Policy Name	Policy Number:
ONGOING PAIN AND SYMPTOM ASSESSMENT: HOSPICE RESIDENTS	**0201**
	Effective Date: May 9, 1996
Approved By: Management Committee	Date Revised: November 4, 2009
Classification: Pain and Symptom Management	Page No: Page 1 of 2

POLICY

Hospice residents will have ongoing pain and symptom assessments by a Registered Nurse until death or discharge occurs.

PROCEDURE

1. An initial pain assessment is to be done on admission. This is completed using the Calgary Inter-Agency Pain Assessment tool form. All areas need to be filled in as thoroughly as possible to get a good baseline pain assessment.

2. Modified Confusion Rating Scale (CRS)
   a) The RN will complete the CRS every shift to track changes in behavior related to delirium. Any changes noted are to be documented thoroughly on the flowsheet or progress notes of the resident's health record. The attending physician or designate is to be made aware of these changes in order to provide timely treatment.
   b) The attending physician is to review the CRS to note any trends or changes in the resident's behavior.

3. Flowsheet
   a) The flowsheet is to be filled out every shift by the Registered Nurse. This will include an assessment of the resident in their 12 hours as well as any noted changes. All areas are to be filled in and initialed.
   b) If more than 3 breakthroughs of analgesic are given on a shift, the attending physician or designate is to be notified. This is also to be noted on the progress notes. Good documentation of pain **should include**:
      - description of the pain (location, severity, type of pain)
      - physical symptoms such as grimacing, diaphoretic, heart rate, furrowed brow, etc.
      - dosage of medication given and/or interventions taken
      - time medication was given
      - effect after 30 minutes
      - follow up if interventions ineffective

4. Progress Notes
   a) Charting is to be completed on progress notes of the resident's health record regarding any changes in the resident's status. Any communication done with the attending physician, their designate or interdisciplinary team regarding these changes is to be documented.

5. Palliative Outcome Scale (POS)

    a) The POS is to be completed as part of the admission process for each resident and every three (3) days for nine (9) days afterwards. After the 9th day, the POS is to be completed weekly or when there is a change in the resident's status. The POS is used to get a better idea of how the resident feels about his/her symptoms.
    ******Ideally, this form is to be completed by the resident. If the resident is unable, the family/health advocate or staff should complete the form with their designation indicated at the bottom of the form.******

6. Edmonton Symptom Assessment System (ESAS)

    a) ESAS is done on a PRN basis to assess resident's physical and emotional symptoms.

ATTACHED FORMS:

Flowsheet
Progress notes
Modified Confusion Rating Scale
Palliative Performance Scale
Edmonton Symptom Assessment System
Calgary Inter-Agency Pain Assessment