Appendix 7:
Aged Care Pain Chart

UR No.: ____________

Surname: ____________

Given Name: ____________

D.O.B.: ____________

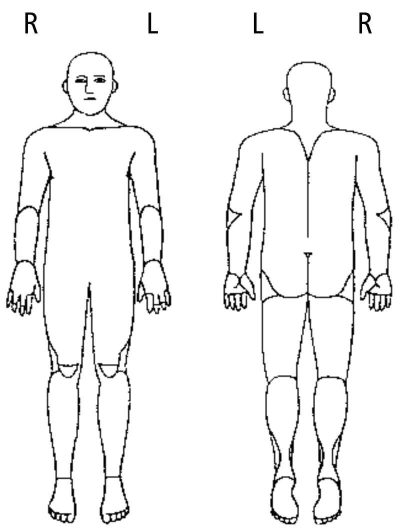
Please fill in if no Patient Label available

DATE ___/___/___		Midnight – 6 a.m.						7 a.m. – Midday						Midday – 6 p.m.						7 p.m. – Midnight					
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
	Pain Assessment																								
	Activity																								
	Behaviour																								
	Intervention																								
	Comments "e.g. intervention was effective or ineffective"																								

DATE ___/___/___		Midnight – 6 a.m.						7 a.m. – Midday						Midday – 6 p.m.						7 p.m. – Midnight					
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
	Pain Assessment																								
	Activity																								
	Behaviour																								
	Intervention																								
	Comments "e.g. intervention was effective or ineffective"																								

On the Diagram below record location of pain:

(x chronic pain, #acute pain).



Instructions for Use

1. **Perform a pain assessment on all admissions.**

2. **Make a clinical decision of how often to perform pain assessment.**
   The frequency of pain charting is a matter of clinical judgment. It may be appropriate once or several times per day, before or after wound dressings or physical activity, or to assess response to analgesics or interventions. If assessment shows pain as a significant problem, perform an initial 3-day charting. If pain is not a significant problem, use routine charts.

3. **Pain assessments must be documented.**

Verbal Persons:

- Select scale using person's preference, see examples below.
- Use the same scale consistently during the stay.
- Assess type of activity at time of pain report.
- Document intervention (can be multiple).
- Document the person's response to intervention.

Persons Unable to Communicate Verbally:

- Observe and document pain behaviours (can be multiple).
- Assess type of activity at time of pain behaviour.
- Document intervention (can be multiple).
- Consider informant history, eg. from spouse or carer.
- Document the person's response to intervention.

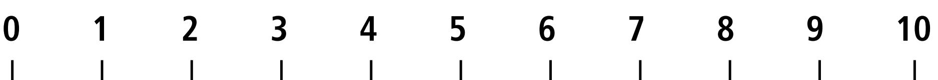
Note:
Self-report is preferred to observational scales. The person's ability to communicate pain may fluctuate.

Verbal Pain Scale
0 – No pain
2 – Mild
3 – Moderate
4 – Severe

Use the following codes to record activities, pain behaviour and interventions

Code: Activities	Code: Pain Behaviour	Code: Interventions
A In bed	1 Verbally describes pain	Z Analgesics
B Seated	2 Facial grimacing	Y Passive therapy e.g. heat packs, massage etc.
C Transferring	3 Looking tense, sad, distressed or frightened	X Cognitive therapy e.g. relaxation, music
D Ambulating	4 Screaming, moaning, groaning or calling out	W Alternative treatments e.g. acupuncture, aromatherapy etc.
E ADL activities	5 Laboured breathing or hyperventilation	V Physiotherapy
F Rehabilitation activity	6 Rigid, fists clenched, pulling away, striking out	T Other e.g. cups of tea, visitors, group activities etc.

Numerical Rating Scale



Edvardsson D, Katz B, Nay R. Australasian Journal on Ageing. 2008;27(2):93-96.
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