

An Audit on the Adequacy of Pain Assessment Documentation, in Paper and Electronic Records of a Home Palliative Care Unit

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Background

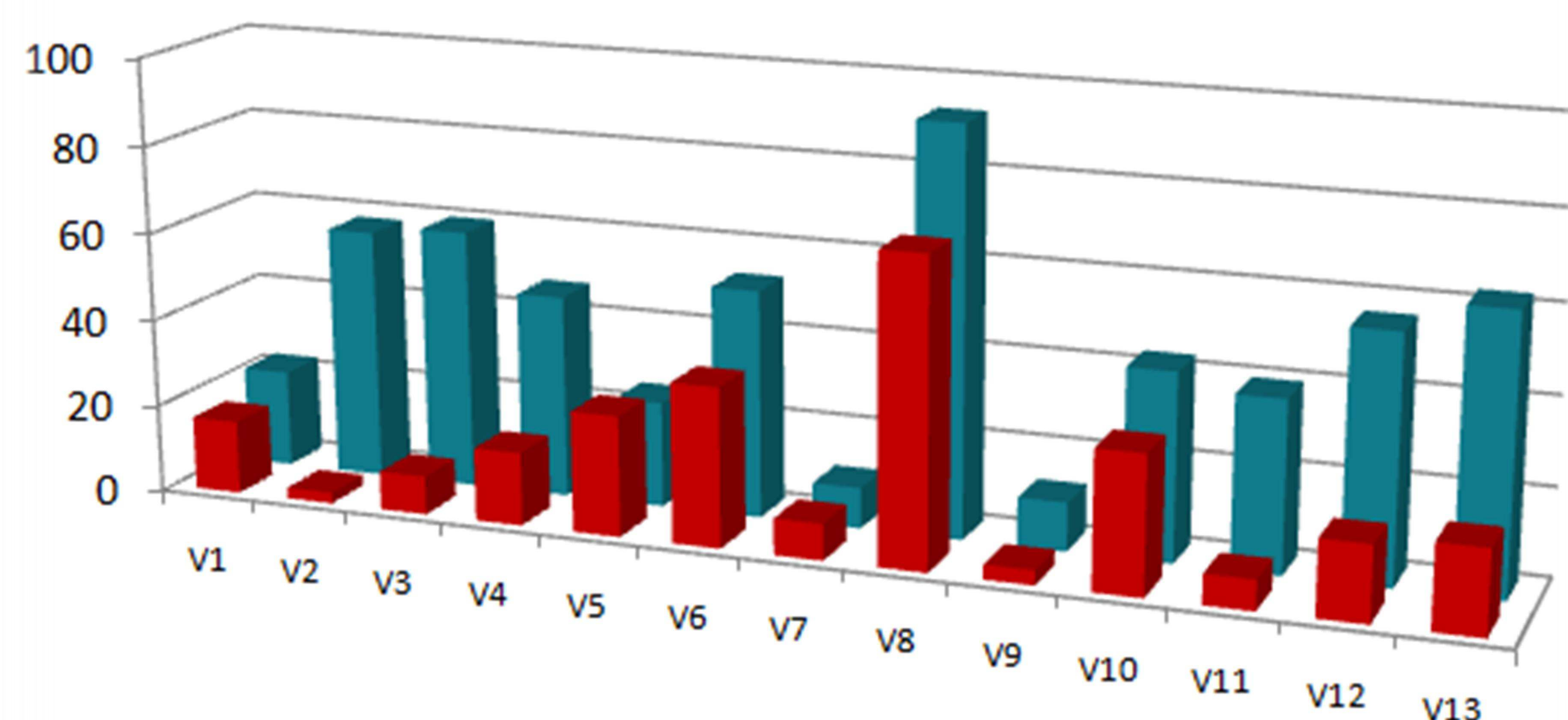
Accurate assessment and documentation is a prerequisite for effective pain management of patients referred to palliative care units. The ONTARIO Pain Management Guidelines provides a best practice framework for pain characteristics assessment documented either in paper or electronic format.

Aim

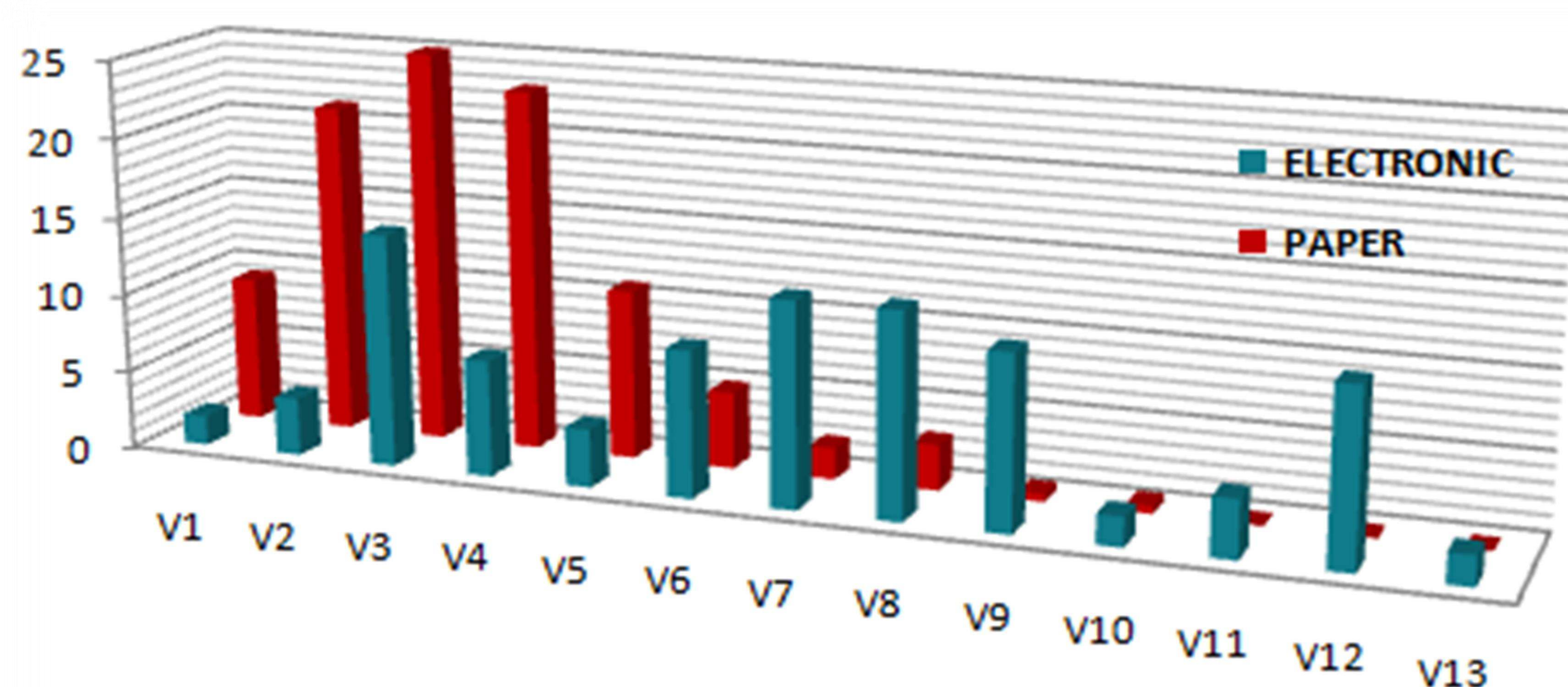
Assess a) whether patients with pain admitted in a home palliative care unit, were fully assessed using the ONTARIO algorithm shortly before and after the implementation of an electronic patient file and b) whether the way of documentation influenced its adequacy.

Methods

Within a six months period before and after the implementation of an electronic patient file, 30 patients' records (paper or electronic) were searched for pain documentation, according to these factors of ONTARIO Pain assessment algorithm (onset, provoking/palliating factors, quality, region/radiation, severity). Before the second audit round, four result feedback meetings and electronic documentation group training sessions were initiated, as the implementation strategy for improvement.



Paper vs Electronic ONTARIO variety records



Mean per variable

Results: 20 out of 23 consecutive patients within two months and 10 out of 16 within one month presented with pain had their records, paper or electronic respectively reviewed. 204 pain assessment episodes (mean 10.2, range 2-21) were retrieved and analyzed from paper files, while 53 (mean 3.92, range 1-18) from electronic records.

Severity was the item most frequently documented in electronic files (62.3%), and region (69.6%) in paper.

None of the patients were fully assessed with the 13 items of the ONTARIO algorithm, while the mean number of characteristics documented was 2.49(1-10) in the paper and 5.94(1-12) in the electronic file ($p=0.002$).

Conclusion / Discussion

Pain assessment documentation was more adequate in electronic than in paper patient records. Both methods documentation failed to comply with best practice recommendations and highlight the need for further staff training.