Post-anaesthesia care unit (PACU) acute pain audit

Please check with your local ethics service or governing body as to the process requirements for conducting an audit of your own practise.

<table>
<thead>
<tr>
<th>Background</th>
<th>Anaesthetists are responsible for the quality of postoperative pain control and this is optimally provided by multimodal analgesia.(^1) Severe acute pain can adversely affect patient outcomes. For example, severe postoperative pain is a consistent risk factor for chronic post-surgical pain (CPSP).(^1) Despite evidence-based acute pain guidelines(^1,2), acute postoperative pain continues to be poorly managed, resulting in increased patient suffering and calls to anaesthetists to manage the situation (increasing their workload). Reducing acute pain may improve patient outcomes, including suffering and CPSP incidence.(^1)</th>
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<tbody>
<tr>
<td>Aim and objectives</td>
<td>The aim of this audit protocol is to ensure individual practice outcomes are consistent with best practice for management of postoperative pain in the post anaesthesia recovery unit (PACU).</td>
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</table>
| Research evidence/best practice | • Best practice for acute pain management is described in the ANZCA and FPM document *Acute Pain Management: Scientific Evidence*.\(^1\)  
  • “Optimal pain relief” is defined as “<4 on a 0 to 10 pain scale or at a level acceptable to the patient”.\(^3\)  
  • Severe pain is defined as “a pain intensity score of 7 to 10 based on an 11-point numerical rating scale” \(^4\) or a verbal rating of “severe” or “very severe” on a descriptive scale (for those unable to report a numerical rating scale).  
  • Severe acute pain not responding to pain protocol in the recovery period and requiring review by an anaesthetist for management in the PACU is an Australian Council on Healthcare Standards clinical indicator.\(^4\)  
  • The Royal College of Anaesthetists proposed standard for best practice is that optimal pain relief is established for >95% of patients before *timely* discharge from PACU.\(^3\) Optimally, discharge from PACU or hospital should not be delayed by pain control issues. |
| Suggested indicators | • The proportion of all patients administered preoperative/intraoperative paracetamol (in the absence of contraindications).  
  • The proportion of those who will be postoperative inpatients who are charted regular postoperative paracetamol (in the absence of contraindications).  
  • The proportion of all patients in whom an IV opioid protocol (or, if applicable, oral/sublingual opioid protocol) for PACU management is prescribed.  
  • The proportion of patients with severe pain on PACU arrival.  
  • The proportion of patients with severe acute pain not responding to pain protocol in the recovery period and requiring review by an anaesthetist for management in the PACU.  
  • The proportion of all patients with severe pain at 45 minutes or on PACU discharge (whichever is earlier).  
  • The proportion of all patients whose PACU discharge is delayed by pain.  
  • The proportion of ambulatory surgery patients whose hospital discharge is delayed by pain. |
Standards and criteria for best practice

- 100% of patients have preoperative/intraoperative paracetamol administered (except where liver disease contraindicates).
- 100% of inpatients have regular paracetamol charted postoperatively (except where liver disease contraindicates).
- 100% of patients have an IV opioid protocol (or, if applicable, oral/sublingual opioid protocol) for PACU management prescribed.
- Less than 10% of patients have severe pain on PACU arrival.
- Less than 5% of patients have severe acute pain not responding to pain protocol in the recovery period and requiring review by an anaesthetist for management in the PACU.
- Less than 5% of patients have severe pain at 45 minutes or on PACU discharge (whichever is earlier).
- Less than 5% of patients have their PACU discharge delayed by pain.
- No day-stay patients have their hospital discharge delayed by pain (ambulatory surgery only).

Method

Data forms for 50 patients managed in PACU.

Data to be collected includes:

- Demographics, surgery type and whether ambulatory or not, factors known to impact on pain report (pre-existing pain, opioid tolerance, addiction).
- Planned analgesia.
- Prescribing practices: use of preoperative/intraoperative paracetamol (all patients), regular postoperative paracetamol (inpatients only), IV opioid protocol for PACU management (or, if applicable, oral/sublingual opioid protocol) (all patients).
- Workload outcomes: severe acute pain not responding to pain protocol in the recovery period and requiring review by an anaesthetist for management in the PACU.
- Pain outcomes: first recorded pain score, pain score at 45 minutes or on PACU discharge (whichever is earlier), PACU discharge delayed by pain (all patients), hospital discharge delayed by pain (ambulatory surgery only).

Common reasons for failure to meet the standard

- Failure to prescribe and administer multimodal analgesia.
- Failed local or regional block.
- Failure to recognise factors which increase postoperative pain (pre-existing chronic pain, opioid tolerance, pre-existing addiction).

References


Acknowledgement

Authors: Dr Lindy Roberts FANZCA FFPMANZCA and Professor Stephan Schug FANZCA FFPMANZCA. January 2017.

Associated documents:
PACU acute pain audit data collection form
PACU acute pain audit summary of results and conclusions form