Dear Colleague:

We appreciate your interest in the Pain Audit Tools developed and used at the City of Hope Medical Center. Attached for your information and use are three examples.

Example 1 is the Chart Audit Form. A few comments about the items are:

1. Item 3 identifies disease status based on our oncology population. You may want to modify this to represent different patient groups in your setting.

2. Items 8 & 9 identify how pain is currently charted. For example, you might note that the physician states pain is mild; evening nurse states that pain is better. No recordings on days or evening shifts.

3. Items 10 and 11 refer to follow-up evaluation. This is particularly useful since JCAHO looks at evaluation very closely.

Example 2 is the Patient Interview Component of the audit. You may also need to modify this form based on your patient population. We have found item 14 to be particularly helpful when compared to item 7 of the chart review form so that we can contrast what medication and dose is ordered for the patient versus what they are actually taking. In each of these audits we have found that the patients are consuming only a fraction, generally approximately 50%, of the medicines that are prescribed. This points to our need to improve compliance with medications already available in addition to ordering more appropriate medications.

Example 3 is a chart review form that was developed specifically for our Surgical Service. We have designated some specific surgeries to be reviewed. You may want to modify this based on the surgical procedures that you are interested in. This form serves as an example of modifying the audit to meet specific areas or needs.
You may also find the following articles useful in your efforts to conduct pain audits:


You may also wish to contact the American Pain Society for their QA guidelines (5700 Old Orchard Road, First Floor, Skokie IL 60077-1057, 708/966-5595).

We hope that these forms are useful to you. We have found auditing charts and doing patient interviews is a very important component of quality assurance to improve pain management. We look forward to hearing about your efforts.

Sincerely,

Betty R. Ferrell, RN, PhD, FAAN
Research Scientist
Nursing Research and Education
CHART AUDIT

Subject #__________
Medical Record #_______
Interviewer Initials_______
Date____________________

1. Patient Setting/Unit_________________________________________

2. Patient Diagnosis___________________________________________

3. Disease Status:  ____Cancer/Active Treatment
                   ____Cancer/Remission
                   ____Cancer/Palliative Care
                   ____Other than cancer________

4. Current Treatments
   ____ Radiation _____ Chemo ______ Surgery ______ Other (List)________

5. Reason for Admission/Visit__________________________________

6. Admitting Medical Service____________________________________

Chart Review

7. What is currently prescribed for the patient's pain?

<table>
<thead>
<tr>
<th>Medication</th>
<th>When Started</th>
<th>Dose</th>
<th>Route</th>
<th>Schedule</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
8. Is there evidence of use of objective ratings (i.e. visual analogues, rating scales, pain tools)?

   ___ No    ___ Yes
   (If yes identify both the rater and rating, example: "0-5 rating scale in nurse's notes")

9. Documented descriptions of pain other than objective ratings for the previous 24-hour period.
   If present, specify rater and description. (Example: "Physicians progress report says "Pain better.""

10. Has a follow-up evaluation been charted for:

   Medications:    Yes  No    Other Modalities    Yes  No

11. Is pain assessment reflected in:

   RN Admission/Hx:    Yes  No    RN Notes-Last 24 Hrs    Yes  No
   RN Care Plan:    Yes  No    MD H&P    Yes  No
   Last MD Progress Note:     Yes  No
   Other:    Yes  No

______________________________
PATIENT PAIN INTERVIEW

Your comfort is very important to us. We would appreciate your input on the following survey so that we might learn how to better relieve your pain. Your answers to this survey will remain confidential. Your participation is completely voluntary.

1. Your Age __ 2. __ Male __ Female

3. Your Diagnosis 

4. When was your cancer first diagnosed? ___ Month ___ Year

5. When did your pain first begin? ___ Month ___ Year

6. Who writes the prescriptions for your pain medications? (List doctors' names)

Please answer the following questions by circling the one number on each line that best describes your pain or other symptoms.

7. How much pain do you have right now?

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain As Bad As You Can Imagine

8. Over the past 24 hours, what is the average amount of pain you have had?

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain As Bad As You Can Imagine

9. What is the worst amount of pain you have had in the last week?

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain As Bad As You Can Imagine

10. Do you have a problem with constipation?

0 1 2 3 4 5 6 7 8 9 10
No Problem Severe Problem

11. Do you have nausea?

0 1 2 3 4 5 6 7 8 9 10
Never All the Time
12. Do you have a problem with drowsiness or sleepiness from your medication?

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<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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<tr>
<td>Never</td>
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<td></td>
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<td>All the Time</td>
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</table>

13. How satisfied are you overall with the current treatment you are receiving for your pain?

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<th>0</th>
<th>1</th>
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<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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<tbody>
<tr>
<td>Not At All</td>
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<td></td>
<td></td>
<td>Very Satisfied</td>
</tr>
</tbody>
</table>

14. What medicines are you taking for pain? Please list.

<table>
<thead>
<tr>
<th>Name of Medicine</th>
<th>How Much Is Ordered</th>
<th>How Much Have You Taken In Last 24 Hours</th>
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</table>

15. Which of the following influence or interfere with your pain management? (Check all that apply.)

- Money to pay for pain medications.
- Communicating or explaining your pain to others.
- Coming in to pick up prescriptions.
- Being afraid of being addicted to pain medicines.
- Side effects of pain medicine.
- Concern that I should save some pain medicine in case my pain gets worse.
- Other (Describe) ________________________________

16. Are you seeing any specialists for help with your pain? (Check any that apply.)

- Anesthesia
- Physical Therapy
- Pain Team
- Neurology
- Psychologist
- Occupational Therapy
- Radiation
- Other (Describe) ________________________________

17. Are you using anything other than medicines for your pain?

- Cold
- Massage
- Heat
- Relaxation
- Imagery
- TENS Unit
- Other (Describe) ________________________________

Please write any other information you would like to share on the back of this survey. Thank you for your help.
METHODS: Nursing staff to complete on day of discharge.

1. Patient setting: 

2. Patient diagnosis

   Primary surgical: 

   Primary medical: 

   Other medical: 

3. Cause of pain: 

4. Surgical procedures

   **Abdominal:**
   - Gastric, subtotal w/ bypass
   - Gastric, total w/ bypass
   - Gastric, other specify
   - Colon, hemicolecotomy w/ colostomy
   - Colon, hemicolecotomy w/ primary anastomosis
   - Colon, other, specify
   - Rectal, abdominal-perineal resection, w/ colostomy
   - Rectal, abdominal-perineal w/low anastomosis
   - Rectal, other, specify
   - Pancreatic, whipple procedure
   - Pancreatic, biopsy w/ bypass
   - Pancreatic, other, specify

   **Breast**
   - Mastectomy
   - Lumpectomy
   - Axillary node dissection
Gynecologic:

- Ovarian, TAH/BSO
- Corpus uteri, TAH/BSO
- Cervix uteri, TAH/BSO
- Vulva, Radical vulvectomy
- Pelvic exenteration
- Other

Disease Status:

- Active treatment
- Remission
- Palliative

5. Date of surgery: ________________________________

6. Date of first ambulation: ________________________________

7. Complications:
   - Pneumonia ________________________________
   - Wound infection ________________________________

8. Prior substance abuse history:
   - Alcohol ________________________________
   - Narcotics ________________________________
   - Other ________________________________

(taken from H&P)

9. Is there evidence of use of objective ratings (i.e. visual analogues, rating scales, pain tools)?
   - No
   - Yes Rater ________________________________ , rating __________________

10. Are there documented descriptions of pain other than objective ratings for the previous 24-hour period?
    - No
    - Yes Rater ________________________________

    Description ________________________________

DOCUMENTATION:

11. Has a follow-up evaluation been charted for:
    - Medications: Yes No
    - Other modalities: Yes No
12. Is pain assessment reflected in:

- RN Admission/HX: \( \Gamma \) Yes \( \Gamma \) No
- RN Notes-Last 24 hrs: \( \Gamma \) Yes \( \Gamma \) No
- RN Care plan: \( \Gamma \) Yes \( \Gamma \) No
- MD H&P: \( \Gamma \) Yes \( \Gamma \) No
- Last MD progress: \( \Gamma \) Yes \( \Gamma \) No
- Other: \( \Gamma \) Yes \( \Gamma \) No

13. Perioperative pain medications:

<table>
<thead>
<tr>
<th>Location</th>
<th>Date</th>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Taken</th>
<th>Schedule</th>
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<tbody>
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<td>Pre-Op</td>
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<td>Discharge Meds</td>
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<td>Home Phone Follow-Up</td>
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