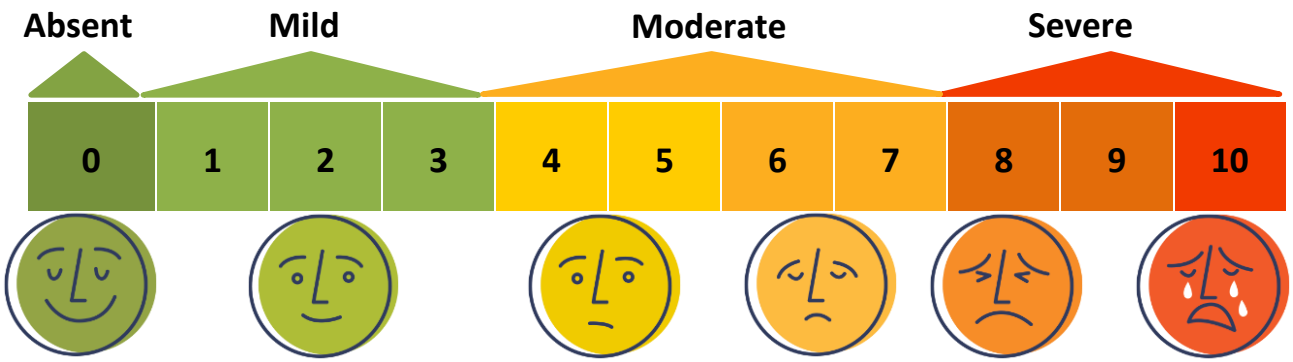
# Symptom Assessment Scale Guide




| ACTION | | | |
|---|---|---|---|
| **Absent (0)** | **Mild (1-3)** | **Moderate (4-7)** | **Severe (8-10)** |
| **No Action** | Report to RN/Supervisor **WITHIN SHIFT** | Report to RN/Supervisor **WITHIN 30 MINUTES** | Report to RN/Supervisor **IMMEDIATELY** |

| SYMPTOM | SAS SCORE GUIDE |
|---|---|
| **PAIN** | **Any discomfort, ache, soreness, stabbing, sharp or dull pain** |
| 0 1 – 3 | Score 0 Resident states there is no distress from pain **OR** does not show signs of distress from pain |
| | Scores 1-3 or may appear slightly uncomfortable or unsettled |
| 4 - 7 | Scores 4 to 7 **OR** shows signs such as groaning, moaning, or grimacing, being agitated or restless |
| 8 - 10 | Scores 8-10 **OR** shows signs such as crying, groaning, grimacing; holding or guarding parts of the body, signs appear to worsen on movement, being very restless or agitated or aggressive |
| **FATIGUE** | **Loss of strength, low energy, very tired, weakness** |
| 0 1 – 3 | Score 0 Resident states there is no distress from fatigue **OR** does not show signs of distress from fatigue |
| | Scores 1-3 **OR** appears mildly frustrated when try to complete usual activities |
| 4 - 7 | Scores 4 -7 OR appears moderately frustrated or annoyed when trying to complete usual activities. Disinterested in usual activities. |
| 8 - 10 | Scores 8-10 **OR** appears very irritated and/or frustrated when attempting to complete usual activities. Resident may give up part way through activity, or not even attempt activity. ???Sleepiness at inappropriate times (e.g. at meals). |
| **BREATHING** | **Rapid breathing, noisy breathing, shallow breathing, irregular breathing** |
| 0 1 – 3 | Score 0 Resident states there is no distress from breathing problems **OR** does not show signs of distress from breathing |
| | Scores 1-3 **OR** seems a bit breathless and worried. Gets breathless when moving around. |
| 4 - 7 | Scores 4- 7 **OR** seems quite short of breath, and is taking big breaths in and out, and appears to be concentrating/fixating on their breathing. Gets breathless when talking uninterrupted for a time. |
| 8 - 10 | Scores 8-10 **OR** seems short of breath and signs of panic such as grabbing onto staff, refusing to eat or drink, avoiding talking more than a couple of words at a time, restless, agitated |

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| | |
|---|---|
| **BOWELS** | **Constipation, diarrhoea, abdominal discomfort** |
| 0 1 – 3  | Score 0 Resident states there is no distress from bowels **OR** does not show signs of distress from bowels |
| | Scores 1-3 **OR** appears concerned with opening their bowels, or mild lower stomach discomfort shown by holding or touching lower stomach |
| 4 - 7  | Scores 4-7 OR appears quite concerned with opening their bowels, appears have pain or discomfort in their lower stomach, may request to go to the toilet constantly. Straining to open bowels. OR may be upset by diarrhoea or faecal incontinence |
| 8 - 10  | Scores 8-10 **OR** is very fixated with opening their bowels, appears to be in a lot of pain or discomfort in their lower stomach, may be restless and agitated, may not have opened their bowels for a few days but now have a small amount of runny faeces, may refuse food. OR may be highly distressed by diarrhoea or faecal incontinence. |
| **NAUSEA** | **Feeling sick, wanting to vomit, dislike of food odours** |
| 0 1 – 3  | Score 0 Resident states there is no distress from nausea **OR** does not show signs of distress from nausea |
| | Scores 1-3 **OR** shows dislike of food & drink, may dry retch, may vomit |
| 4 - 7  | Scores 4-7 **OR** may actively push away or turn away from food, may dry retch, may vomit, and appears upset when this happens |
| 8 - 10  | Scores 8-10 **OR** is refusing food and drink, gags, dry retches or vomits often, and appears very upset and/or exhausted when this happens |
| **APPETITE** | **Not wanting to eat, decrease in food intake** |
| 0 1 – 3  | Score 0 Resident states there is no distress relating to appetite **OR** are eating and drinking normally |
| | Scores 1-3 **OR** may only eat part of their meal and appears mildly frustrated |
| 4 - 7  | Scores 4-7 **OR** attempts to eat and drink, may sigh and stop eating or attempts to eat/drink but gives up partway through meal/snack and appears frustrated or annoyed |
| 8 - 10  | Scores 8-10 **OR** may refuse food/drink, and appears very irritated/frustrated/annoyed. May push food away or is upset by sight of food. Refuses to attend dining room or is upset when food is placed near them. |
| **SLEEPING** | **Awake during the night-sleeping during the day, restless and/or irritable during the night** |
| 0 1 – 3  | Score 0 Resident states there is no distress from sleeping problems **OR** shows no signs of distress from sleeping problems |
| | Scores 1-3 **OR** may be tossing and turning throughout the night or when trying to sleep |
| 4 - 7  | Scores 4-7 **OR** may be tossing and turning when trying to sleep, and sighing, or calling out for staff, may be unable to sleep for more than short periods of time. Upset about being tired and sleepy during the day. |
| 8 - 10  | Scores 8-10 **OR** unable to fall asleep or stay asleep for long, very restless, very agitated, calling repeatedly for staff, constantly tired and low in mood, irritable. Falls asleep during normal activities (e.g. shower, meals) |