

Objective

To improve the consistency of the assessment and management of severe pain scores on the Palliative Care Problem Severity Score (PCPSS) and/or Symptom Assessment Scale (SAS).

Rationale

- Improve the application and communication of PCPSS and SAS tools
- Determine if clinical notes provide evidence for:
 - Phase allocation or phase change
 - Appropriate and timely follow up reflective of pain scores
- Identify areas for education

Instructions

1. Work in pairs or as a team. Print/open the 'Severe Pain' page of the 'Supplementary Info' Excel spreadsheet.
2. Select up to ten patients from the spreadsheet and obtain their medical records and progress notes.
3. Using the table overleaf, enter their Patient ID into the box (1) then place a tick for yes/cross for no in response to Question #1. Using the evidence documented in the patient's progress notes, complete each of the questions for the first patient.
4. Repeat case review for each of the (up to) ten patients.
5. Tally the number of ticks for each question and use this information to help inform feedback.

Summary of findings, and action plan for improvement

1. Can you identify a quality improvement action/change in processes that would help to address your findings?

2. How do you plan to provide feedback to staff?

Records management

Date/time of case review:

Case review completed by (Name/Positon):

Questions	Patient ID										
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	Total # Yes
1. Did the severe SAS (patient rated) pain score trigger a response*?											
2. Did the severe PCPSS pain score trigger a response*?											
3. Preceding the severe pain scores, were there mild to moderate pain scores recorded?											
4. Was there documented evidence that the response resulted in an improvement (i.e. reduced pain score)?											

*NB. Response includes review of current care plan, and/or changes to current care plan, and/or referral and/or an intervention (pharmacological and/or non-pharmacological)

Key points for feedback



- Severe SAS or PCPSS scores should trigger an unstable phase (excluding the dying patient in the terminal phase), accompanied by urgent intervention and a new plan of care which should be reviewed daily for improvement.
- Severe SAS pain scores that are reported in conjunction with absent or mild clinician-rated PCPSS pain scores may require **non-pharmacological interventions** (i.e. psycho-social support to address the fear of pain returning or existential pain).
- **Patient reporting of SAS is the gold standard.** If possible, consider who has been provided the SAS scores (patient, family/carer or clinician) and the effect this may have on the result. Evidence shows that clinicians tend to under-report a patient's pain, while families/carers tend to over-report compared to a patient's self-report.