

RESOURCE 01 / PRACTICE WORKSHEET

Pain Assessment & Functional Goals

Practice a patient-centered interview and connect pain findings to everyday function.

For supervised learning or simulation. Use a case code only; omit patient identifiers. Never upload completed worksheets containing patient information.

Case code: _____ Learner: _____ Practice date: _____

1 Hear the pain story [1]

Onset	When did it start? Sudden or gradual? Related event? _____
Location / radiation	Where is the pain? Does it travel elsewhere? _____
Quality	Use the patient's own words: aching, burning, sharp, etc. _____
Pattern / timing	Constant or comes and goes? Duration and daily pattern? _____
Worse / better	Activities, positions, treatments, or other triggers? _____

2 Record the report and functional impact [1,2]

Measure / context	Facility-approved scale: _____ Score: _____ At rest or during which activity? _____
Patient priorities	Effect on walking, self-care, sleep, mood, or school/work: _____
Meaningful goal	"I want to be able to ..." Include a realistic task and timeframe. _____

3 Check context before planning

Treatments tried, benefit/side effects, relevant findings, and communication supports:

New/worsening concerns to report; supervisor notified and next step:

RESOURCE 01 / LEARNING NOTES & SELF-CHECK

Listen. Measure. Clarify.

Use the worksheet to learn a process, not to reduce a person to a pain score.

Start with the person, not the number [1]

Respect the person's report. Pain is a personal experience; appearance or vital signs alone do not determine how much pain someone has. Ask without judgment and use an interpreter or other communication support when needed.

Use the right method [1,3]

Use self-report when the person can communicate reliably. A 0-10 numeric rating may be appropriate: 0 = no pain; 10 = worst pain imaginable. Record the scale and whether the rating was at rest or with activity.

When reliable self-report is not possible, use a population-appropriate, facility-approved observational tool with supervision. Include caregiver knowledge and clinical findings. No verbal report does not mean no pain; do not convert a behavior score into a verbal pain rating.

Describe progress in daily life [2]

Agree on a task that matters to the patient, the assistance required, and a realistic review time. Follow mobility restrictions and the established care plan. A score change is only one part of the response.

Fictional goal-writing example

Instead of: "Pain will be zero."

Try: "By the next therapy review, the patient will walk to the dining room using the prescribed device and required staff assistance, as tolerated and consistent with the care plan."

Recognize urgent changes

New chest pain, severe breathing difficulty, sudden neurologic changes, or new bladder/bowel dysfunction with groin numbness require immediate escalation. Follow the site's emergency process and notify the supervising clinician; do not finish the worksheet first. This is not a complete warning-sign list.

Before you submit

☐ I recorded the patient's words and the scale/context used.

☐ I described at least one activity affected and one patient-chosen goal.

☐ I separated patient report from my observations and reported urgent changes.

Preceptor feedback / one assessment skill to improve:

Teaching sources

[1] Raja, S. N., et al. (2020). The revised IASP definition of pain: Concepts, challenges, and compromises. *Pain*, 161(9), 1976-1982. [Source](#)

[2] Dowell, D., et al. (2022). CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022. *MMWR*, 71(RR-3), 1-95. [Source](#)

[3] Herr, K., et al. (2019). Pain assessment in the patient unable to self-report: Clinical practice recommendations in support of the ASPMN 2019 position statement. *Pain Management Nursing*, 20(5), 404-417. [Source](#)

The CDC source addresses adult outpatient prescribing; its scope excludes sickle cell disease, cancer-related pain, palliative care, and end-of-life care. Use the appropriate specialty guidance for those settings.

Original educational worksheet, not a validated assessment instrument, medication order, or clinical protocol. Follow current site policies, approved resources, and supervision requirements.

RESOURCE 02 / PRACTICE WORKSHEET

Intervention & Reassessment

Practice the full care cycle: assess, intervene, reassess, communicate, and document.

For supervised learning or simulation. Use a case code only; omit patient identifiers. Never upload completed worksheets containing patient information.

Case code: _____ Learner: _____ Practice date: _____

1 Establish a baseline [1,2]

Baseline / goal	Practice time: _____ Scale / pain rating: _____ Activity affected and agreed goal: _____
Safety / context	Relevant findings, alertness, breathing if indicated, restrictions, allergies, and patient preference: _____

2 Describe what was actually done

Intervention	Method, patient agreement, and actual time: _____ If medication: record verified order details from an approved source. _____
Supervision / plan	Supervising clinician / role: _____ Reassess at: _____ Based on intervention, condition, and policy.

3 Compare before and after [1,2]

Measure	Before intervention	At reassessment
Actual time	_____	_____
Same scale / activity context	_____	_____
Function / agreed task	_____	_____
Alertness / breathing, if indicated	_____	_____
Adverse effects / new findings	_____	_____

4 Close the loop

Patient-reported benefit, concerns, and next action / monitoring plan:

Who was notified, when, response received, and follow-up responsibility:

Do not delay urgent escalation to wait for a planned reassessment time.

RESOURCE 02 / LEARNING NOTES & SELF-CHECK

Show What Changed

A useful reassessment includes benefit, function, safety, and the next action.

Choose the timing deliberately [1,2]

There is no single reassessment interval that fits every intervention. Use the route and expected effect of a medicine, the non-drug intervention used, patient risk, orders, and site policy. Record the planned time and the actual time. Reassess sooner when the condition changes.

Compare like with like [1,2]

Use the same pain scale when appropriate and describe the activity context. A resting rating before treatment and a walking rating after treatment are not directly equivalent. Ask whether the patient can do the agreed task more comfortably or with less assistance.

Keep safety separate from pain relief [2]

Less pain does not automatically mean a medicine is safe. When relevant, reassess arousability, respiratory rate and quality, oxygenation as ordered, dizziness, nausea, and other adverse effects. Record actual findings rather than "tolerated well" without supporting observations.

Escalation practice

If a patient is difficult to awaken or has slow, shallow breathing, activate the site's emergency response and notify the supervising clinician immediately. Follow emergency protocols; do not wait for routine reassessment.

Documentation practice

Fictional non-medication example

14:00: Patient reports low-back ache, 5/10 while sitting, and requests repositioning. Assisted to a supported position within the care plan.

14:20: Still sitting, now supported; reports 3/10 and can continue eating lunch; no new symptoms reported. Supervising nurse updated. Continue the agreed plan and reassess if symptoms change.

The example shows documentation structure only; the 20-minute interval is not a universal recommendation.

Write one sentence showing response, function, and a safety finding:

Teaching sources

[1] Chou, R., et al. (2016). Management of postoperative pain: A clinical practice guideline. The Journal of Pain, 17(2), 131-157. [Source](#)

[2] Dowell, D., et al. (2022). CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022. MMWR, 71(RR-3), 1-95. [Source](#)

The postoperative and adult outpatient sources apply to different settings. Neither replaces local reassessment or emergency-response policy; CDC prescribing guidance has specialty exclusions.

Original educational worksheet, not a validated assessment instrument, medication order, or clinical protocol. Follow current site policies, approved resources, and supervision requirements.

RESOURCE 03 / PRACTICE WORKSHEET

Non-Medication Pain Care Planner

Match one feasible strategy to the patient's goal, preferences, and safety needs.

For supervised learning or simulation. Use a case code only; omit patient identifiers. Never upload completed worksheets containing patient information.

Case code: _____ Learner: _____ Practice date: _____

1 Agree on a goal

Pain / function	Main concern and activity affected: _____ _____
Patient preference	What has helped? What would the patient like to try? _____
Practical barriers	Language, equipment, cost, fatigue, mobility, sensory needs: _____

2 Choose a supervised option [1,2]

- ☐ Positioning ☐ Pacing ☐ Gentle movement / rehabilitation
☐ Breathing / relaxation ☐ Preferred music / distraction
☐ Heat or cold, if appropriate ☐ Other: _____

Safety checks	Restrictions, sensation/skin, fall risk, or other precautions: _____
Agreed plan	Method, duration per approved guidance, equipment, and support: _____
Teaching / choice	Explain expected comfort benefit, stop signals, and the right to decline. How will the patient show understanding? _____

3 Evaluate rather than assume benefit

Response	Before / after: same pain scale and activity context. What changed in comfort, function, or symptoms? _____
Next step	Continue, adapt with supervision, or stop and report? Review time / person responsible: _____

Choose an Option With Care

These are discussion prompts, not a menu of proven treatments for every pain condition.

Options and safety questions [1,2]

Option	Possible use / purpose	Check before trying
Positioning / support	Comfort during rest or an agreed task.	Follow mobility and postoperative restrictions; check skin and support needs.
Pacing	Break a task into manageable steps and planned rests.	Avoid an all-or-nothing activity pattern; coordinate with the rehabilitation plan.
Movement / PT / OT	Physical therapy (PT), occupational therapy (OT), and appropriate activity for daily function.	Confirm weight-bearing status, fall precautions, and individualized exercise guidance.
Heat / cold	Comfort for selected conditions; heat is an option for some acute low-back pain.	Follow device directions and policy. Protect skin; impaired sensation or circulation needs clinician review. Do not sleep on a heating device.
Breathing / relaxation	Reduce tension and support coping.	Use comfortable, unforced breathing; stop if dizzy or distressed.
Preferred music / distraction	Support comfort or relaxation according to patient preference.	Ask permission; keep volume safe and preserve communication and awareness.

How to explain the plan

Patient-centered language

"We can try an option you feel comfortable with while following your care plan. We will check whether it helps you do what matters to you. Please tell me if it worsens your symptoms or you want to stop."

Self-check

- ☐ The patient chose or agreed to the option; declining was respected.
- ☐ I checked restrictions and documented response, not just completion.
- ☐ I reported new or worsening symptoms and did not substitute this for needed evaluation.

Teaching sources

[1] Qaseem, A., et al. (2017). Noninvasive treatments for acute, subacute, and chronic low back pain: A clinical practice guideline. *Annals of Internal Medicine*, 166(7), 514-530. [Source](#)

[2] Dowell, D., et al. (2022). CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022. *MMWR*, 71(RR-3), 1-95. [Source](#)

The ACP reference is specific to low-back pain. The CDC source discusses multimodal care within its adult outpatient scope. These sources do not establish equal benefit for every option or condition.

Original educational worksheet, not a validated assessment instrument, medication order, or clinical protocol. Follow current site policies, approved resources, and supervision requirements.

RESOURCE 04 / PRACTICE WORKSHEET

Pain Medication Safety Study Sheet

Study one medication using an approved drug reference and supervised clinical reasoning.

For supervised learning or simulation. Use a case code only; omit patient identifiers. Never upload completed worksheets containing patient information.

Case code: _____ Learner: _____ Practice date: _____

1 Identify the medicine and purpose

Medication / class	Generic name: _____ Class: _____ Indication in this learning case: _____
Verified regimen	Dose, route, frequency, and PRN (as needed) indication from the order: _____
Reference / review	Approved source, version/date accessed: _____ Supervisor review: _____

2 Complete the pre-administration study check [1-3]

Reconciliation	Allergies/reactions; other prescriptions, OTC products, supplements; last dose; duplicate ingredients/classes: _____
Patient factors	Renal/hepatic function, bleeding/ulcer history, pregnancy concerns, respiratory disease, falls, or other relevant risks: _____
Monitoring	Relevant labs, vitals, alertness, interactions, and parameters from the order/policy: _____

3 Define benefit, risk, and teaching

Intended benefit	Pain type targeted and functional goal: _____ How and when will benefit be reassessed? _____
Safety / education	Key adverse effects, when to report, safe use/storage, and teach-back: _____

Unanswered question to resolve with the pharmacist / supervising clinician:

Study worksheet only. Do not use it to prescribe, calculate a new dose, change an order, or authorize medication administration.

Look Beyond the Drug Name

Non-opioid does not mean risk-free. Use current labeling, orders, and site policy.

Safety points to investigate [1-3]

Medication group	Questions for the student
Acetaminophen	Is it also in a combination product? What total daily amount is ordered across all products? What liver-related risks or individualized limits need review?
NSAIDs	Nonsteroidal anti-inflammatory drugs, such as ibuprofen, naproxen, and diclofenac. Check kidney, gastrointestinal/bleeding, cardiovascular, and pregnancy-related risks; avoid assuming topical products are risk-free.
Topical pain medicines	Confirm the exact ingredient, indication, application limits, skin condition, heat restrictions, and safe disposal on the product label.
Selected prescription non-opioids	Examples: duloxetine, gabapentin, pregabalin. Verify the specific pain indication, interactions, adjustment needs, sedation/falls, and stopping instructions. Gabapentinoids can add breathing risk with opioids or other risk factors.
Opioids	Verify indication, functional goal, last dose, alertness/breathing, interacting sedatives, adverse-effect prevention, and monitoring. Ask about naloxone education and secure storage.

Opioid safety learning check [1,3]

- ☐ I checked for alcohol, benzodiazepines, and other sedating medicines.
- ☐ I know the site's sedation/respiratory assessment and escalation process.
- ☐ I can explain that naloxone does not replace an emergency response.
- ☐ I would not recommend abrupt discontinuation or a taper from this worksheet.

Act on respiratory warning signs

If a patient is difficult to awaken or has slow, shallow breathing, activate the site's emergency response and notify the supervising clinician immediately. Follow emergency protocols, including naloxone when indicated and within training/authorization.

Teaching sources

[1] Dowell, D., et al. (2022). CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022. MMWR, 71(RR-3), 1-95. [Source](#)

[2] National Library of Medicine. Pain relievers. MedlinePlus. General medication education; consult current product labeling for individual medicines. [Source](#)

[3] U.S. Food and Drug Administration (2019, December 19). Drug Safety Communication: Serious breathing problems with gabapentin and pregabalin, especially with respiratory risk factors. [Source](#)

CDC 2022 guidance addresses adult outpatient prescribing, not sickle cell disease, cancer-related pain, palliative care, or end-of-life care. FDA link opens its safety-information hub; search the named 2019 communication. Verify current labeling before clinical use.

Original educational worksheet, not a validated assessment instrument, medication order, or clinical protocol. Follow current site policies, approved resources, and supervision requirements.

RESOURCE 05 / PRACTICE WORKSHEET

Pain SBAR Handoff & Teach-Back

Practice concise communication, a clear request, and a shared follow-up plan.

For supervised learning or simulation. Use a case code only; omit patient identifiers. Never upload completed worksheets containing patient information.

Case code: _____ Learner: _____ Practice date: _____

1 Organize your SBAR message [1]

S Situation	What is happening now? Main concern, current pain report, functional impact, and urgency: _____ _____
B Background	Relevant diagnosis/history, baseline, allergies, recent medicines (with timing), interventions, and restrictions: _____ _____
A Assessment	What did the patient report? What did you observe? Include reassessment, relevant safety findings, and your uncertainty: _____ _____
R Recommendation or request	What do you need from the supervising clinician, and how soon? State the request rather than proposing an independent order: _____ _____

2 Confirm that the message led to a plan

Receiver / time	Receiver and role: _____ Practice time: _____ Response / agreed action: _____
Closed loop	Read back or confirm key instructions per site policy. Who will do what, by when? _____
Follow-up	What will be reassessed, and who will receive the update? _____

Emergency findings: use the site's urgent response process immediately. SBAR structure must not delay emergency care.

Teach Back, Then Check In

Teach-back checks how clearly you explained something; it is not a test of the patient. [2]

1 Use a short explanation and an open request [2]

Example language

"I want to make sure I explained this clearly. In your own words, how will you use this comfort strategy, and what symptoms would make you stop and call for help?"

Use an interpreter or other communication aid when needed. Ask for a demonstration when teaching a hands-on skill. Re-explain in a different way and check again if the first explanation was unclear. [2]

2 Document what the patient understood

Topic / key message	One or two points taught in plain language: _____
Teach-back response	Patient's actual explanation or demonstration: _____
Clarify / recheck	What needed reteaching? What was understood after rechecking? _____
Support / follow-up	Patient questions, interpreter/caregiver involvement with permission, and agreed next step: _____

3 Compare with a fictional SBAR example [1]

S: "I am concerned that the current pain plan is not helping the patient transfer to the chair."

B: "They have postoperative knee pain and require assisted transfers. We just reassessed after supported repositioning."

A: "Pain remains 6/10 during the same transfer task. The patient is alert, breathing comfortably, and reports no new symptoms."

R: "Could you assess the patient with me and confirm the next action and reassessment plan?"

Self-check

☐ I made a specific request, named the receiver, and confirmed follow-up.

☐ I documented the patient's response, not only "verbalized understanding."

Teaching sources

[1] Institute for Healthcare Improvement. SBAR Tool: Situation-Background-Assessment-Recommendation. Communication framework; this worksheet is an original adaptation. [Source](#)

[2] Agency for Healthcare Research and Quality (2015). Health Literacy Universal Precautions Toolkit, 2nd ed., Tool 5: Use the Teach-Back Method. Publication No. 15-0023-EF. [Source](#)

The linked AHRQ page may reflect a newer toolkit edition; the teaching reference here is the 2015 second edition. Use current institutional communication and documentation policies.

Original educational worksheet, not a validated assessment instrument, medication order, or clinical protocol. Follow current site policies, approved resources, and supervision requirements.