

A clinical audit aimed at optimizing pain assessment in resident cancer patients in a Sri Lankan oncology setting: Reflection on the experience

Fernando G V M Chamath*, Fiona Rawlinson

University of Sri Jayewardenepura, Sri Lanka

Abstract

Being a commonly experienced distressful symptom, 'pain' is not sufficiently managed in worldwide cancer patients. One of the principle obstacle identified is an inadequate assessment of pain which in turn leads to its poor management. This is heralded by the lack of medical or nursing professionals qualified in Palliative Medicine/Care to date in Sri Lanka. Hence, the aim of this clinical audit was to optimize the assessment of pain among resident patients of a tertiary care cancer hospital by oncology doctors. A simple "pain and associated symptom chart" was designed for the doctors to document pain experienced by resident cancer patients in terms of intensity, both upon admission and on daily clerking (expected to be documented 100% each, regardless of the presence or absence of pain on a Visual Analog Scale from 0-10). Documentation of the site and character of pain were expected to be 80% each if the pain was present on assessment. Despite conducting three audit cycles with appropriate staff training and clarifications between each cycle, the pain assessment practices could not be improved among the doctors concerned. In the third audit cycle, it was noted that 23.5% of the charts were marked as '0' pain intensity upon admission and have been neglected thereon.

Keywords: Palliative Medicine; tertiary care cancer; pain assessment

*Corresponding author: Fernando G V M Chamath

✉ chemetf@sjp.ac.lk

University of Sri Jayewardenepura, Sri Lanka

Citation: Fernando G, Fiona R A clinical audit aimed at optimizing pain assessment in resident cancer patients in a Sri Lankan oncology setting: Reflection on the experience. J Clin Exp Orthop Vol. 7 No. 7: 70.

Received: Nov 05, 2021, **Accepted:** Nov 15, 2021, **Published:** Nov 25, 2021

Introduction

It was also noted that some patients were documented elsewhere than the form to experience nor pain neither breathlessness and were still on opioid analgesics which could potentially have led to litigation. Therefore, it is of utmost importance to incorporate clinical audit as a mandatory practice to the clinical oncology settings where it is not practiced. Relevant training has to be delivered to the concerned medical professionals. Appointment of health care practitioners dedicated to palliative care is essential to ensure a better quality of life (QOL) for patients with life-limiting illnesses. Introduction Pain is experienced by 30–75% of people with cancer and is rated as moderate to severe by 40–50% and severe by 25–30%.¹ The burden of cancer pain is likely to increase as people live longer with cancer and experience other chronic conditions and adverse effects from prolonged treatment regimens.² A number of evidence-based therapies are available and have been manualized as clinical practice guidelines. However, cancer pain continues to be undertreated worldwide, causing unnecessary distress to patients and their families. Research suggests that failure to implement evidence-based therapies results from barriers at the patient, health professional, and the health care system

levels.

A greater understanding of these barriers is needed to inform implementation strategies aimed at ensuring evidence based assessment and management that will improve outcomes. Qualitative research can provide important insights into health care barriers and ways of overcoming them. By elucidating beliefs and motivations, qualitative studies inform approaches to reducing or increasing behaviors that impede or support effective health care. A comprehensive understanding requires that all stakeholder perspectives are considered. In the case of cancer pain, stakeholders include not only patients and providers but also informal caregivers and families, who play important roles both as providers of care and as sources of psychosocial support. To date, there have been three reviews of qualitative research on cancer pain assessment and management, each focusing on a particular stakeholder perspective or issue of concern. Health professionals alike and contribute substantially to the under treatment of cancer pain. Stakeholders of all kinds were found to hold disproportionate concerns regarding opioid addictiveness and tolerance, and to mistakenly assume that opioids were indicated only at the end of life.

Additional barriers identified by reviewers were patient reluctance to report pain, a lack of requisite management knowledge among caregivers, and insufficient recognition of caregiver roles by health professionals. Education was highlighted as an important strategy for overcoming barriers by all three review teams. However, none of the reviewers provided a framework for structuring education to overcome barriers across patient, professional, and health care system levels. We undertook a new synthesis aimed at integrating information from all relevant, recent qualitative studies to inform management of barriers and optimization of facilitators to adult cancer pain assessment and management within a comprehensive framework of patient care. Eligibility Criteria Qualitative data were defined as raw data (e.g., verbatim patient statements) and themes identified by article authors. To ensure a minimum standard of reporting, we required articles to report at least one sample of raw data. Data could be collected using any method (e.g., interviews, focus groups,

online fora, or open-ended survey questions). Qualitative data from mixed methods studies were included. Themes were defined as any summary of respondent perspectives provided by the article authors. To be eligible, patient perspectives had to be those of adults or adolescents living with cancer. Specific exclusions were children with cancer and people of any age undergoing screening for cancer or disease-free at the time of research. Synthesis of Results Several approaches are available for synthesizing qualitative studies, each with different underlying epistemological assumptions. Thematic synthesis followed a three-stage approach: 1) free line-by-line coding of sections entitled "Results" or "Findings" in each article, 2) organization of these "free codes" into related areas to construct "descriptive" themes, and 3) the development of "analytical" themes designed to be informative to the review's objective. 4) software for all stages. Synthesis focused on information relevant to cancer pain and ignored results relating to other issues.

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