ACUTE POSTOPERATIVE PAIN

APOP:
A Quality Improvement Initiative

Guide to data collection

April 2009

Funded and supported by

An independent, Australian organisation for Quality Use of Medicines,
funded by the Australian Government Department of Health and Ageing.

Table of contents

Table of contents 2
Data collection 3
  Patient population 3
  Identification of patients 3
  Coding patients 3
  Patient Consent for inpatient interview postoperatively 3
Guide to data collection 4
  How to use this guide 4
  APOP e-DUE Audit tool instructions 5
  1. Patient Demographics 6
  2. Surgical information 7
  3. Brief medical and pain history 8
  4. Postoperative Pain Management 9
  5. Discharge Management 12
  6. Inpatient Interview 14
Appendices 15
  Appendix 1: Analgesics 15
  Appendix 2: Selective serotonin reuptake inhibitors (SSRIs) 17
  Appendix 3: Serotonin and noradrenaline reuptake inhibitors (SNRIs) 17
  Appendix 4: Antiemetics 17
  Appendix 5: Laxatives 18
  Appendix 6: Routes of Administration - Analgesic 19
  Appendix 7: Routes of Administration - Antiemetic 19
  Appendix 8: Pain Assessment Scales 20
  Appendix 9: Sedation Scores 22

Data collection

Patient population

Participating hospitals are required to select a surgical patient group of interest for inclusion in APOP. You may wish to give particular consideration to surgical types or procedures which are known to result in severe acute postoperative pain and/or patients who are outside the care of acute pain services (APS).

The number of patients collected can be determined by the hospital. A suggestion would be a minimum of 20 patients.

Eligible patients can be identified either pre or postoperatively.

Identification of patients

The identification of surgical patients will be dependent upon the individual institution. The following sources maybe used to prospectively identify patients:

- Pre-admission clinic,
- Day of surgery list,
- Theatre list,
- Surgical ward list.

Eligible patients will be screened against the inclusion/exclusion criteria below.

Inclusion Criteria

Surgical patients who are:

- prescribed at least one analgesic postoperatively
  and
  who require hospitalisation after their procedure for up to 48 hours:
  - after returning to the ward, post operation
  - post-care of Acute Pain Service or cessation of patient-controlled analgesia (PCA)/epidural, whichever comes first.

This can also include day surgery patients. It is not intended for monitoring in recovery.

Coding patients

To ensure confidentiality is maintained throughout APOP, you may wish to use a coding system to de-identify individual patients. The application accepts up to 8 numbers as patient identification. Each hospital should identify a coding system, e.g UR No., combination of audit date and patient number – YYMM####. Data identifying individual patients or health practitioners must not be transmitted beyond the hospital.

Patient Consent for inpatient interview postoperatively

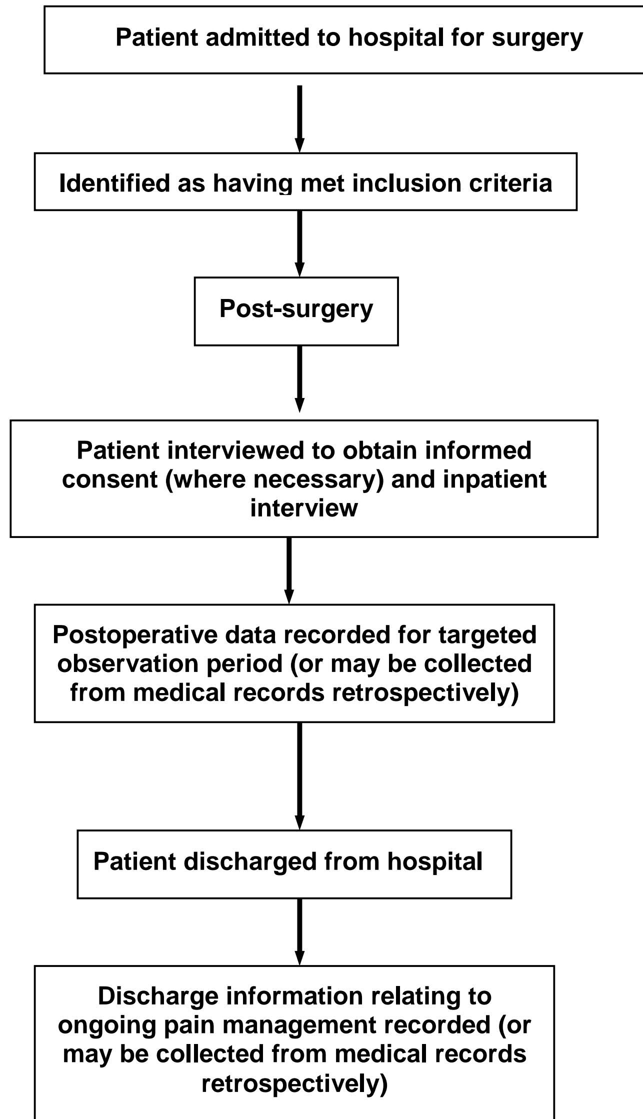
Prior to conducting the interview, check whether your hospital has any ethics requirements regarding contact with patients for this questionnaire and whether consent is required. If written consent is required, consent can occur at preadmission clinics or on the ward.

Guide to data collection

How to use this guide

This guide is a resource designed to assist in the collection of data. The guide is divided into a number of sections, structured around the *data collection form*. Within these sections data fields are defined. Explanatory notes about each field are also found in the APOP e-DUE Audit tool.

Figure 1: Summary of data collection processes for audit period.



APOP e-DUE Audit tool instructions

Following the collection of de-identified patient data for APOP, information is to be entered into the APOP e-DUE Audit tool (*APOP e-DUE*).

The *APOP e-DUE* allows data entry, automated analysis of entered data and generation of a summary report on selected key measures following data collection. The summary report is intended to help identify aspects of care in acute postoperative pain management requiring improvement, including outcomes, processes and systems of care.

Please note the following key points relating to data entry in APOP:

1. All information collected on the *data collection form* is an account of what has been documented in the patient's notes. Please ensure that all information collected is based on what has been documented. If it is not written down it should not be included on the data collection form.
2. All medications must be entered into *APOP e-DUE* using the generic drug name, which can be obtained from the tables provided in the appendix. If the medication is not included in the tables, other drug references can be used.
3. All dates must be entered carefully. For example, ensure that the date of discharge is after the data of admission.

The appendix contains a number of tables which may be of use when recording and entering data, including:

- Generic drug and trade names.
- Common units of dose used when prescribing medications.
- Common pain and sedation assessment scales.

To enter patients into the *APOP e-DUE*, click on the hyperlink on the Welcome screen, then click on [Add patient]. This will bring up a box in which to enter the Patient Number. You may use the patient's medical record number or another identifying number (see Coding Patients, page 3). See the Guide to using the *APOP e-DUE* Audit tool for further information.

A separate form, the '**Patient Record Form'** has been provided to record each patient's name, UR number and patient number. This form is confidential and should not be disclosed outside the hospital.

1. Patient Demographics

Section in the data collection form:

1. Patient Demographics	
Patient Number ____________	1.1 Gender: Male / Female
1.2 Age last birthday: _________ 1.3 Date of admission: __ / __ / __ 1.4 Date of discharge:__ / __ / __	
1.5 History of allergies/ADRs* to analgesics: Yes / No *(if Yes, please specify)* Drug (generic): _________	

Patient Number:

This number is unique to each patient. The patient's medical record number (MRN), or 'UR' number may be used or a unique patient number developed (see Coding Patients, page 3 for more detail).

1.1 Age last birthday:

For adults, enter the age last birthday in years. For children less than 1, enter the age in months.

1.3 Date of Admission:

This is the date on which the patient was admitted to hospital to undergo this surgical procedure and is usually found in the admission notes or admission details form. Alternatively, check the first progress notes entry.

1.4 Date of Discharge:

This is the date the patient left hospital. This may be found either on the last note in the admission notes, written on the discharge summary or on the front sheet of the admission.

1.5 History of allergies/ADRs to analgesics:

This is documentation of previous suspected/actual allergies or adverse drug reactions (ADRs) to analgesics. If nothing is documented, select 'No'. If there is something documented, select 'Yes' and record the name of the drug (generic). If more than one drug is to be entered, separate each entry by a comma.

See Appendix 1 for a list of analgesics, or alternatively, check a current suitable drug reference such as the Australian Medicines Handbook, or MIMs.

Allergies/ADRs may be found in any of the following documentation:

- The drug chart
- Alert sheet/medical alert inside the front cover of the medical notes
- Pre-admission clinic notes
- Admission work up in medical progress notes
- Peri-operative anaesthetic record

2. Surgical information

Section in the data collection form:

2. Surgical Information

2.1 Surgical procedure: ____

2.2 This surgery was: ELECTIVE / EMERGENCY / UNKNOWN

2.3 Did the patient attend a pre-admission clinic? Yes / No

2.4 Was preop patient education regarding postop pain management options documented? Yes / No

2.1 Surgical Procedure

This is the name of the actual operation being performed and can be found in any of the following places:

- Intra-operative record
- Theatre report
- Medical progress notes
- Admission notes

2.2 This surgery was elective / emergency / unknown

If '*emergency'* surgery, likely to state in the medical record - admitted via emergency department, directly from doctor's rooms or outpatient clinic, brought in by ambulance (BIBA), family etc.

If '*elective'*, likely to state booked admission, have copies of correspondence to patient, general practitioner and specialist, have evidence of attendance at a pre-admission clinic.

If cannot be clearly deduced from the record, select '*unknown*'.

2.3 Was preop patient education regarding postop pain management options documented?

This is documentation of any form of pre-operative education regarding postoperative pain, including pamphlets, other written information, verbal counselling provided by a hospital staff member, DVD or video presentations or combination. It may be documented in the pre-admission clinic or pre-operative forms or the medical progress notes. If there is no evidence of documentation of education, select 'No'.

3. Brief medical and pain history

Section in the data collection form:

3. Brief Medical and Pain History

3.1 Please indicate if any of the following were DOCUMENTED in the patient's admission notes:

Seizures	☐	Bleeding diathesis	☐
Renal failure / impairment	☐	Concurrent SSRI*, SNRI* use	☐
Pre-existing pain condition	☐	Regular analgesic use	☐
Previous GI bleed or PUD*	☐	None of the above	☐

3.1.1 If 'Yes' to *Regular analgesic use*, select type of analgesic(s) taken *(you may select more than one answer)*

Paracetamol NSAID* COX-2 inhibitor* Opioid Other

Please note: These measures are designed to identify evidence of *documentation*, not whether or not the patient actually had them. These may be documented in the patient's notes from pre-admission clinic, admission or peri-operative record.

3.1 Please indicate if any of the following were DOCUMENTED in the patient's admission notes:

- *Seizures:* This may also be documented as epilepsy.
- *Renal failure/ impairment:* This may be listed as renal dysfunction, elevated creatinine or end stage renal disease.
- *Pre-existing pain condition*: This is documentation indicating that the patient had a pre-existing pain condition, normally requiring analgesics, e.g. osteoarthritis, rheumatoid arthritis, chronic back pain, prior to admission to hospital. The presence of analgesics in the medication history may suggest a pain history, but if a history of pain is not documented, select 'No'.
- *Previous GI bleed or PUD:* This may be listed as active, recent (in the last 12 months) or history of peptic ulcer disease or gastrointestinal (GI) bleeds.
- *Bleeding diathesis:* An unusual susceptibility to bleeding due to a defect in coagulation. Examples of bleeding diathesis include haemophilia, Von Willebrand's disease, leukaemia, scurvy and Glanzmann thrombasthenia.
- *Concurrent SSRI, SNRI use:* SSRI = selective serotonin reuptake inhibitor, SNRI = serotonin and noradrenaline reuptake inhibitor.
- *Regular analgesic use:* Taking analgesics regularly (at least daily, for a minimum of a week) at the time of admission. If selected, select the type of analgesic taken, e.g. Paracetamol, NSAID, COX-2 inhibitor, Opioid, Other. Note – if patient is taking a combination analgesic e.g. Panadeine, select both 'paracetamol' and 'opioid'.

4. Postoperative Pain Management

- **Patient observations recorded during the audit period**

Section in the data collection form:

4. Postoperative Pain Management
Patient observations recorded during the audit period
4.1 Select the audit period chosen: Immediate Postop **/** Post-PCA or Epidural
4.2 How many pain scores were actually documented during the audit period? __________
4.2.1 What was the HIGHEST pain score documented during the audit period? ________ / N/A
4.2.2 How many were used to assess pain both at rest and movement in the same set of observations? N/A
4.3 How many sedation scores were documented during the audit period? _________
4.4 Were any episodes of nausea and/or vomiting documented during the audit period? Yes / No

4.1 Select the audit period chosen: Immediate Postop / Post-PCA or Epidural
This is to identify which observation period has been chosen for this patient. This is dependent on which option has been chosen and will be determined prior to data collection.

The choices are:

- *Immediate Postop* – Up to first 48 hours after operation, starting from when the patient first arrives on the ward from recovery (i.e. do not include observations made in recovery). May include or exclude patients under the Acute Pain Service (APS).
- *Post-PCA or Epidural* – Up to first 48 hours after a PCA or Epidural has been ceased or after the patient has been discharged from the APS.

4.2.1 What was the HIGHEST pain score documented during the audit period?

Pain scores are usually obtained through the use of validated pain assessment tools and are often documented as a number between 0 – 10, where 0 is no pain, and 10 is the worst pain possible, or as a descriptor e.g. mild, moderate or severe pain.

Pain scores may be documented in the patient observation chart, but may also be recorded on specialised pain charts and/or the medical progress notes.

4.2.2 How many were used to assess pain both at rest and movement in the same set of observations?

If a pain score was measured at rest 'R' may be recorded adjacent to the pain score. If the pain score was measured on movement 'M' may be recorded adjacent to the pain score. Count only those scores where an 'R' and an 'M' have been documented for pain scores at the same time, e.g. both at 0800.

4.3 How many sedation scores were documented during the audit period?

Sedation can be assessed using a score of 0 – 3 plus the use of 'S' to indicate that the patient was asleep. Record the number of sedation scores documented during the audit period.

- **Patient analgesia during the audit period**

Section in the data collection form:

Patient analgesia during the audit period

4.5 If a range of doses PRESCRIBED (eg 5 - 15 mg), was dose ADMINISTERED always documented? Yes / No / N/A

4.6 If multiple routes PRESCRIBED (eg PO/IV), was chosen administration route always documented? Yes / No / N/A

4.7 Were any ADR(s) attributed to an analgesic(s) documented during this admission? Yes / No

4.7.1 If yes, specify drug(s): ______________________________

4.8 Was naloxone required during this admission for reversal of opioid-induced respiratory depression? Yes / No

4.5 If a range of doses PRESCRIBED (eg 5 - 15 mg), was dose ADMINISTERED always documented? Yes / No / N/A

Only answer 'Yes' if dose administered was specified **every** time the medication was administered, where a dose range was prescribed.

4.6 If multiple routes PRESCRIBED (eg PO/IV), was chosen administration route always documented? Yes / No / N/A

Only answer 'Yes' if the route administered was specified **every** time the medication was administered, where multiple routes of administration were included in a single medication order, e.g. paracetamol 1g q6h *PO/IV*.

4.8 Was naloxone required during this admission for reversal of opioid-induced respiratory depression? Yes / No

Naloxone may be prescribed and administered on the "stat" section of the drug chart, on the PCA or epidural charts and/or recorded in the progress notes. Answer 'Yes' if naloxone was required in the patient for reversal of opioid-induced respiratory depression.

4.9 Analgesics prescribed and administered during the audit period

Section in the data collection form:

4.9 Analgesics prescribed and administered during the audit period

Analgesic *(generic)*	Route	Frequency	Administered
		Reg / PRN / stat	Yes / No
		Reg / PRN / stat	Yes / No
		Reg / PRN / stat	Yes / No
		Reg / PRN / stat	Yes / No
		Reg / PRN / stat	Yes / No

A record of all analgesics prescribed, i.e. available to be administered. Please note analgesic orders may have a prescription dated prior to the start of the observation period, but if the prescription remains active during this data collection time, these must be recorded. Record the generic name for each analgesic prescribed. Note if aspirin 100mg prescribed this in not an analgesic dose.

Record the Route (s) prescribed. See lists in Appendix 6 and 7, for choices.

Frequency: Medications are prescribed to be taken regularly (Reg) or on a 'when required' (PRN) basis.

- If a prescriber wants a medication to be taken 'PRN', 'PRN' will be specified in the frequency section of the chart or the order will be written on a separate chart
- For prescribed items to be given regularly, only the frequency, such as 'once a day' or 'four times a day' or 'STRICT' will be specified.
- If there is an order for a single dose only, then the 'STAT' option should be chosen

Administered: Indicate in the appropriate column whether it was administered to the patient at all during the audit period.

4.10 Antiemetics prescribed and administered during the audit period

Section in the data collection form:

4.10 Antiemetics prescribed and administered during the audit period

4.10.1 Were antiemetics prescribed? Yes / No If yes, record antiemetic prescriptions below:

Antiemetic *(generic)*	Route	Frequency	Administered
		Reg / PRN / stat	Yes / No
		Reg / PRN / stat	Yes / No
		Reg / PRN / stat	Yes / No
		Reg / PRN / stat	Yes / No

			Reg / PRN / stat	Yes / No

This is a record of all antiemetics prescribed (available to be administered) during the data collection period.

Please note, antiemetics may have a prescribed date prior to the start of the observation period, but if the prescription remains active during this data collection time, this must be recorded.

The data collection process is the same as for 'Analgesics prescribed and administered'.

5. Discharge Management

Section in the data collection form:

5. Discharge Management

5.1 Were analgesics prescribed at discharge? Yes / No

5.1.1 If yes, record discharge analgesic prescriptions relating to ongoing pain management:

Analgesic *(generic)*	Frequency	Duration of therapy (days) if specified	Administered in last 24 hours of inpatient stay
	Reg / PRN		Yes / No
	Reg / PRN		Yes / No
	Reg / PRN		Yes / No
	Reg / PRN		Yes / No
	Reg / PRN		Yes / No

5.2 Was an antiemetic(s) prescribed at discharge? Yes / No

5.3 Was a laxative(s) prescribed at discharge? Yes / No

5.4 Was any component of a management plan for analgesics documented? Yes / No
(e.g. medication action plan)

5.4.1 Please indicate if the documented plan contained any of the following information for all analgesics:

Drug name	☐	Clear instructions if one analgesic was prescribed	☐
Dose and frequency	☐	Clear instructions if a combination of analgesics (≥2) were prescribed	☐
Duration of therapy	☐	Clear instructions for maximum daily dose if more than one product containing paracetamol was prescribed	☐
None of the above	☐		

5.4.2 If 'yes' to management plan *(item 5.4 above)*, indicate if communicated to the:

☐ Patient ☐ GP ☐ Neither the patient nor the GP

5.1.1 Administered in last 24 hours of inpatient stay

Identify medications on the discharge script which were also prescribed during the inpatient admission (both regular and PRN medication orders), of these check the medication administration section of drug chart, to see if the patient had been administered the medication during the final 24 hours of the inpatient stay.

5.1.1 Duration of therapy (days) if specified

Only include the duration of therapy if it is specifically stated e.g. for 5 days. Do not try & calculate based on the number of tablets dispensed.

5.4 Was any component of a management plan for analgesics documented?

A medication management/action plan is defined in Guiding Principle 6 of the Guiding Principles to Achieve Continuity in Medication Management, APAC, July 2005 (http://www.health.gov.au/internet/wcms/publishing.nsf/Content/nmp-guiding) and should include specific information such as drug name, dose and frequency, duration and indication of therapy. Information specifically related to pain management which should be in the management/action plan includes clear instructions for pain management if one analgesic was prescribed and clear instructions for pain management if a combination of analgesics (≥2) were prescribed. Information about the appropriate use of paracetamol is also important; particularly if one or more medicines are prescribed which contain paracetamol; therefore we are also investigating if clear instructions for the maximum daily dose of paracetamol are provided. Please note that a management/action plan is not the same as a discharge prescription and that a 'PRN' direction without additional information is not considered to be clear instructions.

Although there may not be a documented plan, some information which would form a plan may be documented. This includes specific information such as drug name, dose and frequency, duration and indication of therapy. If this is the case then select 'Yes'.

5.4 .1 Please indicate if the documented plan contained any of the following information for all analgesics

The intention here is to determine whether the plan contained the information for *ALL* analgesics i.e. not just for at least one if two or three were prescribed etc.

Note: While this is the intention of the APOP software development team, it remains the decision of the hospital if they do still wish to record where this information is just recorded for 'at least one' analgesic instead. The most important point here is that this be done consistently through the audit.

6. Inpatient Interview

The intention of the inpatient interview is to facilitate the reconciliation of information documented in the patient's medical history with the patient's self-report of their postoperative pain and nausea and vomiting.

It is recommended that the interview be performed once during the defined postoperative observation period at a time which is at least approximately 24 hours (or one night) following surgery in order to allow the patient sufficient recovery time from the anaesthetic. For day surgery patients, just prior to discharge from the day surgery ward is sufficient.

Pain is to be assessed using the pain scale that the patient is familiar with where possible and pain scores noted accordingly. If not, the patient should be asked to rate their pain on a scale of 0 – 10 where 0 is no pain and 10 is the worst pain imaginable. See Appendix 8 for different pain scales used.

Note that the timing of this activity is such that patients who have undergone surgery on a Friday will be excluded unless the interview can be conducted on a weekend.

Appendices

Appendix 1: Analgesics

Generic	*Trade Name*
Alfentanil	Rapifen
Aspirin	Solprin Disprin - Common trade names
Bupivacaine	Bupivacaine Marcain
Buprenorphine	Norspan (patch) Suboxone Subutex Temgesic
Celecoxib	Celebrex
Clonidine	Catapres
Codeine	Codeine Phosphate
Dextropropoxyphene	Doloxene
Diclofenac	Voltaren Clonac Diclohexal Dinac Imflac Diclac Fenac
Diflusinal	Dolobid
Fentanyl	Actiq (lozenge) Durogesic (patch) Fentanyl (injection)
Fentanyl + ropivacaine	Naropin with fentanyl
Gabapentin	Gabahexal Gabapentin Gabaran Gabatine Gantin Neurontin Nupentin Pendine
Hydromorphone	Dilaudid
Ibuprofen	Advil Bugesic Butalgin Compufen Migraine Pain Nurofen Panafen IB ProVen Rafen Tri-profen
Indomethacin	Arthrexin Indocid
Ketamine	Ketalar
Ketoprofen	Orudis SR

Generic	***Trade Name***
	Oruvail
Ketorolac	Toradol
Lignocaine	Xylocaine
Meloxicam	Mobic Movalis
Methadone	Biodone Forte Methadone Syrup Physeptone
Midazolam	Hypnovel
Morphine	Anamorph Morphine sulfate Ordine Sevredol
Morphine SR	Kapanol MS Contin MS Mono
Naproxen	Aleve Femme Free Inza Anaprox Crysanal Nurolasts Naprogesic Eazydayz
Naproxen SR	Naprosyn/Naprosyn SR
Oxycodone	Endone OxyNorm Proladone
Oxycodone SR	OxyContin
Paracetamol	Panadol Panamax - common trade names Tylenol
paracetamol with codeine	Codalgin Codapane forte Comfarol forte Dolaforte Panadeine Panamax Co Prodeine
paracetamol with codeine and doxylamine	Mersyndol
paracetamol with dextropropoxyphene	Capadex Di-gesic Paradex
Parecoxib	Dynastat
Pethidine	Pethidine
Piroxicam	Feldene / Feldene-D Mobilis / Mobilis D Pirohexal-D
Remifentanil	Ultiva
Ropivacaine	Naropin
Sulindac	Aclin
Tiaprofenic acid	Surgam
Tramadol	Tramahexal

Generic	Trade Name
	Tramal Zydol
Tramadol SR	Tramahexal SR Tramal SR

Appendix 2: Selective serotonin reuptake inhibitors (SSRIs)

Generic	Trade Name
Citalopram	Celapram Celica Ciazil Cipramil Citalopram Citalobell Talam Talohexal
Escitalopram	Esipram Lexapro
Fluoxetine	Auscap Fluohexal Fluoxebell Lovan Prozac Zactin
Fluvoxamine	Faverin Luvox Movox Voxam
Paroxetine	Aropax Extine Paxtine Paroxetine
Sertraline	Concorz Eleva Sertra Sertraline Setrona Xydep Zoloft

Appendix 3: Serotonin and noradrenaline reuptake inhibitors (SNRIs)

Generic	Trade Name
Desvenlafaxne	Pristiq
Duloxetine	Cymbalta
Venlafaxine	Efexor-XR

Appendix 4: Antiemetics

Generic	Trade Name
Dexamethasone	Dexamethasone
Dolasetron	Anzemet

Domperidone	Motilium
Droperidol	Droleptan Droperidol
Granisetron	Kytril
Metoclopramide	Maxalon Pramin
Ondansetron	Zofran
Prochlorperazine	Stemetil Stemzine
Promethazine	Avomine Fenezal Phenergan
Tropisetron	Navoban

Appendix 5: Laxatives

Generic	***Trade Name***
Bisacodyl	Bisalax Durolax Lax-Tab
Bisacodyl + docusate	Coloxyl Supps
Docusate	Coloxyl Enemax Rectalad
Docusate + senna	Coloxyl with Senna Sennesoft
Fibre supplement	Metamucil
Glycerol	Glycerin Glycerol
Lactulose	Actilax Duphalac Glenlac Lac-Dol Lactol
Microlax	Microlax
Paraffin	Agarol
Senna	Sennetabs Senokot
Sorbitol	Sorbilax

Appendix 6: Routes of Administration - Analgesic

Route of Administration	*Abbreviation*	*Term in APOP e-DUE tool*
Epidural	Epidural (epi)	epidural
Intramuscular	IM, im	IM
Intramuscular/subcutaneous		IM/SC
Intravenous	IV, iv	IV
Intravenous/intramuscular		IV/IM
Intravenous/intramuscular/subcutaneous		IV/IM/SC
Intravenous/subcutaneous		IV/SC
Intravenous/Patient controlled analgesia		IV-PCA
Oral	PO, po	oral
Oral/intravenous		oral/IV
Oral/ intravenous/intramuscular		oral/IV/IM
Oral/intravenous/rectal		oral/IV/PR
Oral/intravenous/subcutaneous		oral/IV/SC
Oral/nasogastric/rectal		oral/NG/PR
Oral/rectal		oral/PR
Rectal	PR, pr	PR
Subcutaneous	Sc, SC, sc	SC
Subcutaneous/Patient controlled analgesia		SC-PCA
Transdermal/Topical	Top	transdermal

Appendix 7: Routes of Administration - Antiemetic

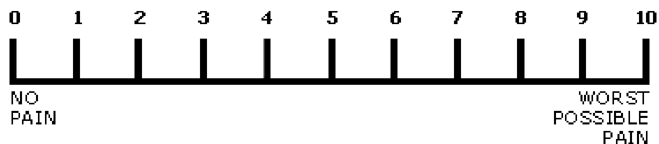
Route of Administration	*Abbreviation*	*Term in APOP e-DUE tool*
Intramuscular	IM	IM
Intravenous	IV	IV
Intravenous/intramuscular		IV/IM
Intravenous/subcutaneous		IV/SC
Intravenous/sublingual		IV/SL
Oral	PO	oral
Oral/intramuscular		oral/IM
Oral/intravenous		oral/IV
Oral/ intravenous/intramuscular		oral/IV/IM
Oral/intravenous/subcutaneous		oral/IV/SC
Sublingual	sl	SL

Appendix 8: Pain Assessment Scales

A) Visual Analogue Scale (VAS)

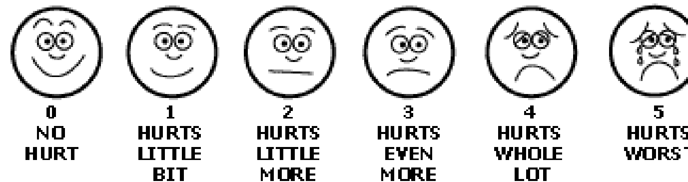
Instruct the patient to slide the pointer to the position in between the faces to indicate how much pain they are currently feeling. Positioning the pointer to the far left end indicates 'No Pain' and the far right end indicates 'Worst Pain Ever'.

B) Numerical Rating Scale (NRS)



Instruct the patient to choose a number from 0 to 10 that best describes your current pain. 0 would mean 'No Pain' and 10 would mean 'Worst Possible Pain'.

C) Faces Rating Scale (FRS)



Adults who have difficulty using the numbers on the Visual / Numerical Rating Scales can be assisted with the use of the 6 facial expressions suggesting various pain intensities. Ask the patient to choose the face that best describes how they feel. The far left face indicates 'No Hurt' and the far right face indicates 'Hurts Worst'. Document number below the face chosen.

D) Behavioural Rating Scale

Face	0 Face muscles relaxed	1 Facial muscle tension, frown, grimace	2 Frequent to constant frown, clenched jaw	Face Score:
Restlessness	0 Quiet, relaxed appearance, normal movement	1 Occasional restless movement, shifting position	2 Frequent restless movement may include extremities or head	Restlessness Score:
Muscle tone*	0 Normal muscle tone, relaxed	1 Increased tone, flexion of fingers and toes	2 Rigid tone	Muscle Tone Score:
Vocalisation**	0 No abnormal sounds	1 Occasional moans, cries, whimpers or grunts	2 Frequent or continuous moans, cries, whimpers or grunts	Vocalisation Score:
Consolability	0 Content, relaxed	1 Reassured by touch or talk, distractible	2 Difficult to comfort by touch or talk	Consolability Score:
Behavioural Pain Assessment Scale Total (0 to 10)				**/10**

The behavioural pain assessment scale is designed for use with non-verbal patients unable to provide self-reports of pain:

1. Rate each of the five measurement categories (0,1 or 2)
2. Add these together
3. Document the total pain score out of 10

Appendix 9: Sedation Scores

The sedation score measures the patient's level of wakefulness and their ability to respond appropriately to verbal command. It is a four-point scale using the following criteria:

Sedation Score 0-3

0 = Awake, Alert

1 = Mild Sedation, Easy to Rouse

1S = Asleep, Easy to Rouse

2 = Moderate Sedation, Unable to Remain Awake

3 = Difficult to Rouse

0 = Awake, Alert
The patient is awake, alert and responds appropriately to verbal command.

1 = Mild Sedation, Easy to Rouse
The patient rouses easily from sleep/rest, is able to stay awake and is alert and cooperative.

1S = Asleep, Easy to rouse
This sedation scoring option is to be used at night when the patient would normally be expected to be asleep. The idea is that the patient must be assessed, if they are on any opioid or sedative agents, at this time to ensure the patient is not slipping further in their sedation level despite having a normal respiratory rate. When doing your normal BP and Pulse observations at night your patient should stir or move at this time. If this does not occur then you should attempt to wake the patient to ensure the patients sedation score has not increased.

2 = Moderate Sedation, Unable to remain awake The patient is frequently asleep or drowsy when observed. Is drowsy on waking. Able to follow commands but is unable to remain awake.

3 = Difficult to Rouse
The patient is difficult to rouse or unrousable. Has difficulty with or inability to follow commands

The optimal aim is for a sedation score of 0 or 1. Patient assessment should be documented in the sedation score column allocated on the patient observation chart if available or in the medical notes as appropriate.