L524
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§418.54(c) Standard: Content of the comprehensive assessment

The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process.

Interpretive Guidelines §418.54(c)

The assessment would include, but not be limited to, screening for the following: pain, dyspnea, nausea, vomiting, constipation, restlessness, anxiety, sleep disorders, skin integrity, confusion, emotional distress, spiritual needs, support systems, and family need for counseling and education. The hospice would then gather additional information, as necessary, to be able to meet the patient/family needs. For example, in addition to screening the patient for the presence of pain, a comprehensive assessment of the

patient's pain based on accepted clinical standards of practice may necessitate gathering the following information, as applicable to the patient:

- History of pain and its treatment (including non-pharmacological and pharmacological treatment);
- Characteristics of pain, such as:
  - Intensity of pain (e.g., as measured on a standardized pain scale);
  - Descriptors of pain (e.g., burning, stabbing, tingling, aching);
  - Pattern of pain (e.g., constant or intermittent);
  - Location and radiation of pain;
  - Frequency, timing and duration of pain;
  - Impact of pain on quality of life (e.g., sleeping, functioning, appetite, and mood);
  - Factors such as activities, care, or treatment that precipitate or exacerbate pain;
  - Strategies and factors that reduce pain; and
  - Additional symptoms associated with pain (e.g., nausea, anxiety).
- Physical examination (may include the pain site, the nervous system, mobility and function, and physical, psychological and cognitive status);
- Current medical conditions and medications; and
- The patient/family's goals for pain management and their satisfaction with the current level of pain control.