

Participant # _____

Date: _____

Satisfaction with Postoperative Pain management-idiopathic Scoliosis (SAP-S)
Scale for adolescents

© Le May, S.; Charette S; Turgeon I; Lampron A; Villeneuve E; Joncas, J. Parent S (2011)

This questionnaire aims at determining if patients who underwent surgery for idiopathic scoliosis are satisfied with pain management during their hospital stay and when returning home after surgery. The questionnaire doesn't aim at verifying your knowledge because there is no right or wrong answers. We are only interested in your opinion and your impressions. We also remind you that your answers will not be mentioned to the nurses and doctors who took care of you during your stay at the hospital.

SECTION A - DATES:

First, we would like to know the date of your surgery and the exact date at which you filled out the questionnaire. This information will help us to compare your answers to those of other patients.

Date of discharge :

___ / ___ / ____

MM / DD / YYYY

Today's date:

___ / ___ / ____

MM / DD / YYYY

SECTION B - IMPORTANCE and SATISFACTION :

The following questions concern hospital practices in relation with post-operative pain management. For each statement below please indicate the importance and the degree of satisfaction or dissatisfaction you give these statements, **by circling a number** from **1 (least important or least satisfied) to 6 (very important or very satisfied)**. If the statement does not apply, circle N/A (non-applicable). For example :

Concerning the **information** you received **AFTER** surgery in relation to :

1. Intensity of pain

Concerning the **information** you received **AFTER** surgery in relation to :

1. Intensity of pain
2. Medication used to reduce pain
3. The way to measure pain with a "pain scale"
4. Side effects you could have (e.g.: nausea, itching, etc.)
5. Medications used when returning home and their side effects

Concerning **actions** taken by **nurses and doctors**

6. Believing you when you talked to them about your pain
7. Helping you find a comfortable position in your bed in order to reduce pain
8. Asking you questions about pain you are feeling when you breathe deeply, when you sit or when you move around
9. Asking you about your pain level on a scale of 1 to 10, every morning, afternoon and evening
10. Treating your pain until it is relieved

Concerning your current medication:

11. The <u>length</u> of time the medication takes before relieving the pain
12. The <u>amount</u> of pain relief the medication brings you
13. The <u>duration</u> of pain relief the medication brings you

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IS IT IMPORTANT TO YOU?							ARE YOU SATISFIED?								
least important	Important			Very important			N/A	Least satisfied	Satisfied			Very satisfied			N/A
1	2	3	4	5	6	N/A	1	2	3	4	5	6	N/A		

	IS IT IMPORTANT TO YOU?							ARE YOU SATISFIED?								
	Least important	Important			Very important			N/A	Least satisfied	Satisfied			Very satisfied			N/A
1.	1	2	3	4	5	6	N/A	1	2	3	4	5	6	N/A		
2	1	2	3	4	5	6	N/A	1	2	3	4	5	6	N/A		
3	1	2	3	4	5	6	N/A	1	2	3	4	5	6	N/A		
4	1	2	3	4	5	6	N/A	1	2	3	4	5	6	N/A		
5	1	2	3	4	5	6	N/A	1	2	3	4	5	6	N/A		
6	1	2	3	4	5	6	N/A	1	2	3	4	5	6	N/A		
7.	1	2	3	4	5	6	N/A	1	2	3	4	5	6	N/A		
8.	1	2	3	4	5	6	N/A	1	2	3	4	5	6	N/A		
9	1	2	3	4	5	6	N/A	1	2	3	4	5	6	N/A		
10.	1	2	3	4	5	6	N/A	1	2	3	4	5	6	N/A		

11.	1	2	3	4	5	6	N/A	1	2	3	4	5	6	N/A
12.	1	2	3	4	5	6	N/A	1	2	3	4	5	6	N/A
13.	1	2	3	4	5	6	N/A	1	2	3	4	5	6	N/A

SECTION C – SIDE EFFECTS

For each of the following side effects, please indicate (1) if it bothered you and (2) to what extent, by circling the corresponding number on the scale

1. Fatigue / drowsiness (wanting to sleep more then usual)
2. Nausea (feel like vomiting)
3. Dizziness (feel like your head is spinning)
4. Constipation / Abdominal pain (stomach ache)
5. Itchiness (itching everywhere, face, neck, arms)
6. Vomiting
7. Hallucinations (seeing things that aren't there)
8. Doubled vision
9. Strange unpleasant sensations (feeling different than usual)
10. Strange but not unpleasant sensations (feeling different than usual)

	DID IT BOTHER YOU?		TO WHAT EXTENT?									
	Yes	No	Not at all Very much									
1.	Yes	No	1	2	3	4	5	6	7	8	9	10
2.	Yes	No	1	2	3	4	5	6	7	8	9	10
3.	Yes	No	1	2	3	4	5	6	7	8	9	10
4.	Yes	No	1	2	3	4	5	6	7	8	9	10
5.	Yes	No	1	2	3	4	5	6	7	8	9	10
6.	Yes	No	1	2	3	4	5	6	7	8	9	10
7.	Yes	No	1	2	3	4	5	6	7	8	9	10
8.	Yes	No	1	2	3	4	5	6	7	8	9	10
9.	Yes	No	1	2	3	4	5	6	7	8	9	10
10.	Yes	No	1	2	3	4	5	6	7	8	9	10

SECTION D –FORMAT OF THE MEDICATION

In this section, we ask that you indicate your level of satisfaction for each way that medication was given to you, by circling one from **1 (least satisfied) to 6 (very satisfied)**. If the statement does not apply, please circle N/A (non-applicable)

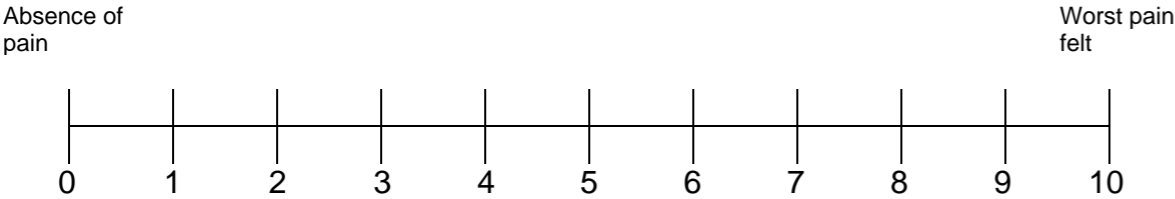
1. Patient control analgesia pump (Pump with a mechanism where you push a button to get a dose of medication)
2. Oral medication (by mouth: pills and capsules)
3. Patch medication (sticker on the arm)
4. Rectal medication (suppository)

<u>ARE YOU SATISFIED WITH THE FORMAT OF THE MEDICATION?</u>							
	Least satisfied			Satisfied		Very satisfied	N/A
1.	1	2	3	4	5	6	N/A
2.	1	2	3	4	5	6	N/A
3.	1	2	3	4	5	6	N/A
4.	1	2	3	4	5	6	N/A

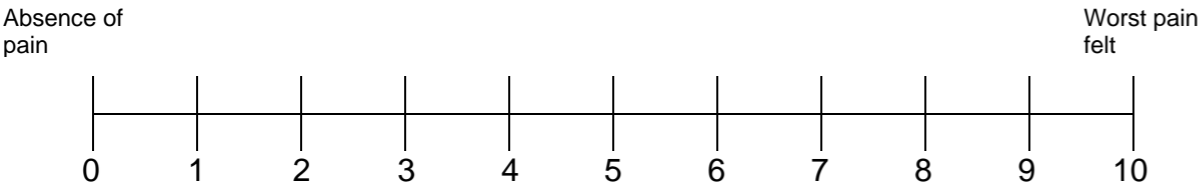
SECTION E – PAIN

For each of the following statements, circle the number corresponding to your level of pain.

1. What is your **present** level of pain?



2. What was your **worst pain in the past week**?



3. What level of pain did you **most often feel in the past week**?



SECTION F

Finally, in this last section, we would like you to tell us, in your own words, what was the most helpful and the least helpful aspect of pain management during your stay in the hospital. We also ask that you give us your suggestions on ways to improve the treatment of pain.

1. What was the **most helpful** during your hospitalization?

2. What was the **least helpful** or **most unpleasant** during your hospitalization?

3a. Besides **medication**, were there other methods used to relieve your pain? (ex.: Breathing techniques, games, music, visualization, hot-cold therapy, etc...)

Yes ☐ No ☐

3b. If yes, which ones were used? If no, go to **question 4**.

3c. Which of these **other pain relief methods** were **helpful**?

4. Do you have any suggestions on how we could improve the treatment of pain for someone who will undergo the same type of surgery as you? In particular, on issues for which you responded that you were not satisfied in SECTION C.

All you need to do now is insert the completed questionnaire in the envelope that was given to you, seal it and drop it in the mail. Thank you for your participation and collaboration!