in progress ... work in progress ... work

PAIN MANAGEMENT

INFLUENCING THE NURSING TEAM

Brighton ● Camberwell ● Southport ● West Dorset

Nursing Development Units

PAIN MANAGEMENT

INFLUENCING THE NURSING TEAM

MOLLY ALLEN

KING'S FUND CENTRE

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A personal crusade

Our nursing team is based on an acute medical ward. The ward is on the top floor of a red-brick hospital, which has a history that dates from the eighteenth century. I have worked on the ward for ten years and seen the nursing evolve from the regimentation of traditional care, which created a pristine environment but was also uncomfortable and restrictive, to a ward which is open at all times to visitors and where the wishes of the patients are more important than tidiness.

For the nursing team the late 1980s heralded a change. A new sister arrived with a philosophy of humanistic, holistic nursing care and a belief in education for her staff. It soon followed that we became a Nursing Development Unit.

Although the ward is known as a female ward, there is no hard and fast rule about this. There are twenty-four beds arranged at two 'ends' of a corridor.

As there is no hospice available in this area, we sometimes nurse patients who are terminally ill. However, the majority of patients admitted to our ward are acutely ill and come in via the Accident and Emergency Department. Other patients are admitted following a domiciliary visit from a rheumatologist or another medical consultant. A significant number of these patients suffer from varying degrees of pain. Almost all of them suffer from anxiety related to coming into hospital and worry about the symptoms of their illness. The exceptions are patients admitted on a regular basis who have come to know and trust our primary nursing teams. It is well documented that anxiety increases the perception of pain[1].

Patients and relatives are provided with holistic, understanding nursing care by primary nursing teams who know of their wishes

and desires and do their best to provide nursing which suits their individual needs.

This paper describes how we turned a personal crusade into a team mission: to improve the management of pain in general hospital settings. Interest in sharing in our work has come from other nurses working in the local community hospital and from other acute settings. This interest was given a boost by our appearance on the BBC television programme 'No More Nightingales'.

Pain — a high priority

Twenty years ago, suffering from a painful condition known as pericarditis, I was 'nursed', and I use that term loosely. I shudder as I remember being told that I could not be in pain as my pain controlling injection was not yet due. I was also informed that the injection contained a dangerous drug (what we call these days a controlled drug) and as such it was addictive. Feeling wretched, nauseous with waves of pain made worse by the thought that the nurses thought I might be addicted to my analgesia, I asked the doctor to let me go home, promising to take my medication and rest. Unfortunately the doctor did not think this was a good idea. He told the sister of my request and this seemed to incense her. Her cold hostility lives with me to this day. On a more positive note, my personal interest in pain control and the spiritual and psychological needs of people in pain was kindled.

More recently this was fuelled by attendance at a lecture entitled 'Pain relief in terminal illness' by Dr K Gill, the anaesthetist in charge of our pain control clinic. Dr Gill opened his lecture with this statement: 'Pain control is one aspect of symptom management in terminal, malignant disease which assumes a high priority.'

He went on to say that if the estimate that 30 per cent of patients dying of malignant disease within the United Kingdom have less than satisfactory pain control, we should compare it with the work in hospice units where satisfactory pain control is achieved in all but 1 per cent of patients. He concluded that the principles of effective pain management could be applied to patients nursed at home or in general hospital beds.

Later, as I reflected on Dr Gill's lecture, I considered whether patients, other than the terminally ill, had adequate pain relief and what the percentage might be if all our patients were included. I recalled conversations with members of our nursing team who had expressed anxiety about inadequate pain control and who felt concerned for the ill or injured people in their care who suffered pain. They sometimes felt impotent in getting a patient's pain treated or even recognised. 'Why don't the doctors do something about it?' they would ask.

Visits to hospices and Cancer Help Centres consolidated my belief that the spiritual and psychological aspects of pain control were being grossly overlooked within acute care settings. This period of reflection led to the re-emergence of a desire to redress the balance in favour of those patients nursed in hospital beds who suffered acute or chronic, often unbearable, pain.

The power to change things

Two years on, we can say that we now feel well able to manage and control patients' pain. We have the tools and the evidence to demonstrate when patients are in pain and, as a team and individually, we have the power to change things.

We started primary nursing on our ward three years ago. From the

moment of admission, patients are aware that the nurse who greets them is there for them. A relationship develops built on trust which helps to relieve anxiety and stress and therefore reduces pain.

We constantly revise the way we plan and deliver care and particular effort has gone into the assessment of pain on admission as well as during the patient's stay in hospital. The question 'Are you in pain?' is included in the admission assessment and nurses now have at their disposal two different types of assessment tools, one 'home grown' and the other 'off the shelf', to help them monitor the control of pain.

The use of such charts has two significant advantages for the patient. First, they increase the level and quality of communication between the nurse and the patient around the subject of pain management. Secondly, the involvement of the patient in his or her own pain control assessment increases trust and confidence in the nursing staff, enabling alternative pain control methods to be introduced and evaluated.

Awareness and strategies

A well-designed chart does not make for a good assessment by itself. As a team, we now have a much greater understanding of the different types of pain people can suffer and an increased awareness of how hospitalisation can itself exacerbate or even cause pain. We assess and distinguish between the following.

Life pain

We find that if patients feel satisfied with their past life, pain is often easier to manage. Conversely, if they feel bitter and unfulfilled, pain is difficult to manage. We need to be sympathetic and have an understanding of past disappointments.

Unexplained pain

Often a person is in pain and does not know why. Perhaps he or she has put up with it for years. This is when we need to exchange information and a partnership with the patient facilitates this. The patient needs information and so do we. This enables nurses to assess how bad the pain is and to encourage the judicious use of analgesia. Patients are helped to identify and avoid trigger factors. We then have the opportunity to introduce and teach patients about alternative and active pain controlling strategies which they can use themselves.

Disease-related pain

Again we need to assess pain by discussion with the patient, allowing time and opportunity to express fears and anxieties. We can provide information about analgesia, how it can be obtained, when it will start working and for how long. When narcotic administration is the only way to control pain, we assess the patient's attitude to this; both patients and nurses anticipate the possibility of addiction. Wherever possible, we use complementary methods: for example, we gate the pain using TENS, (Transcutaneous Electrical Nerve Stimulation), or teach relaxation or imagery techniques and attend to basic comfort, position and noise limitation.

Therapy-related pain

Therapy often causes more distress than the disease itself. We find that as well as symptom control and complementary therapies, the use of information and feedback, involving patients in assessing and monitoring their own progress, can be effective.

Nursing care pain

Much of this type of pain can be avoided by sympathetic nursing. The introduction of primary nursing has helped us focus on and attune our care to the needs of the patient. We are alert to sensory deficit and sleep deprivation. Painful nursing procedures such as

catheterisation or enemas can be avoided by the prevention of constipation and bladder control programmes.

Pain associated with the decision not to be treated
Negative feelings are carefully looked into and, where appropriate, we offer referral, for example, if there are financial problems associated with the loss of a spouse. We allow time for adjustment, suggest alternative ways of thinking, but ultimately support the patients in his or her decison.

I developed this classification of the different types of pain largely from the work of Professor Copp[2] and Dr Walker[3]. We have now compiled a reference manual for pain management which includes assessment and the use of medication and psychological care as relief for some symptoms. This has been of particular interest to newly qualified staff and students. The manual is kept on the ward, enabling easy and quick reference by nurses.

As a team, we have a variety of skills and a bank of knowledge for the management of pain. These have been fostered by periods of reflection on our practice. Using Benner's method of story telling[4] we have been able to identify successful strategies for relieving pain; we have also been able to share with colleagues the problems that we sometimes face.

Many of our team now have certificates in aromatherapy, several have completed the Care of the Dying course, others have attended courses in counselling and communication skills, all recognising the benefits that these skills bring to improving pain control. The sharing of information ensures we all are aware of the benefits of massage, relaxation, therapeutic touch and music therapy, which we try to incorporate into our nursing care. No longer do we avoid the patient in pain; our ongoing learning and sharing of information enables us to help.

From initial enthusiasm...

This has not happened overnight. Fired by my initial enthusiasm, I decided that one way of improving the assessment of pain was to conduct small-scale research. I designed a tool for pain measurement (see Appendix I) based on Meinhart and MaCaffrey's Criteria for Assessment[5]. Our team piloted its use on our unit and I invited the surgical wards and the orthopaedic unit to participate. I wanted to use the tool in those settings so that the acute pain caused by trauma or major surgery could be assessed and evaluated, as well as the chronic pain caused by rheumatoid arthritis or ischaemic limb disease.

This pilot study was not as successful as I had originally hoped. The returns to the questionnaire were poor: a 20 per cent return overall, but a 100 per cent return from my own ward. It therefore seemed to be appropriate to use the findings to develop our own practice.

From this initial pilot study I was able to identify what modifications to the chart were necessary to make it more effective. Respondents wanted a brighter, more noticeable chart, which would include a back view of the body outline and more space for information on action taken.

In March 1990, I introduced the Evans Medical Pain Control Chart to the team. It is bright orange in colour, more noticeable and includes back and front view of body outline. There is also more space for comments and evaluation. (Sample charts are available from Evans Medical Ltd; their address is given at the end of this paper.)

In June of the same year I evaluated the use of this chart on our ward. Everyone who had used either chart felt that the use of a

chart improved patients' pain control because patients themselves were aware of their pain being assessed and managed. The Evans Medical chart did offer some improvements on the chart I had developed. It was possible to put more information on this chart, the guidelines were preferred, the space for 'Action Taken' was thought to be useful and it seemed to create less paper work. However, the chart was more complicated, the sites and grades of pain were more difficult to evaluate and both these factors could interfere with the patient's ability to understand it.

... *to a team dynamic*

On reflection, doing the pilot studies, especially the first one, was a lonely process. It required a lot of effort and the poor response from the other wards made me think about what I had done wrong, rather than value the response from my own team and the achievement there.

Looking back now, there was so much support from the ward team and an incredible team dynamic. Nurses outside my own primary nurse team started to consult me about the management of their patients who had pain and it was a period in which my expertise both developed and became increasingly recognised.

Through the process of piloting the charts, they had become part of the regular armoury that nurses on the ward would use to help control patients' pain. Although we had evaluated the charts, we had yet to evaluate our effectiveness in managing pain.

Redressing the balance...

We carried out an audit in our unit specifically relating to patients in pain. The audit chart was especially designed to discover the advantages and disadvantages of pain assessment charts, as well as the relationship between morale and coping and the effects of mood on pain control (see appendix 2). I now had the assistance of Joy Warren, the research nurse now based on the NDU, in undertaking the audit.

We audited just one end of the ward, a total of 13 patients. We established that eight patients were pain free. They were not being investigated by the nurses because there was no need. One patient had a little pain and her pain was being monitored by her nurse and her morale was high. Four patients had 'quite a lot of pain'. The pain of three of these patients was being investigated by their nurses and two of them were at least coping and one patient was just coping. However, in this group of patients with 'quite a lot of pain' there was one patient whose pain had not been identified and who was not being investigated for pain by her nurse; *this patient was not coping.*

Although the result was not statistically significant, it is interesting to note the relationship between the amount of pain being experienced, the pain not being investigated and the low level of coping by the patient. The results of this audit were later fed back to the nursing team, prompting further discussion. It was at this point that we introduced the question 'Are you in pain?' to the admission assessment document.

The next stage for us is to audit a larger group of patients, as we feel pain control has improved on our unit since the last audit. I would like to evaluate the benefits of pain assessment tools and to find a way of measuring how much our new knowledge and skills contribute to the relief of pain.

... *in favour of our patients*

Pain management is now a team enterprise. My own development has been nourished by attending seminars, workshops and joining the RCN Pain Research Special Interest Group. These activities have widened my perspective and increased my awareness of the mulifaceted causes of unrelieved pain. My enthusiasm has spread to the team via my new knowledge and the experience of others exchanged in discussions at NDU meetings and NDU study days. We have now moved on to giving information to other staff in our hospital and to other local hospitals. A successful conference, which we arranged jointly with Knapp Laboratories, was held at our hospital.

As a team, we are fortunate in being a Nursing Development Unit as this allows us to determine how developments will take place and gives us the opportunity to support each other in undertaking them. I now feel I have gone a considerable way towards meeting my original aim of redressing the balance in favour of our patients.

Sample pain control charts are available from Evans Medical Ltd, Langhurst, Horsham, West Sussex. Telephone 0403 41400.

References

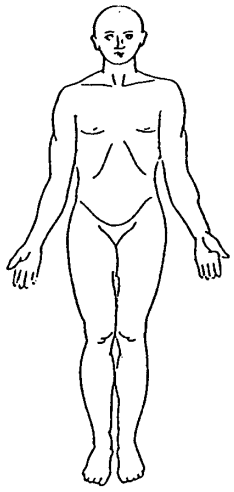
1 McCaffrey M. Nursing management of the patient in pain Lippincott, Harper and Row, 1972.

2 Copp LA. The spectrum of suffering. American Journal of Nursing 1974; 74(3): 491-5.

3 Walker J. et al. The nursing management of elderly patients with pain in the community: study and recommendations. Journal of Advanced Nursing 1990; 15(10): 1154-61.

4 Benner P. From novice to expert: excellence and power in clinical nursing practice. Menlo Park, California, Addison Wesley, 1984.

5 Meinhart MT and McCaffrey M. Pain: a nursing approach to assessment and analysis. Norwalk: Appleton, Century Croft,1983.

SCALE	TIME	DEGREE OF PAIN					ANALGESIA	LOCATION OF PAIN
		1	2	3	4	5		
	02.00							
5 As much pain as I could possibly bear	04.00							
	06.00							
	08.00							
4 A very bad pain	10.00							
	12.00							
3 Quite a lot of pain	14.00							
	16.00							
2 A little pain	18.00							
	20.00							
1 No pain at all	22.00							
	24.00							

PATIENT: NO: WARD: DATE:

CONSULTANT:

PRIMARY NURSE:

ASSOCIATE NURSE:

Based on Meinhart and McCaffrey's criteria for assessment[5]

Appendix 2: *The pain audit chart*

AGE _____

DIAGNOSIS _____

Have you any pain? yes/no

Which of the following describes your pain?
(please tick box)

1. No pain at all ☐
2. A little pain ☐
3. Quite a lot of pain ☐
4. A very bad pain ☐
5. As much pain as I can possibly bear ☐

Is your pain being investigated? yes/no

Are you coping? yes/no

How do you feel?

Please choose the face which describes how you feel at the moment.

a 

b 

c 

d 

e 

f 

g 

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This series looks at some of the ways nurses in Nursing Development Units (NDUs) have tried to make their nursing more beneficial for patients. The nurses assess to what extent their initiatives really do contribute to patient well-being and what has helped them bring about the changes. Each book will help nurses to introduce new ideas to their work and will suggest ways to evaluate changing practices.

The four NDUs which have contributed to this series have been supported by the King's Fund Centre and the Sainsbury Family Charitable Trusts since 1989 as part of a three-year project. A further 30 new projects have just received funding from the Department of Health and join the growing network of Nursing Development Units.

In this booklet, Molly Allen, a primary nurse, describes how she enlisted her colleagues' support in improving pain management in a general hospital setting.

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