Pain Audit Checklists

These checklists can be used to audit the charts to determine whether staff are in compliance with the six QI Pain Questions. To be in compliance, all elements on the checklist should be marked "yes" on 95% of the charts audited.

INITIAL PAIN ASSESSMENT

Was an appropriate, comprehensive, and timely pain assessment completed for this older adult within 24 hours of admission? (Definition: Using a pain assessment tool that is appropriate to the older adult's condition and cognitive status that includes pain history, type of pain, location, intensity, diagnosis/cause, and pain management goal)

Audit Points – Audit 5-15 or 10% of older adult charts	YES	NO	Comments
1. Audit the admission date/time and the assessment date/time – was the assessment completed within 24 hours of admission?			
2. Was the older adult assessed for cognitive status and was the correct comprehensive assessment form used?			
2. Was the comprehensive assessment completed appropriately?			
3. Was the comprehensive assessment form signed by the licensed nurse completing the assessment?			
4. Was the comprehensive assessment dated?			
5. Was the comprehensive assessment form timed?			

ASSESSMENT FOR CHANGE OF CONDITION

Was an appropriate, comprehensive, and timely pain assessment for this older adult completed upon a significant change of condition that affected older adult's pain? (Definition: Using a pain assessment tool that is appropriate to the older adult's condition and cognitive status that includes pain history, type of pain, location, intensity, diagnosis/cause, and pain management goal).

Audit points:

Audit Points – Audit 5-15 or 10% of older adult charts	YES	NO	Comments
1. Was a change of condition that affected older adult's pain condition recognized and documented?			
2. Was a change of condition that affected older adult's pain condition communicated?			
3. Was there a comprehensive pain assessment completed upon change of condition that was relevant to pain management?			
4. Was comprehensive assessment completed appropriately?			
5. Was the comprehensive assessment dated?			
6. Was the comprehensive assessment form timed?			

Older adult Goals in Care Plan

Is there an individual pain goal and treatment plan identified for this older adult documented in the care plan? (Definition: addresses personal pain goals, and interventions/strategies to address the effects of the pain, to alleviate aggravating factors, to support alleviating factors, and to address drug side effects)

Audit Points – Audit 5-15 or 10% of older adult charts	YES	NO	Comments
1. Was the care plan initiated in a timely manner?			
2. Was the older adult and family provided information/education on the older adult's pain and the options for pain management?			
3. Was the older adult and/or their family member involved in developing the care plan for the older adult's pain management?			
4. Does the care plan address the individual pain goals for the older adult?			
5. Was the remainder of the pain care plan consistent with the older adult/family goals?			

Pain Treatment Side Effects

Are the older adult's analgesic/treatment side effects assessed and documented if they have them? If no, state none.

Audit Points – Audit 5-15 or 10% of older adult charts	YES	NO	Comments
1. Are side effects of each treatment part of the medication administration record? Are side effects assessed as part of the nursing pain management process?			
2. Are the potential side effects of each treatment (analgesic or non pharm) listed on the care plan?			
3. Was the older adult assessed for any side effects within four hours of the prescribed treatment?			
4. Were the side effects, if any, documented in the older adult's medical record?			
5. If there were no side effects, was that documented in the older adult's medical record?			

Treatment for Moderate to Severe Pain

Did older adults have their moderate to severe pain treated appropriately? (If the pain was moderate to severe, did nurse choose the medication ordered for moderate to severe pain)

Audit Points – Audit 5-15 or 10% of older adult charts	YES	NO	Comments
1. Was an assessment completed that identified pain as either mild, moderate, or severe?			
2. If the pain was moderate to severe, was the appropriate pain treatment chosen for the older adult?			
3. If there was no order for an appropriate pain treatment for moderate to severe pain, did the nurse promptly call the prescriber for an appropriate order? If not, is there documentation as to why not?			

Reassessment of Pain following Treatment

Was there a reassessment of older adult's pain following therapy? (Definition: within 1 hr of analgesic administration or within 24 hrs of nondrug intervention)

Audit Points – Audit 5-15 or 10% of older adult charts	YES	NO	Comments
1. Was the older adult's complaint of pain documented?			
2. Was the time of the treatment documented?			
3. Was there a reassessment done within one hour of pain treatment?			
4. Was the reassessment documented in the medical record?			
5. If the pain was unrelieved within one hour, did the nurse follow up with the prescriber?			