** ☐ **No** **Patient given pain education tools** ☐ **Yes** ☐ **No**



Medical Professionals Please Note:
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 2** hurts just a little bit. **Face 4** hurts a little more. **Face 6** hurts even more. **Face 8** hurts a whole lot. **Face 10** 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.

Clinician Signature______________________________________ **Date** _______________

____________________________________ _________________
Patient Name (Last, First, Middle Initial **ID #**

www.pnsystem.com SAMPLE

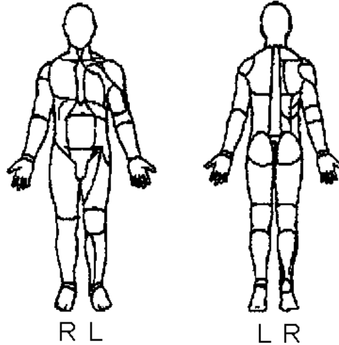
HOME HEALTH NURSING SERVICES, INC.

PAIN ASSESSMENT

INSTRUCTIONS; Complete all sections below, Document findings in the Nurses Progress Notes. Notify the physician if the patient/resident scores 1 or higher on the severity scale and/or non-verbal indicators are exhibited. Initiate/update the Pain Monitor and Care Plan.

LOCATION

Mark pain locations on the illustration(s) below. Indicate the primary pain site. Document the specific information related to the anatomical site listed.



Pain location (anatomical site) ______________________

Date of onset ______________________

Cause of pain ______________________

Duration of pain ______________________

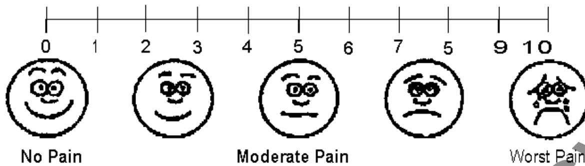
Check all that apply:

Pain is worse: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

Feeling of pain: ☐ Internal ☐ External ☐ Acute ☐ Chronic

SEVERITY

Mark the patient/resident's assessment of the severity of the pain on the scale below. If the patient/resident is unable, complete the non-verbal indicators section.



NON-VERBAL INDICATORS: ☐ Crying ☐ Grimacing ☐ Guarding ☐ Moaning

☐ Retracts body part *(specify)* ______________________

☐ Other ______________________

www.pmrystem.com SAMPLE

CAUSE/RELIEF

Indicate patient/resident responses or mark "unable to respond".

Acceptable pain level (based on scale above): 0 1 2 3 4 5 6 7 8 9 10 Patient/resident unable to respond

What causes/increases pain: ______________________

Medication(s) used: ______________________

Pain relieved by: ______________________

Time elapsed until pain relief: ______________________

PAIN TYPE

Indicate patient/resident's description of how pain feels (check (./) all that apply),

☐ Ache	☐ Burn	☐ Cramp	☐ Dull	☐ Pang	☐ Pinch
☐ Prick	☐ Pull	☐ Raw	☐ Sharp	☐ Smarting	☐ Sore
☐ Stab	☐ Sting	☐ Tender	☐ Thorn	☐ Throbbing	☐ Tight
☐ Tingling	☐ Twinge	☐ Other (specify) ______			
☐ Patient unable to respond					

ADDITIONAL INFORMATION/COMMENTS

List any associated effects of pain that impairs quality of life (e.g. lack of rest/sleep/appetite; nausea; emotional; cannot focus; etc.) and/or other related comments.

____

____

____

Clinician Signature/Title ______________________ Date ____________

NAME-Last	First	Middle	Attending Physician	ID#

Sanz Health Services
Home Care
600 East 25 St. Suite A-B – Hialeah, FL 33013
Tel: (305) 403-7462 – Fax: (305) 403-7463
sanzhealth@yahoo.es

Monthly Pain Management Report

Patient MR#: ______________ Patient Name: ______________________________________ Date: ______________

Etiology/Location

☐ New Site ☐ Non-Cancer Pain ☐ Etiology/Unclear
☐ Consistent with known tumor ☐ Treatment Related

Pain Location Additional Description: ____

____

Character: ☐ Nociceptive ☐ Mixed ☐ Neuropathic

Nociceptive: Aching, Throbbing, Cramping, Tender

Neuropathic: Shooting, Burning, Stabbing, Sharp

Pattern: ☐ Constant ☐ Episodic ☐ Constant & Episodic

Intensity (0-10)

Site #1	Site #2	Site #3
___________ Worst	___________ Worst	___________ Worst
___________ Usual	___________ Usual	___________ Usual

Side Effects

Nausea ☐ Y/N ☐	Dry Mouth ☐ Y/N ☐	GI Distress ☐ Y/N ☐
Drowsiness ☐ Y/N ☐	Other ______________	Constipation ☐ Y/N ☐
Delirium ☐ Y/N ☐	Other ______________	Myoclonus ☐ Y/N ☐

Medication Effectiveness

Is current management regimen effective? ☐ Y/N ☐

Does the pain affect the patient's quality of life in any way? ☐ Y/N ☐

☐ Sleep ☐ Appetite ☐ Emotions ☐ Concentration ☐ Relationship w/ others

If Yes, please explain: ____

www.pnsystem.com
SAMPLE

Is patient using Pain Assessment Tool as a method on assessing his/or her pain? ☐ Y/N ☐
(Wong-Baker FACES pain Rating Scale)

Is patient using noninvasive/complementary interventions to assist in the alleviation of pain?
☐ Massage ☐ Hot/Cold ☐ Repositioning ☐ Stress Reduction
☐ Other: ____________________

Medications (Frequency)
Prescribed Analgesics Medications Only

Medication	Classification	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Additional Comments: ____
____
____
____

www.pnsystem.com
SAMPLE

Employee Signature/Title: ____ Date: ____________

FAXED

Date: ________________________
Time: ________________________
Name of Sender: ____
Name of Person Verifying Receipt: ____________________________________

Revised on: ____________________

FLACC SCALE

FLACC stands for face, legs, activity, crying and consolability. It is an observer rated pain scale, for people who are unable to communicate their pain. FLACC provides a pain assessment scale between 0 and 10.

DATE/TIME						
Face 0 - No particular expression or smile 1 - Occasional grimace or frown, withdrawn, disinterested 2 - Frequent to constant quivering chin, clenched jaw						
Legs 0 – Normal position or relaxed 1 – Uneasy, restless, tense 2 – Kicking, or legs drawn up						
Activity 0 – Lying quietly, normal position, moves easily 1 – Squirming, shifting back and forth, tense 2 – Arched, rigid or jerking						
Cry 0 – No cry (awake or asleep) 1 – Moans or whimpers; occasional complaint 2 - Crying steadily, screams or sobs, frequent complaints						
Consolability 0 – Content, relaxed 1 – Reassured by occasional touching, hugging or being talked to, distractible 2 – Difficult to console or comfort						
TOTAL SCORE						

www.pnsystem.com
SAMPLE

This scales make pain measurable, and can tell when pain is mild, moderate or severe. It can set baselines and trends for patient's pain, making it easier to find appropriate treatments. If the pain rating decreases after you take a certain medication, then clearly that medication worked for the patient. If there was no change, or if the number increased, then the doctor knows it is time to try something else.

_______________________________ _______________

Staff Signature/Title Date