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Original article

Adequacy of pain assessment documentation in older people – Can we do better?

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Abstract

Background: Pain is common in older people causing disability, reduced mobility, and poor quality of life.

Objective: Baseline audit of pain assessment documentation in older patients in a tertiary hospital in Brunei Darussalam.

Methods: Retrospective review of electronic health records for inpatients and outpatients for older patients aged 65 years and older under Geriatric Medicine and Orthopaedics.

Results: There were 30 patients with median age of 75 years. The main aspects that require improvement are documented descriptors and severity of pain, side effects of medication, analgesia taken and review of response to analgesia.

Conclusion: The importance of pain assessment and documentation should be emphasized to clinical staff. Availability of localized tools and training sessions may be required.

Keywords: Aged; geriatric assessment pain; symptom assessment.

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Pain is a common presenting complaint in older people and causes disability, reduced mobility and poor quality of life.[1] When patients present to hospital with pain, it is a reasonable expectation to receive adequate pain assessment and treatment prior to discharge. Internationally, initiatives are undertaken to achieve this goal through pain management quality indicators and setting up 'pain-free hospitals', which integrate pain treatment into routine hospital care.[2]

However, there are several barriers in acute pain assessment and management in hospital, ranging from over-cautious clinicians in prescribing analgesia, the need for a consistent team-based approach and tailoring the clinical approach to different local and cultural preferences.[3] In older people, pain also tends to be underestimated, unrecognised or underreported, resulting in inadequate treatment.[4]

Raja Isteri Pengiran Anak Saleha (RIPAS) Hospital is an 880-bedded tertiary Hospital in Brunei Darussalam. A cross-sectional study found that older patients admitted under Geriatric Medicine have a high burden of comorbidities, dementia and poor functional status, requiring comprehensive geriatric assessment and multidisciplinary intervention.[5] Pain assessment and management is an important component of treatment for this group of vulnerable adults. Inadequately managed pain limits functional status and rehabilitation, thus documentation of diagnosis, severity, analgesia used and response to treatment is required to contribute to a comprehensive management plan. In this paper, findings from a baseline audit of pain assessment documentation in older inpatients is described, with suggestions of improvement provided.

Materials and methods

The objective of this retrospective audit was to assess the quality of pain assessment documentation for older patients aged 65 years and older under Geriatric Medicine and Orthopaedics. Electronic health records for both inpatient and outpatient records were assessed through convenience sampling for 30 patients. Patients with advanced cognitive impairment or non-communicative were excluded from the audit as this will complicate assessment of pain severity and adequacy of response to analgesia. The expected standards were that the following features should be evaluated and documented for pain assessment: descriptors of pain, severity of pain, impact on activities of daily living (ADL), analgesia used, side effects or allergies, diagnosis of pain, and review of pain response to analgesia.

Results

Among the 30 patients, 8 (26.7%) were male and 22 (73.3%) female. The age range was 65 to 91 years (median 75 years). The age distribution is shown in the Figure 1. Only 8 (26.7%) were from Geriatric Medicine (of which 5 were inpatients and 3 outpatients), while 22 (73.3%) were from orthopaedics (9 inpatients and 13 outpatients). Standards achieved in terms of pain assessment documentation are summarized in the Table 1.

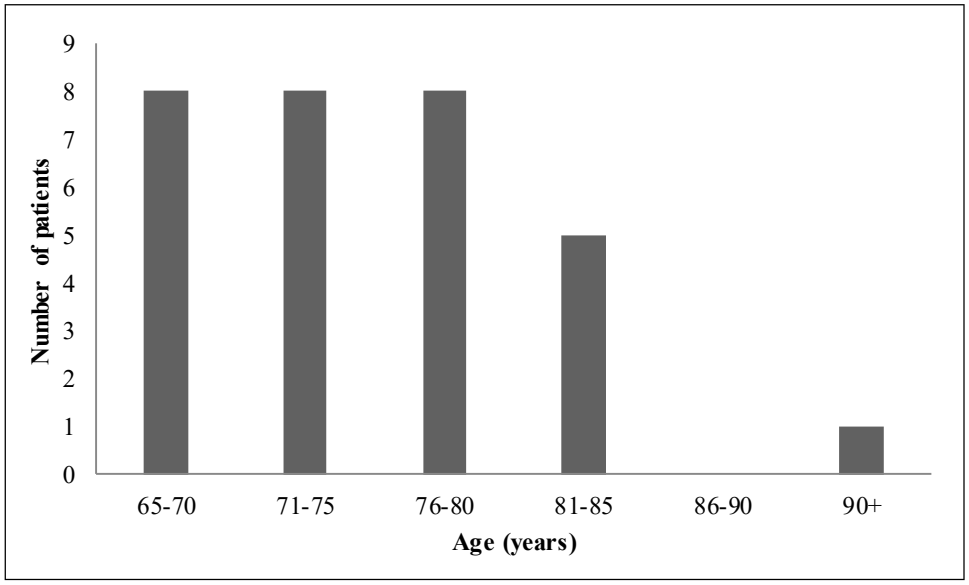

Figure 1. Age range of patients.

Table 1. Standards achieved in documentation of pain assessment.

Standard	Yes: n (%)	No: n (%)
Descriptors	3 (10.0)	27 (90.0)
Severity	2 (7.0)	28 (93.0)
Impact on ADLs	8 (27.0)	22 (73.0)
Analgesia used	3(10.0)	27 (90.0)
Side effects / allergies	2 (7.0)	28 (93.0)
Diagnosis of pain	23 (77.0)	7 (23.0)
Review of response to analgesia	5 (17.0)	25 (83.0)

Descriptors of pain was only performed for 3 (10.0%) of patients. Severity of pain and impact on ADLs were only documented in 2 (7.0%) and 8 (27.0%) of patients. This has implications on the type of analgesia used, which was documented in 3 (10.0%) of patients. Adequacy of response to analgesia was noted in 5 (17.0%) of patients. Documented diagnosis of pain in 23 (77.0%) of patients was the highest achieved standard in this audit.

Discussion

This audit reviewed the quality of documentation of pain assessment in older people in RIPAS Hospital under Geriatric Medicine and Orthopaedics. The majority of patients were recruited from the Orthopaedics service. This was likely due to their larger number of patients per clinic session, and a significant proportion of geriatric medicine inpatients had cognitive impairment at the time of audit. Aspects of pain assessment documentation that significantly needs improvement are: pain descriptors, severity, analgesia used, side effects and review of response to analgesia.

Pain assessment in older people can be challenging, as it relies on patient self-reporting. Sensory losses, such as hearing or visual difficulties should be corrected. Clinicians should then select the appropriate tool to match the older person's capabilities.[6] Assessment tools and localized guidelines may need to be reinforced to empower clinicians to assess pain adequately.

In this audit, documentation of pain descriptors, which has implications on diagnosis of pain and drug treatment was poorly performed. The diagnosis of pain was the highest achieved standard at 77.0%. This was possibly due to the high rate of orthopaedic patients, where the causes of pain were clearer, such as fractures or nerve impingement syndromes. Severity of pain and review of response to analgesia should be improved, as adequacy of pain relief is important for outcomes and quality of life.[1]

In terms of analgesia, while valid prescriptions are accessible via the electronic health records, it is worthwhile for clinicians to document medications taken by the patient, and those which were effective. Follow-up review should ideally assess the response to each analgesic agent rather than overall pain scores alone for medication adjustments.

Implementation of changes for improvement may require staff training or mentorship, with pain 'champions' to ensure a consistent clinical approach.[3] Pain descriptors should also be applicable to local languages; locally, the Short-form McGill Pain Questionnaire (SF-MPQ-2) has since been translated and validated for clinical use (available online via Mapi Research Trust).[7]

Limitation of this study: There was only a small number of patients. Patient co-morbidities that may influence the quality of pain experienced by the patients were not included in the analysis, as the audit focused on the documentation of pain assessment.

Conclusion

There is a need to emphasize to clinical staff regarding the importance of pain assessment and documentation. Availability of localized tools and training sessions may assist with improving pain assessment.

Conflict of interest

The author has no conflicts of interests to declare.

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