

CNA/Nurse Resident Assessment of COPD

Resident's Name:

Date:

1) In the past month, how often did you feel short of breath?

- Never Some of the time Most of the time All of the time

If not, skip to question 4.

2) When do you get short of breath? (**Check all that apply**)

- When dressing Walk a short while Exercise Get in a hurry
 Other _____

3) Do you ever wake up at night because you feel short of breath?

- No, never Couple nights a week Most nights of the week Every night of the week

4) Do you ever cough up stuff such as mucous/phlegm?

- No, never Only when I have a cold Yes, a few times a month Most days of the week
 Everyday

5) Do you ever feel depressed or down because of breathing problems?

- No, never Some of the time Most of the time All of the time

6) In the past month, have you done less than you used to because of breathing? *e.g. socializing, talking, participating in any group events*

- No Yes If yes, what activities of daily living?

7) Do you think you walk slower than most people your age because of breathing?

- Not applicable (not mobile) No Yes

8) Do you feel anxious or nervous because of your breathing problems?

- No, never Some of the time Most of the time All of the time

9) How is your breathing right now? _____

CHARGE NURSE PLEASE CHECK IF ANY OF THE FOLLOWING APPLY:

Has your resident in the past 3 months:

_____ Visited the E.R., Hospital or Urgent Care because of breathing?

_____ Increased their use of rescue medication?

_____ Used an antibiotic or oral steroid?

_____ Had a severe cold or flu?

If question 9 indicates an issue with breathing was the resident assessed by a nurse and the outcome of the assessment:

Yes _____ No _____ Analysis:

COMPLETE IF A RESIDENT IS ON A HAND-HELD INHALER:

Is your resident:

Capable of following proper inhalation techniques?

Able to generate enough inspiratory flow to inhale the full dose of the medication?

COMPLETE IF YOUR RESIDENT IS ON A NEBULIZER TREATMENT

Does the resident self-administer this treatment?

Is there a physician order for self-administration?

Has a self-administration assessment been done within the last 3 months?

Nurse's Signature & Title

Date Completed