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