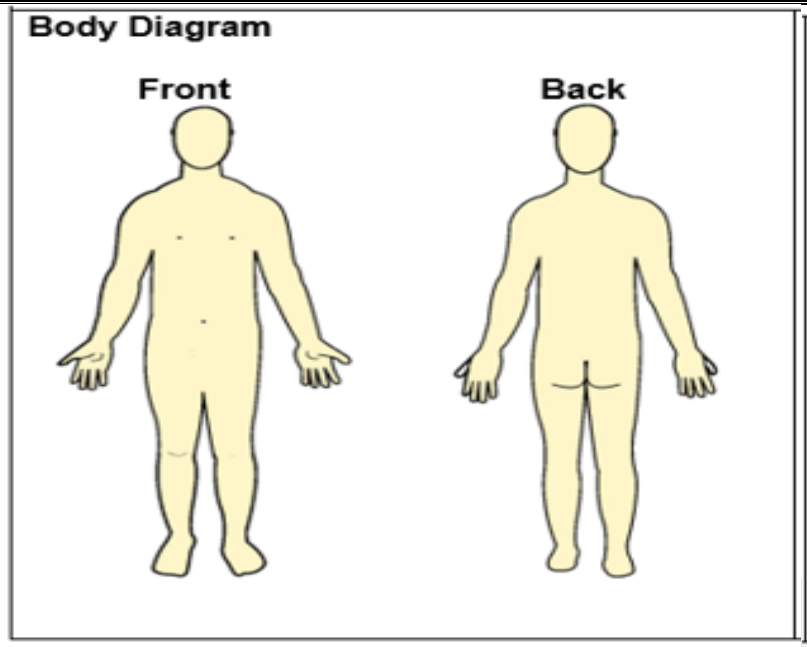
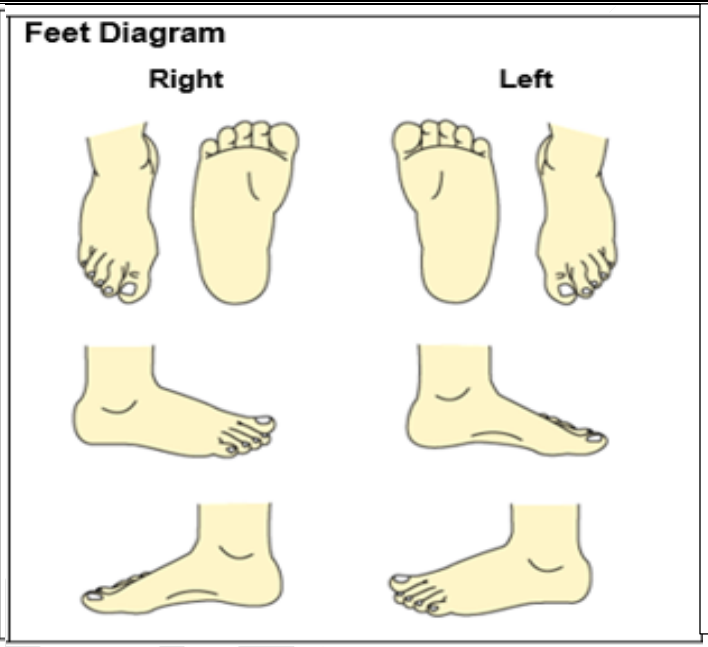
INTEGUMENTARY	
Structure/Function Assessment (check all that apply)	**Interventions/Comments (check all that apply)**
Skin Turgor: ❑ Good ❑ Fair ❑ Poor Skin Color: ❑ Pink ❑ Pale ❑ Flushed ❑ Cyanotic ❑ Jaundiced ❑ Mottled Skin Temperature: ❑ Cool ❑ Warm ❑ Hot Skin Moisture: ❑ Normal ❑ Dry Skin Integrity: ❑ Intact ❑ Bruises ❑ Lesions ❑ Tears ❑ Rash ❑ Odor ❑ Signs of skin breakdown ❑ Open wounds ❑ Necrotic Skin Sensitivity: ❑ Yes ❑ No ❑ Describe: _____ _____ Nails: ❑ Normal ❑ Clubbing ❑ Onycholysis Intravenous access site: ❑ Yes ❑ No Access type: ❑ Peripheral ❑ PICC ❑ Central Line ❑ Port Condition of access site: _____ Access site dressing/ schedule of change: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	❑ Wound assessment reviewed with physician and wound care orders obtained: _____ _____ _____ _____ _____ ❑ Wound care to be completed by: ❑ Hospice nurse ❑ Nursing facility nurse ❑ Patient ❑ Caregiver: _____ ❑ Other: _____ ❑ Education provided to patient/caregiver: ❑ Disease process ❑ Signs and symptoms of infection ❑ Medication and treatment ❑ Pressure reduction ❑ Support surface-Low air loss APP mattress ❑ Wound care goals and management ❑ Wound care supplies ❑ Other: _____ _____ _____ ❑ Pt/caregiver response to education: ❑ Verbalizes understanding ❑ Needs additional instruction ❑ Comments: _____ _____ _____ _____

WOUND ASSESSMENT





PLACE THE CORRESPONDING WOUND # ON THE DIAGRAM TO SHOW THE APPROXIMATE LOCATION OF THE PATIENT'S WOUND(S)

Wound #: _____**Stage:** I II III IV Unstageable (for pressure ulcers only
Wound Type: ❑ Pressure ulcer ❑ Arterial ulcer ❑ Venous ulcer
❑ Mixed ulcer ❑ Suspected Deep Tissue Injury ❑ Diabetic ulcer
❑ Surgical ❑ Burn ❑ Skin tear
Measurements: Length _____Width _____Depth_____(cm)
❑Tunneling (cm)_____
Wound bed: ❑ Epithelial (new skin desc.as shiny, light pink)
❑ Granulation (red) ❑ Slough (yellow) ❑ Fibrinous (white) ❑ Eschar
How much of the wound bed? ❑ 25% ❑ 50% ❑ 75% ❑ 100%
Able to visualize: ❑ Bone ❑ Muscle ❑ Tendon ❑Other: _____
Exudate: ❑ Serous ❑ Serosanguinous ❑ Purulent **Amount:** ❑ Scant
❑ Minimal ❑Moderate ❑ Large **Wound odor:** _____
Peri-wound skin: ❑ Clear ❑Macerated ❑Denuded ❑ Erythematous
Wound edges: ❑ Well defined ❑ Rolled under ❑ Not attached
❑ Callous ❑With undermining **Pain:** ❑ None ❑ With dressing change
❑ Intermittent ❑ Constant
Wound care completed per physician order:❑Yes ❑No ❑NA

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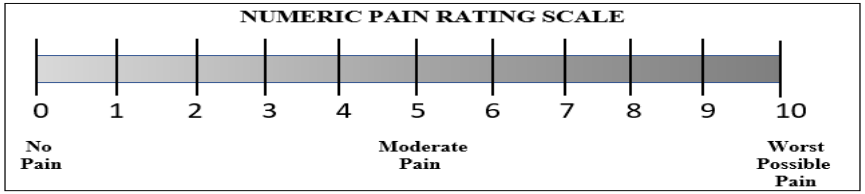
PAIN ASSESSMENT

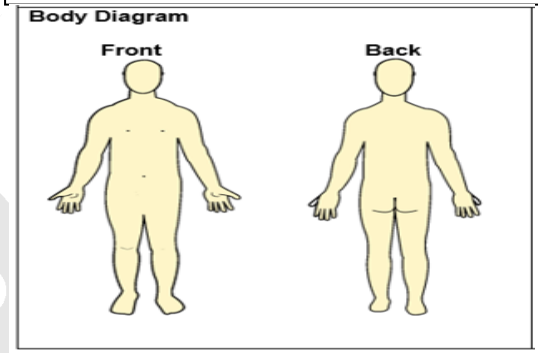
PAIN ASSESSMENT IN ADVANCED DEMENTIA (PAINAD) SCALE

Items	Score=0	Score=1	Score=2	SCORE
Breathing (independent of vocalization)	Normal	• Occasional labored breathing • Short period of hyperventilation	• Noisy labored breathing • Long period of hyperventilation • Cheyne-Stokes respirations	
Negative vocalization	None	• Occasional moan or groan • Low level of speech with a negative or disapproving quality	• Repeated troubled calling out • Loud moaning or groaning • Crying	
Facial expression	Smiling or inexpressive	• Sad • Frightened • Frown	• Facial grimacing	
Body language	Relaxed	• Tense • Distressed pacing • Fidgeting	• Rigid • Fists clenched • Knees pulled up • Pulling or pushing away • Striking out	
Consolability	No need to console	• Distracted or reassured by voice or touch	• Unable to console, distract, or reassure	
TOTAL				

PAINAD Instructions: Observe the patient for five minutes before scoring his or her behaviors. Score the behaviors according to the following chart. Total scores range from 0 to 10 (based on a scale of 0 to 2 for each of five items), with a higher score indicating more behaviors indicating pain (0 = no observable pain to 10 = highest observable pain).



Pain Scale Instructions: Ask the patient to choose a number from 0 to 10 that best describes their current pain. 0 would mean "no pain" and 10 would mean "worst possible pain." Rating from 1-3 is considered **MILD** pain; 4-6 is **MODERATE** pain; and 7-10 is **SEVERE** pain.



Place "X" for all locations of the patient's pain.

Structure/Function Assessment (check all that apply)

❑ Is pain an active problem for the patient ❑ Yes ❑ No

(NQF #1634): Pain Screening: *HIS J0900*

- ❑ A. Was the patient screened for pain? ❑ Yes ❑ No
- ❑ B. Date of the first screening for pain: _____/_____/_____
- ❑ C. The patient's pain severity: ❑ None ❑ Mild ❑Moderate ❑ Severe ❑ Pain not rated
- ❑ D. Type of standardized pain tool used: ❑ Numeric ❑ Verbal descriptor ❑ Patient visual ❑ Staff observation ❑ No standardized tool used

(NQF #1637): Pain Assessment: *HIS J0910*

- ❑ A. Was a comprehensive pain assessment completed? ❑ Yes ❑ No
- ❑ B. Date of the comprehensive pain assessment: ____/____/___
- ❑ C. Check all that apply:
  - ❑ 1. Location: _____

Interventions/Comments (check all that apply)

(NQF #1617): Treated with an Opioid Who Are Given a Bowel Regimen

Scheduled Opioid: *HIS N0500*

- ❑ A. Was a scheduled opioid initiated or continued? ❑ Yes ❑ No
- ❑ B. Date scheduled opioid was initiated or continued: ___/___/___

Comment: _____

PRN Opioid: *HIS N0510*

- ❑ A. Was a PRN opioid initiated or continued? ❑ Yes ❑ No
- ❑ B. Date PRN opioid was initiated or continued: ____/____/_____

Comment: _____

Bowel Regimen: *HIS N0520*

A. Was a bowel regimen initiated or continued? ❑ Yes ❑ No
❑ No, but there is documentation of why a bowel regimen was not initiated or continued

❑ 2. Severity: _____ ❑ 3. Character: ❑ Sharp ❑ Aching ❑ Gnawing ❑ Cramping ❑ Dull ❑ Throbbing ❑ Stabbing ❑ Burning ❑ Shooting ❑ Radiating _____ ❑ 4. Duration: _____ ❑ 5. Frequency: ❑ Frequent ❑ Intermittent/occasionally ❑ Constant _____ ❑ 6. What relieves/ worsens pain? _____ _____ ❑ 7. Effect of pain on function or quality of life: ❑ Sleep: ❑ Difficulty going to sleep due to pain ❑ Difficulty staying asleep due to pain ❑ Decrease in appetite ❑ Decreased mobility ❑ Irritability ❑ Increased assistance with ADLs ❑ Fear _____ ❑8. None of the above: _____ ❑ What is the pt./caregiver's goal for pain management (acceptable level etc.)? _____ _____ _____	B. Date bowel regimen was initiated or continued: ____/____/____ Comment: _____ ❑ Routine pain medication: _____ _____ ❑ Pain medication for break through pain: _____ _____ ❑ Current medication effective? ❑ Yes ❑ No_____ ❑ Pain medication reviewed with physician and new orders received:_____ _____ ❑ Education provided to patient/caregiver regarding: ❑ Possible side effects (SE) of opioids e.g. sedation, constipation ❑ Reinforce bowel regimen ❑ Call hospice nurse if no BM in 3 days ❑ Dry mouth ❑ Nausea ❑ Medications to ease SE ❑ Disease process ❑ Use of Opioid for pain and/or SOB ❑ Comfort measures: _____ _____ ❑Non-pharmacological interventions for SOB/pain including: ❑ Gentle massage ❑ Change in position ❑ Distraction (TV, Radio, music etc.) ❑ Therapeutic touch _____ _____ _____
ENVIRONMENTAL SAFETY AND MEDICATION REVIEW	
Structure/Function Assessment (check all that apply)	**Interventions/Comments (check all that apply)**
Patient or Caregiver's residence assessed for (check all applicable findings): ❑ Unsound structure ❑ Unsafe functional barriers ❑ Inadequate heating/electricity ❑ Inadequate sanitation/plumbing ❑ Unsafe gas/electrical appliances ❑ Inadequate cooking facilities ❑ Inadequate sleeping arrangements ❑ Inadequate ventilation ❑ Inadequate running water ❑ Presence of infestation of pests	**Medication Safety Review:** ❑All current medications reviewed for: ❑ Patient allergies: _____ _____ _____ _____ ❑ The effectiveness of drug therapy ❑ Duplicate drug therapy ❑ Medication side effects ❑ Immediate desired effects of medications ❑ Allergic reactions or adverse effects. ❑ Actual or potential medication interactions

- ❑ Unsafe placement of rugs, cords, furniture
- ❑ Unsafe storage of supplies/equipment
- ❑ Neighborhood unsafe
- ❑ Emergency Plan ❑ Yes ❑ No
- ❑ Fire Assessment ❑ Yes ❑ No
- ❑ Oxygen in Home ❑ Yes ❑ No
- ❑ "No Smoking" Signs Posted? ❑ Yes ❑ No
- ❑ Functioning Smoke Detector ❑ Yes ❑ No ❑ Needs
- ❑ Functioning Fire Extinguisher ❑ Yes ❑ No ❑ Needs
- ❑ Intact electrical cords near oxygen? ❑Yes ❑No
- ❑ Electrical medical equipment away from oxygen? ❑Yes ❑ No
- ❑ Medical gas cylinders stored on sides in a well-ventilated area? ❑NA ❑Yes ❑No
- ❑ Smoking materials ❑ Yes ❑ No
- ❑ Open flames ❑ Yes ❑ No
- ❑ No safety issues found during assessment
- ❑ Comments: _____

Summary of care provided: _____

- ❑ Any medication therapies associated with lab monitoring
- ❑ Changes in the pt.'s condition that contraindicate continued medication administration
- ❑ Safe administration/management of medications: ❑ Pt ❑ CG
- ❑ Pt manages own medication despite having cognitive impairment or "forgetfulness"
- ❑ History of medication non-compliance: ❑ Patient ❑ Caregiver
- ❑ History of missing medications in the home
- ❑ Suspected medication misuse or abuse
- ❑ Suspected controlled substance diversion
- ❑ Comments: _____

❑ <u>Oxygen Safety:</u>

- ❑ Never smoke or allow anyone else to smoke around oxygen and post NO SMOKING signs in each room where oxygen is used.
- ❑ Keep petroleum-based products e.g. lotions and creams away from flow of oxygen
- ❑ Keep oxygen and canisters 10 ft. away from open flames such as gas stoves, lit fireplaces, wood burning stoves, candles or lighters and at least 5 feet from electrical equipment (anything that may produce a spark) e.g. electrical heaters, blankets or razors, hair dryers or friction toys.
- ❑ Informing pt.'s power company that pt. is oxygen dependent
- ❑ Storing oxygen canisters in upright position and away from heat source and the sun; and in a well-ventilated area and in the approved oxygen storage cart
- ❑ Turn off oxygen when not in use.

❑ Initial Plan of Care: Reviewed with Pt./ Caregiver: _____

❑ Physician(s): _____

	❑ Services accepted include: ❑ Nursing ❑ Social Work ❑ Spiritual counseling ❑ Hospice Aide ❑ Volunteer ❑ Other _____ ❑ Education provided to patient/caregiver regarding**:** _____ ❑ Patient/caregiver verbalizes understanding ❑ Yes ❑ No

Technology (application/device) used:_____
Who is onsite with the patient during the visit _____**(names)**
Assistance provided Yes No Describe_____

RN Signature:_____**Date:**_____