PAIN ASSESSMENT IN ADVANCED DEMENTIA - PAINAD*

**TOTAL**

**Instructions:** Observe the older person both at rest and during activity/with movement. For each of the items included in the PAINAD, select the score (0, 1, or 2) that reflects the current state of the person's behavior. Add the score for each item to achieve a total score. Monitor changes in the total score over time and in response to treatment to determine changes in pain. Higher scores suggest greater pain severity.

### MUSCULOSKELETAL

<table>
<thead>
<tr>
<th>Disorder(s) of musculoskeletal system (type):</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] No Problem</td>
</tr>
<tr>
<td>[ ] Change(s) identified this visit documented below</td>
</tr>
</tbody>
</table>

### MEDICATIONS/TREATMENTS

Medication and/or treatments (collect information per agency policy):

- [ ]
- [ ]
- [ ]
- [ ]

### DME/MEDICAL SUPPLIES

DME Company:
Phone: __________________________

Oxygen Company:
Phone: __________________________

- [ ] Community Organizations
- [ ] Services:

List DME/Medical Supplies/Assistive Devices:

- [ ]
- [ ]
- [ ]
- [ ]

### FUNCTIONAL LIMITATIONS

| [ ] Amputation | [ ] Vision |
| [ ] Bowel/Bladder (Incontinence) | [ ] Legally blind |
| [ ] Contracture | [ ] Dyspnea with minimal exertion |
| [ ] Hearing | [ ] Other (specify): |
| [ ] Paralysis | [ ]
| [ ] Endurance | [ ]
| [ ] Ambulation | [ ]
| [ ] Speech | [ ]

### ADL/IADLs

| [ ] No Problem | [ ] 30-Day Evaluation | [ ] No Changes |
| [ ] Change(s) identified this visit documented below |

- [ ]
- [ ]
- [ ]
- [ ]

Examples of ADLs/IADLs, transfer/amputation, bathing, dressing, toileting, eating/feeding, meal preparation, housekeeping, laundry, telephone, shopping and finances.

- [ ] Independent with
- [ ] Needs minimal help with
- [ ] Needs moderate help with
- [ ] Needs maximum help with

The patient receives assistance from a caregiver to complete the following activities:

- [ ] Hygiene
- [ ] Dressing
- [ ] Toileting
- [ ] Transfers
- [ ] Meal Preparation
- [ ] Medication Administration
- [ ] IADL
- [ ] Medical Treatments
- [ ] Equipment Management
- [ ] Supervision and Safety
- [ ] Safety measures to protect against injury:

### ACTIVITIES PERMITTED

- [ ] Complete bedrest
- [ ] Bathroom privileges
- [ ] Up as tolerated
- [ ] Transfer bed/chair
- [ ] Exercises prescribed
- [ ] Partial weight bearing
- [ ] Independent in home
- [ ] Crutches
- [ ] Cane
- [ ] Wheelchair
- [ ] Walker

- [ ] No restrictions
- [ ] Other (specify): |
- [ ] Other (specify): |
- [ ] Other (specify): |

### REFUSED CARES

- [ ] Did the [ ] Patient [ ] Representative [ ] Other:
  - [ ] care(s) [ ] service(s) in advance? [ ] No [ ] Yes

If yes, explain:

- [ ]

Could the [ ] care(s) [ ] service(s) they refused significantly affect the recommended plan of care? [ ] No [ ] Yes

If yes, explain how:

- [ ]

### EMERGENCY PREPAREDNESS CARE PLANNING

Complete this section per agency policy for applicable activities completed during this visit and coordinate with case management.

(check all that apply)

- [ ] Change(s) identified this visit documented below
- [ ] Emergency Priority Code assigned to this patient is _______________

(Note: Record the code on the front page of this form and other places per agency policy)

- [ ] Obtained the patient’s emergency contact number(s) for the medical record
- [ ] Discussed the therapy service plans for supporting their patients during a natural or man-made disaster
- [ ] Discussed patient specific emergency planning options
- [ ] Discussed the development of the patient’s individualized emergency preparedness plan of care, including self-care readiness and the procedure to follow up with the HHA in the event services are interrupted
- [ ] Written materials to restate/reinforce the emergency preparedness procedures given to the [ ] Patient [ ] Representative (if any)
- [ ] Caregiver [ ] Other:

- Comments: __________________________

- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]

PATIENT NAME – Last, First, Middle Initial

PHYSICIAN NAME / TITLE

ID#
### Functional Independence/Balance Evaluation

#### Upper Extremity
- **Shoulder**
  - Flex/Extend
  - Abduction/Adduction
  - Int. Rot./Ext. Rot.
- **Elbow**
  - Flex/Extend
- **Forearm**
  - Supinate/Pronate
- **Wrist**
  - Flex/Extend
- **Fingers**
  - Flex/Extend

#### Lower Extremity
- **Hip**
  - Flex/Extend
  - Abduction/Adduction
  - Int. Rot./Ext. Rot.
- **Knee**
  - Flex/Extend
- **Ankle**
  - Plantar/Dorsal
- **Foot**
  - Inversion/Eversion

### Muscle Strength/ROM Evaluation

#### Manual Muscle Test (MMT) Muscle Strength

<table>
<thead>
<tr>
<th>GRADE</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Normal functional strength - against gravity - full resistance</td>
</tr>
<tr>
<td>4</td>
<td>Good strength - against gravity with some resistance</td>
</tr>
<tr>
<td>3</td>
<td>Fair strength - against gravity - no resistance - safety compromise</td>
</tr>
<tr>
<td>2</td>
<td>Poor strength - unable to move against gravity</td>
</tr>
<tr>
<td>1</td>
<td>Trace strength - slight muscle contraction - no motion</td>
</tr>
<tr>
<td>0</td>
<td>Zero - no active muscle contraction</td>
</tr>
</tbody>
</table>

### Physical Therapy Evaluation/Plan of Care

#### Bed Mobility
- **Roll/Turn**
- **Sit/Supine**
- **Scoot/Bridge**

#### Transfers
- **Sit/Stand**
- **Bed/Wheelchair**
- **Toilet**
- **Floor**
- **Auto**

#### Gait
- **Stairs**
- **Stride**
- **Weight Bearing**

#### Balance
- **Static Sitting**
- **Dynamic Sitting**
- **Static Standing**
- **Dynamic Standing**

#### W/C Skills
- **Propulsion**
- **Pressure Reliefs**
- **Foot Rests**
- **Locks**

#### Community Mobility
- **Level Surface**
- **Uneven Surface**

### Functional Independence Scale (For Balance/Mobility, Self Care/ADL Skills, IADL Skills)

<table>
<thead>
<tr>
<th>GRADE</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Independent</td>
</tr>
<tr>
<td>6</td>
<td>Modified independent - verbal cues, extra time</td>
</tr>
<tr>
<td>5</td>
<td>Stand-by assist (SBA) - 100% effort w/supervision</td>
</tr>
<tr>
<td>4</td>
<td>Minimal assist - 75% effort</td>
</tr>
<tr>
<td>3</td>
<td>Moderate assist - 25-50% effort</td>
</tr>
<tr>
<td>2</td>
<td>Maximum assist - 25% effort</td>
</tr>
<tr>
<td>1</td>
<td>Dependent/unable to do task &lt;25% effort</td>
</tr>
</tbody>
</table>

**Patient Name** – Last, First, Middle Initial  
**Physician Name/Title**  
**ID#**
### FALL RISK ASSESSMENT
#### MAHC 10 - FALL RISK ASSESSMENT TOOL

<table>
<thead>
<tr>
<th>REQUIRED CORE ELEMENTS</th>
<th>Points</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age 65+</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diagnosis (3 or more co-existing)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes only documented medical diagnosis.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prior history of falls within 3 months</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A unintentional change in position resulting in coming to rest on the ground or at a lower level.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Incontinence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inability to make it to the bathroom or commode in timely manner. Includes frequency, urgency, and/or nocturia.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Visual impairment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes but not limited to, macular degeneration, diabetic retinopathies, visual field loss, age related changes, decline in visual acuity, accommodation, glare tolerance, depth perception, and night vision or not wearing prescribed glasses or having the correct prescription.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Impaired functional mobility</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>May include patients who need help with IADLs or ADLs or have gait or transfer problems, arthritis, pain, fear of falling, foot problems, impaired sensation, impaired coordination or improper use of assistive devices.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Environmental hazards
  - May include but not limited to, poor illumination, equipment tubing, inappropriate footwear, pets, hard to reach items, floor surfaces that are uneven or cluttered, or outdoor entry and exits.

- Poly Pharmacy (4 or more prescriptions – any type)
  - All PRESCRIPTIONS including prescriptions for OTC meds. Drugs highly associated with fall risk include but not limited to, sedatives, antidepressants, tranquilizers, narcotics, antihypertensives, cardiac meds, corticosteroids, anti-anxiety drugs, anticholinergic drugs, and hypoglycemic drugs.

- Pain affecting level of function
  - Pain often affects an individual's desire or ability to move or pain can be a factor in depression or compliance with safety recommendations.

- Cognitive impairment
  - Could include patients with dementia, Alzheimer's or stroke patients or patients who are confused, use poor judgment, have decreased comprehension, impulsivity, memory deficits. Consider patient's ability to adhere to the plan of care.

- A score of 4 or more is considered at risk for falling

**TOTAL**

List other validated tools used to complete this evaluation and the score obtained for example; physical, psychosocial or cognitive assessment:

- Patient ☐ caregiver ☐ family ☐ representative were present during evaluation. □ Patient ☐ caregiver ☐ family ☐ representative actively participated with the therapy plan of care to facilitate future discharge? □ Yes ☐ No (comment):

- When the □ patient ☐ caregiver ☐ family ☐ representative was asked to state their specific goal(s) from the therapy service they stated:

- List any care preferences stated by the □ patient ☐ caregiver ☐ family ☐ representative (include refusal of cares):

- Assess the patient's psychosocial status (refers to mental health, social status, and functional capacity) within the community (e.g., education and marital history etc.). Include barriers to care and possible referral(s) for other care services and/or outside entities.

- Assess the patient's cognitive ability (ability to understand, remember, and participate in developing and implementing the plan of care).
  - (Note: CMS is not requiring the use of any particular tool, nor are they prescribing the extent of the cognitive status assessment.)

- List the patient's strengths that will help them to meet their realistic functional goal(s) (for example physical, psychosocial, cognitive ability [such as motivation] and support system):

- Education ☐ Training that was ☐ needed ☐ received during this visit (explain):

- Patient ☐ caregiver ☐ family ☐ representative response to today's visit:

### SIGNATURE/DATE

<table>
<thead>
<tr>
<th>Signature and Title of Person</th>
<th>Who Completed Evaluation:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT NAME – Last, First, Middle Initial</td>
<td>PHYSICIAN NAME / TITLE</td>
<td>ID#</td>
</tr>
</tbody>
</table>

PHYSICAL THERAPY
EVALUATION/PLAN OF CARE
List identified risk factors the patient has related to an unplanned hospital admission or an emergency department visit (M1033, M1034 and M1036).

RISK FACTORS/HOSPITAL ADMISSION/EMERGENCY ROOM

Risk factors identified and followed up on by: □ Discussion □ Education □ Training
Literature given to: □ Patient □ Representative □ Caregiver □ Family Member □ Other:
List identified risk factors the patient has related to an unplanned hospital admission or an emergency department visit (M1034 and M1036).

Note: Following a patient’s hospital discharge, HHA are required by CMS to include an assessment of the patient’s level of risk for hospital ED visits and hospital admission. Interventions are required in the patient’s plan of care. When assessing the patient, pay particular attention to patients with CHF, AMI, COPD, CABG, pneumonia, diabetes or hip and knee replacements. Consider these factors co-morbidities, multiple medications, low health literacy level, history of falls, low socioeconomic level, dyspnea, safety, confusion, chronic wounds, depression, lives alone, support system, etc.

REHABILITATION POTENTIAL FOR ANTICIPATED DISCHARGE PLANNING

❑ Return to an independent level of care (self-care)
❑ Able to remain in residence with assistance of: □ Primary Caregiver □ Support from community agencies
❑ Restorative Potential, based on clinical objective assessment and evidence based knowledge the patient’s condition is likely to undergo functional improvement and benefit from rehabilitative care
❑ Discussed discharge plan with: □ Patient □ Representative □ Other:
❑ Intermittent therapy services are reasonable and necessary to continue based on the evaluation finding. See Summary below.

Estimated duration of continued services for this patient is ______________, and anticipated discharge date is ______________.

Prognosis: ______________
Rehabilitation Potential: ______________

SUMMARY CHECKLIST

CARE PLAN: Collaboration with: □ Patient □ Caregiver □ Representative □ Family involvement

MEDICATION STATUS: □ Medication regimen completed □ No change □ Order obtained
Therapy only case: List of medications submitted to HHA RN for drug regimen review? □ No □ Yes
If yes, name of RN who reviewed medications and contacted physician, if indicated:
Check if any of the following were identified:
❑ Potential adverse effects □ Drug reactions □ Ineffective drug therapy □ Significant side effects
❑ Significant drug interactions □ Duplicate drug therapy □ Non-compliance with drug therapy

CARE COORDINATION: □ Certifying Physician □ PT □ OT □ SLP □ MSW □ Aide □ Other (specify):
Was a referral made to MSW for assistance with: □ Community resources □ Living will □ Counseling needs □ Unsafe environment
❑ Other:
Date: ______________ □ Yes □ No □ Refused □ N/A

Summary:

Verbal Order obtained: □ No □ Yes, specify date: ______________

SIGNATURE/DATE

X
Person Completing This Form (signature/title) Date Time
Agency Name Phone Number

PATIENT NAME – Last, First, Middle Initial PHYSICIAN NAME / TITLE ID#
# INSTRUCTIONS
FOR COMPLETING CARE PLAN PAGES

Complete frequency and duration then develop plan of care.

Guidelines for Goal Statement:
- Goal template: **Who** The __ patient ___ caregiver will ___ increase ___ improve ___ maintain; **what** (identified deficit, need or functional limitation); **amount of measurable change/objective measure** (from baseline score/measurement, with a device or human assistance if needed, to reach a specific goal with a device or human assistance, if needed; objective measurement can be a validated assessment score or other measurement methods); **why/functional relevance** (related to patient's clinical need and the patient's personal goal); **when/time frame projection** (within ___ days ___ weeks or by a specific date); indicate short or long term goal: to facilitate the patient's discharge.

Short term goal (STG) or long term goal (LTG). See examples below.

### #1.
**Patient** will **improve** right shoulder ROM from 90 degrees to 135 degrees in 6 weeks (LTG), to be able to comb her hair, to facilitate discharge/referral.

### #2.
**Patient** will **increase** hip extensor strength from 3+/5 to 4/5 in 3 weeks (STG), to allow sit to stand transfer on 1st attempt, to facilitate discharge/referral.

### #3.
**Patient** will **increase** distance ambulated from 20 feet to 40 feet with front wheel walker in two 2 weeks (STG) to allow ability to walk from bedroom to bathroom safely with standby assist, to facilitate discharge/referral.

The purpose of this Therapy Care Plan is to add new goals to the current plan of care when the nursing clinical manager is responsible for case management. Goals can be short or long term.

Guidelines for filling out the Plan of Care pages:
- Fill-in **Certification Date** in top right corner of form.
- Fill-in **Today’s Date** in top left corner of form.
- Write in **Frequency and Duration**.
- Assign a number to each goal that is written. Write the goal number in the box labeled **Goal #**.
- Write the date the goal will start in the column labeled **Start Date**.
- When a goal is completed/met put the date in the column labeled **Date Completed/Met**.
- Write the expected discharge date in the column labeled **Date of Expected Discharge**.
- If applicable, write the date that a goal changes in the column labeled **Date Goal Changed/Updated**.

<table>
<thead>
<tr>
<th>GOAL #</th>
<th>IDENTIFIED NEED/IMPAIRMENT (based on evaluation)</th>
<th>EXPECTED PATIENT OUTCOME/OBJECTIVE GOAL(S)</th>
<th>THERAPY INTERVENTION/ACTION (Therapy will...)</th>
<th>EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Start Date</td>
<td>Date Goal Changed/Updated</td>
<td>Date Completed/Met</td>
<td>Date of Expected Discharge</td>
</tr>
<tr>
<td>3/1/2018</td>
<td>Patient will increase distance ambulated from 20 feet to 40 feet with front wheel walker in two 2 weeks (STG) to allow ability to walk from bedroom to bathroom safely with standby assist, to facilitate discharge/referral.</td>
<td>3/14/2018</td>
<td>3/14/2018</td>
<td></td>
</tr>
<tr>
<td>3/14/2018</td>
<td>Patient will increase distance ambulated 40 feet without walker in two 2 weeks (STG) to allow ability to walk from bedroom to bathroom safely with standby assist, to facilitate discharge/referral.</td>
<td>3/28/2018</td>
<td>3/28/2018</td>
<td></td>
</tr>
</tbody>
</table>

Write one goal per box of the care plan. Do not change the goal numbers. For example, goal #1 will always be goal #1. If goal #1 is changed/updated continue to call it goal #1. See example directly above.

Use this form when nursing provides case management. The information will be added to the plan of care and sent to the physician to be signed.

If you need more space or new goal boxes, use Therapy Care Plan Addendum (Briggs form 3502P).
Complete section below based on findings of comprehensive evaluation. 
Note: some information below may be duplicated on other documents, for example comprehensive OASIS assessment.

All pertinent diagnoses (include ICD codes):

Probable diagnosis: ___________________________  Advance Directives: ○ Yes  ○ No
Rehabilitative potential: _______________________
Patient’s mental, psychosocial and cognitive status: ____________________________________________

Types of services/supplies and equipment required: ____________________________________________

Nutritional/diet requirements: ______________________________________________________________

Functional limitations: _________________________________________________________________

Activities permitted: _________________________________________________________________

Safety measures to protect against injury: ________________________________________________

Education  Training needed:
Medication list and treatment list (included per agency policy): ○ Yes  ○ No  ○ N/A (explain):

If patient post hospitalization at the time of home health admission, list appropriate interventions necessary to address and mitigate identified risk factors for re-hospitalization and/or ED visits (this can be specific to disease process):

<table>
<thead>
<tr>
<th>SIGNATURE/DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician Print Name/Title</td>
</tr>
<tr>
<td>PATIENT NAME – Last, First, Middle Initial</td>
</tr>
<tr>
<td>GOAL #</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Start Date</td>
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<td>GOAL #</td>
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<tr>
<td>GOAL #</td>
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</tr>
</tbody>
</table>

**Signature/Date**

Clinician Print Name/Title

Clinician Signature/Title

Date

Time

口 Verbal orders read back (if applicable)

**Patient Name** – Last, First, Middle Initial

**Physician Name/Title**

**ID#**

**Physiotherapy Care Plan**

**Briggs Healthcare**

Page 2 of 2