

## 4.2 Percentage of postoperative patients that are given a written pain management plan at discharge AND a copy is communicated to the primary care clinician

### Purpose

This indicator assesses the effectiveness of processes intended to ensure that patients and their caregivers receive adequate information for safe and effective medicines management following discharge or transfer to another care level.

### Background and evidence

Moderate to severe pain commonly occurs in postoperative patients after transfer to community care.<sup>1,2</sup> One-fifth of postoperative patients report that they did not receive analgesia at discharge and 10–14% report inadequate pain relief from analgesic medicine.<sup>1</sup> Additionally, pain that is not well controlled is perceived as impacting on time of recovery from surgery.<sup>1</sup> Ongoing postoperative pain is a risk factor for the development of chronic pain,<sup>3</sup> and poorly controlled pain is a risk factor for myocardial infarction, pneumonia and venous thromboembolism.<sup>4</sup>

Educating patients about their medicines and communication about medicines management between hospital and community practitioners are guiding principles in the Australian Pharmaceutical Advisory Council Guiding Principles to Achieve Continuity in Medication Management.<sup>5</sup> Recognition of the practice gap in communication of pain management at discharge was the focus of the National Prescribing Service Acute Postoperative Pain Management Drug Use Evaluation conducted in 2006.<sup>2</sup>

### Key definitions

**A written pain management plan** should be tailored to individual needs, desires, and circumstances,<sup>6</sup> and be easily understood by the patient. Details should include: medicine names, dose and frequency; planned duration of analgesia; clear instructions for pain management (e.g. instructions for managing moderate, severe or

ongoing pain and instructions for multimodal therapy); clear instructions for maximum daily doses. A copy of the plan given to the patient should be included in the medical record, or documentation made in the medical record that an individualised plan was given.

**A copy is communicated to the primary care clinician** means a copy of the plan is sent to the community-based health practitioner nominated by the patient, or included in the discharge summary or discharge or transfer letter. Such communication should be explicitly documented in the medical record.

### Data collection for local use

Please refer to the section *Using the National Quality Use of Medicines Indicators for Australian Hospitals* for guidance on sample selection, sample size, measurement frequency and other considerations.

**Inclusion criteria:** Adult, paediatric and neonatal postoperative patients.

**Exclusion criteria:** Nil.

**Recommended data sources:** Medical records, operating theatre lists and discharge referral documentation.

The data collection tool for QUM Indicator 4.2 assists data collection and indicator calculation.

## Data collection for inter-hospital comparison

This indicator may be suitable for inter-hospital comparison. In this case, definitions, sampling methods and guidelines for audit and reporting need to be agreed in advance in consultation with the coordinating agency.

## Indicator calculation

$$\frac{\text{Numerator}}{\text{Denominator}} \times 100\%$$

**Numerator** = Number of postoperative patients that were given a written pain management plan at discharge AND a copy was communicated to the primary care clinician

**Denominator** = Number of postoperative patients in sample

## Limitations and interpretation

Data collection for this indicator relies on documentation in the medical record. Good documentation supports quality patient care<sup>7</sup> and is a critical component of management. Poor communication can result in adverse medicine events.<sup>8</sup> Thus it is assumed that absence of explicit documentation in the medical record means a pain management plan was not provided to the patient or their primary care clinician.

This indicator does not measure the quality of the written pain management plan or whether the patient's primary care clinician actually received a copy of the plan.

Appropriate postoperative pain management is informed by regular pain assessment. *Indicator 4.1: Percentage of postoperative patients whose pain intensity is documented using an appropriate validated assessment tool* may also be relevant. It may be appropriate to collect Indicators 4.1 and 4.2 concurrently where possible.

## Further information

NPS acute postoperative pain (APOP) drug utilisation evaluation (DUE) toolkit is a quality improvement tool to assist hospital surgical, anaesthetic, pharmacy and nursing staff working with surgical patients to conduct an audit of patient care in the area of acute postoperative pain. The toolkit is available at [www.nps.org.au/health-professionals/cpd/activities/du-for-hospitals/acute-postoperative-pain/apop/](http://www.nps.org.au/health-professionals/cpd/activities/du-for-hospitals/acute-postoperative-pain/apop/)

Medication Safety Self Assessment for Australian Hospitals<sup>9</sup> (MSSA) can help identify potential strategies for improvement with this and other indicators. The MSSA encourages development of robust systems for safe prescribing, dispensing, administration and monitoring of medicines. The MSSA is available at [www.cec.health.nsw.gov.au](http://www.cec.health.nsw.gov.au)

This indicator can be used to assist hospitals in meeting the National Safety and Quality Health Service Standard 1 [items 1.2.1, 1.2.2, 1.5.2, 1.6.1, 1.6.2, 1.18.1], Standard 4 [items 4.2.1, 4.2.2, 4.5.1, 4.5.2, 4.11.1, 4.13.1, 4.13.2, 4.14.1] and Standard 6 [items 6.1.1, 6.2.1, 6.3.1, 6.4.1, 6.4.2].<sup>10</sup>

## References

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