Role of patient education in postoperative pain management

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None declared

Abstract
Postoperative pain continues to be a significant issue in healthcare, with a considerable proportion of patients experiencing severe pain after surgery and finding pain management at home challenging. There are several barriers to effective pain management, involving both patients and healthcare professionals. Patient education may be a useful way to overcome many of these barriers. This article outlines the four stages of the education process, which can be used to provide patient education: assessing the patient’s educational needs and potential barriers to learning; setting educational objectives; teaching; and evaluating the patient’s learning. This article discusses the issue of postoperative pain and how structured patient education, from admission to discharge, provided by skilled healthcare professionals, may improve postoperative recovery.

Keywords
analgesia, pain management, patient education, postoperative care, postoperative pain, self-care, surgery, teach-back method

Aims and intended learning outcomes
This article aims to raise nurses’ awareness of the importance of patient education in effective postoperative pain management, and appropriate methods of providing such education. Nurses have an important role in educating patients about pain management and this can support their postoperative recovery. Therefore, knowledge about effective ways to assess and deliver patient education is a fundamental nursing skill. After reading this article and completing the time out activities you should be able to:

» Evaluate the effectiveness of the education a patient has received.

Relevance to The Code
Nurses are encouraged to apply the four themes of The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives to their professional practice (Nursing and Midwifery Council (NMC) 2015). The themes are: Prioritise people, Practise effectively, Preserve safety, and Promote professionalism and trust. This article relates to The Code in the following ways:

» It emphasises the importance of patient education in effective self-management and self-care for postoperative pain. The Code states that nurses must recognise and respect the contribution that people can make to their own health and well-being.

» Nurses must act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need
it. This article outlines how nurses can provide such information and support using the education process.

» It outlines the benefits of shared decision-making and using patient education to empower patients in relation to their postoperative pain management. The Code states that nurses must encourage and empower people to share decisions about their treatment and care.

» The Code theme of prioritising people states that nurses must treat people as individuals and respond to their preferences and concerns. This article advocates providing individualised patient education on postoperative pain management that best meets the patient’s needs.

**Introduction**

As a result of advances in surgical technology, anaesthesiology and postoperative treatment, patients are being discharged earlier after surgery, and day case surgery is significantly increasing, accounting for almost 70% of all surgery performed (British Association of Day Surgery 2014). As a result, there is increased responsibility on patients to undertake self-care activities, including monitoring and treating symptoms that may occur after surgery, such as pain.


Pain is a common reason for hospital readmission after surgery (Helgstrand et al 2011, Clement et al 2013), and may delay discharge following day care surgery (Rae 2016). Importantly, inadequate pain management after surgery can increase the risk of chronic postoperative pain (Joshi and Ogunnaik 2005). The prevalence of chronic postoperative pain ranges from 10-50%, depending on the type of surgery, with around 2-10% of patients experiencing moderate to severe pain (Schug and Pogatzki-Zahn 2011). Given the high number of surgical procedures undertaken each year, chronic postoperative pain is a serious issue, and therefore requires preventative measures.

Patient and family education is an important component of effective pain management (Zoëga et al 2016). According to the Donabedian (1988) model, quality in healthcare refers to the structure, process, and outcomes of care. Structure relates to institutional factors such as staff being qualified and skilled to provide postoperative patient education, policies and standards; process refers to how care is provided, for example how patients are informed and if pain is assessed; and outcomes refer to the results of care being provided, for example if the patient has sufficient knowledge to manage their pain, pain severity is low, and side effects from treatment are limited.

It is essential for patients to understand why pain management is necessary for their recovery and comfort, and how they can have an active role in their pain management. This is important because patient participation in decision-making is related to improved pain-related outcomes. Zoëga et al (2015b) found that patients in hospital who were able to participate in pain management decisions spent less time in severe pain, and had improved pain relief, compared with those who did not participate in treatment decisions. Moreover, patients who received information on their pain management options were increasingly likely to participate in treatment decisions. Similarly, a German study found that patients who received adequate information regarding their pain treatment options were more likely to be satisfied with their pain management, had lower pain severity, and had less functional impairment as a result of pain than patients who did not receive information on their pain treatment options (Meissner et al 2017).

Table 1 shows characteristics of patient education in relation to pain management according to the Donabedian (1988) model of quality in healthcare.
Clinical guidelines recommend that pain is assessed regularly using validated scales to measure pain severity (Registered Nurses Association of Ontario 2013, Chou et al 2016), for instance a numerical, verbal or visual rating scale. Such scales can be used to assess how well the patient is responding to treatment. Treatment recommendations for pain include using multimodal analgesia, such as pain medications with varying modes of action, and non-pharmacological methods, such as heat or cold packs, distraction and relaxation techniques. Prevention and treatment of side effects is also an important aspect of pain management (Schug et al 2015, Chou et al 2016).

Patients should take analgesics on a regular basis while pain is constant (Pasero 2010), provided there are no contraindications to the medications. Guidelines on postoperative pain management recommend that healthcare professionals ‘provide patient and family-centred, individually tailored education to the patient (and/or responsible caregiver), including information on treatment options for management of postoperative pain, and document the plan and goals for postoperative pain management’ (Chou et al 2016). Therefore, patient education is an important aspect of postoperative care.

Pain management should be extended from the hospital to the patient’s home, because usually postoperative pain has not resolved at the time of their discharge (Bjørnnes et al 2016). Pain management follow-up after discharge can be important in improving postoperative recovery and preventing pain-related complications such as chronic pain (Tiippana et al 2014). It is necessary for patients to be prepared to manage their pain at home; however, research indicates that many find this challenging. Patients do not always take the prescribed analgesics as recommended, despite experiencing considerable pain (Leegaard et al 2010, Bjørnnes et al 2016, Stessel et al 2017). Patient education should address the importance of managing pain, rather than only providing information about which analgesics to take and when (Leegaard et al 2010).

**TIME OUT 1**

Reflect on your practice. Can you remember an experience when a patient you were providing care for:

- Was readmitted because their pain was not managed effectively at home?
- Seemed disinterested in learning about pain management at discharge?
- Was reluctant to take pain medication?
- How did staff address this issue? What could have been done differently?

**Patient education**

Patient education refers to all educational activities directed at patients and/or their families (Deccache and Aujoulat 2001). The aim of patient education is to develop

### TABLE 1. Characteristics of patient education in relation to pain management according to the Donabedian (1988) model of quality in healthcare

<table>
<thead>
<tr>
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<tr>
<td><strong>Structure</strong></td>
<td>Organisational policies related to patient education</td>
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<tr>
<td></td>
<td>Staff qualified and skilled to provide postoperative patient education</td>
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<td>Necessary resources for educational purposes, for example time, staff and facilities</td>
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<td>Inclusion of patient education as a component of perioperative care</td>
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<td><strong>Process</strong></td>
<td>Assessment of educational needs</td>
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<td>Assessment of attitudes and beliefs hindering knowledge acquisition</td>
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<td>Assessment of previous experience and knowledge of patients</td>
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<td>Individual patient education</td>
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<td>Family* education</td>
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<td></td>
<td>Patient participation</td>
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<td></td>
<td>Caring attitude of healthcare professionals</td>
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<td><strong>Outcomes</strong></td>
<td>Increased knowledge of patient and/or family members regarding postoperative pain management</td>
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<td></td>
<td>Reduced barriers related to the patient’s attitude to pain management</td>
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<td>Increased ability of the patient and/or their family to manage postoperative pain at home</td>
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<td></td>
<td>Reduced pain severity</td>
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<td>Reduced functional impairment as a result of pain</td>
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<td>Increased patient satisfaction</td>
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<td>Improved pain relief</td>
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<td>Reduced time spent in severe pain</td>
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*‘Family’ refers to anyone the patient considers significant, whether they are an actual family member or not (Adapted from Zoëga et al 2016)
patients’ competence and confidence in undertaking health behaviours that are consistent with their life plans and support their autonomous decision-making (Redman 2004). The European Patients’ Forum (2015) recognised education as one of the cornerstones of its empowerment campaign, since: ‘patients can make informed decisions about their health if they are able to access all the relevant information, in an easily understandable format’.

In the past few decades, patient education has developed from healthcare professionals deciding what patients need to know, to an emphasis on shared decision-making (Hoving et al 2010). Shared decision-making involves the healthcare professional discussing pain management options and their potential risks and benefits with the patient, and collaboratively selecting appropriate options (National Institute for Health and Care Excellence 2017).

Shared decision-making is especially important in pain care because pain is subjective, so it is the patient who can best describe the pain. Furthermore, since pain is subjective, it is important to adjust the patient’s treatment plan in accordance with their needs and preferences, which requires direct input from the patient (Jansen 2001). However, it should be noted that not all patients want to participate in treatment decisions (Zoëga et al 2015b), and healthcare professionals must respect the willingness of patients to be involved in decision-making about their care (NMC 2015).

There is increasing evidence to indicate that patient education can improve postoperative pain management, knowledge, satisfaction with care and use of healthcare services, reduce fear and anxiety, and support behaviour change (Ronco et al 2012, Shahmansouri et al 2014, Waller et al 2015, Powell et al 2016). Furthermore, patients undergoing day surgery are better prepared to recover at home if they have received preoperative and postoperative education (Mitchell 2015).

Theories of adult learning can be beneficial when planning and providing patient education. Knowles et al (2015) stated that the characteristics of adult learners include being autonomous and self-directed, and having previous experience and knowledge on which to develop new knowledge. Adult learners are usually goal-oriented and want to learn relevant and practical information. Adults are thought to learn best when they perceive that their situation requires new learning and when their motivation is high (Knowles et al 2015). Knowledge of these principles of adult learning may be useful for healthcare professionals when preparing and providing patient education in practice.

When an individual becomes a patient, they require new knowledge and skills and may have to reconsider their attitudes or behaviour, all of which can affect their health. For example, patients who undergo surgery are required to learn and perform specific self-care activities, such as pain management. Self-care refers to the behaviours and processes used by patients to manage their illness (Riegel et al 2012). Through undertaking self-care activities, patients promote their health by attending to daily activities of living, such as ensuring sufficient nutritional intake, rest and activity, monitoring their pain, and responding to pain with measures such as taking medication, relaxing, or seeking support and advice from healthcare professionals or family and friends. The patient monitors their pain after undertaking these measures, to assess if they were effective, and uses reflection and decision-making to determine whether to continue with self-care.

Patient empowerment is the basis of health and self-care (Leino-Kilpi 2009). As a nursing intervention, patient education aims to improve the patient’s knowledge, which is the basis of empowerment. Such empowering knowledge is multidimensional and has been categorised as biophysiological, functional, experiential, ethical, social and financial knowledge (Leino-Kilpi et al 2005). Table 2 shows the dimensions of empowering knowledge and their role in patient education on postoperative pain management.
TIME OUT 2
Access and read the following fact sheets on pain after surgery from the International Association for the Study of Pain (2017a, 2017b):

Did any of these facts challenge your beliefs about postoperative pain? Did the fact sheets include any information you could use in providing patient education?

### TABLE 2. Dimensions of empowering knowledge and their role in patient education on postoperative pain management

<table>
<thead>
<tr>
<th>Dimensions of empowering knowledge</th>
<th>Issues to address in relation to postoperative pain management</th>
<th>Role in postoperative pain management</th>
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<tbody>
<tr>
<td>Biophysiological</td>
<td>» What are the causes, signs and symptoms of postoperative pain?</td>
<td>» To understand the role of pain and the pain trajectory following surgery</td>
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<td></td>
<td>» How is pain assessed?</td>
<td>» To assist in communication with healthcare professionals, and to assist the patient to monitor their pain and evaluate treatment outcomes</td>
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<td></td>
<td>» When should pain be reported?</td>
<td>» To enable pain to be treated in a timely manner</td>
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<tr>
<td></td>
<td>» What pharmacological and non-pharmacological pain management options are available? What times should any medications be taken?</td>
<td>» To recognise and select available treatment options and understand how the treatment works</td>
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<td></td>
<td>» What is a realistic goal for pain management?</td>
<td>» To understand the importance of ensuring pain is mild to prevent adverse effects of pain while understanding that it may not be possible to completely eliminate pain</td>
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<td></td>
<td>» What are the possible side effects of pain medications? How can these be prevented? What would be the consequences of ineffectively managed pain?</td>
<td>» To recognise and be able to prevent and manage common side effects that may be harmful or inconvenient for the patient and may hinder effective treatment</td>
</tr>
<tr>
<td>Functional</td>
<td>How can pain and its management affect mobilisation, sleep, appetite and other daily functions?</td>
<td>To support the patient to manage daily activities and self-care despite the pain</td>
</tr>
<tr>
<td>Experiential</td>
<td>How can previous experience or expectations about pain affect current pain and pain management? What are the patient’s perceptions about pain and analgesics?</td>
<td>To enable the patient to recognise their capabilities and barriers that can support or hinder effective treatment</td>
</tr>
<tr>
<td>Ethical</td>
<td>What is the patient’s responsibility in pain management, how can they participate in treatment and how can healthcare providers respect the patient’s self-determination in the treatment?</td>
<td>» To ensure the patient’s rights are respected and that care is in accordance with the ethical principles of autonomy, beneficence, non-maleficence and justice</td>
</tr>
<tr>
<td></td>
<td>» To potentially improve postoperative pain management and recovery</td>
<td></td>
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<tr>
<td>Social</td>
<td>How can family and others provide support in pain management?</td>
<td>To enable the patient to manage their pain</td>
</tr>
<tr>
<td>Financial</td>
<td>What costs are associated with pain management? For example, prescription costs</td>
<td>To address financial issues in a timely manner and ensure the patient is aware of the possible cost of treatment</td>
</tr>
</tbody>
</table>

Role and skills of nurses in patient education

Nurses have an important role in organising and delivering patient education in their healthcare organisations. Conditional factors that can either support or hinder patient education may be internal factors, such as the nurse’s personal beliefs about the educative role, their potential to accomplish that role, and perceptions about their own knowledge and competence; external factors may include the environment and the healthcare organisation, interdisciplinary cooperation and teamwork, and educational activities (Friberg et al 2012).

While nurses have been found to assess themselves as competent in the teaching or coaching role (Meretoja et al 2004, Bergh et al 2014), studies have indicated that many nurses are not updated on the development of patient education (Bergh et al 2012). Nurses often do not provide sufficient evidence-based patient education (Lipponen et al 2006) and healthcare professionals may have inadequate knowledge of patients’ condition following hospital treatment and have to develop skills in supporting patients’ self-care (Kääriäinen and Kyngäs 2010). Therefore, providing patients and healthcare professionals with skills to optimise this education has been recognised as a future challenge in relation to patient education (Hoving et al 2010). Healthcare professionals should also critically evaluate the existing relevant knowledge that they base their education on, and consider how they can effectively support individual patients in processing and structuring knowledge to support postoperative recovery (Leino-Kilpi 2009). This begins with the education process.

Education process

Teaching and learning are the two major interdependent operations of the education process (Bastable 2017), whereby the patient’s learning is assisted by the educator’s teaching strategies and selected instructional material. This education process consists of four steps (Bastable 2017):
1. Assessment of the patient’s educational needs and potential barriers to learning.
2. Planning by setting educational objectives.
3. Implementation through teaching, using instructional methods and tools.

Table 3 shows an example of a teaching plan that could be used to provide patient education on pain medication.

Assessment of the patient’s educational needs and potential barriers to learning

This first step in the education process is assessment. This is crucial and the basis for the other steps. The nurse should assess the patient’s readiness to learn, their priorities, possible barriers and concerns, and their educational needs. Assessment can be undertaken through informal conversations, structured interviews, questionnaires, observation or by reading the patient’s medical notes.

It is well documented that patients who undergo surgery have multidimensional educational needs (Rankinen et al 2007, Valkeapää et al 2014) and that

| TABLE 3. Example of a teaching plan that could be used to provide patient education on pain medication |
| Assessment of the patient’s educational needs and potential barriers to learning | Planning by setting educational objectives | Implementation through teaching, using instructional methods and tools | Evaluation of the patient’s learning |
| Assess the patient’s previous experience and knowledge of pain medications, their educational needs, and possible barriers to effective pain management | After the teaching session the patient should be able to: | Provide verbal information in individual or group education sessions, as well as written material, such as leaflets or details of relevant websites | Use the teach-back method to check the patient’s understanding of the information provided |
| » Explain why pain management is important for their postoperative recovery | » Identify their prescribed pain medications and differentiate between them | » List the common side effects of pain medications and measures they can take to prevent these | |
| » Provide written material to patients | » Use the teach-back method to check the patient’s understanding of the information provided | | |

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KEY POINT

Patients’ concerns after surgery tend to focus on how to manage pain at home following hospital discharge, including what medication to take, how to manage or prevent associated side effects, what to do if pain persists, and when and where to seek support (Kastanias et al 2009, Mitchell 2015, Mavridou et al 2016).

Common beliefs recognised in patients who undergo surgery that can hinder effective pain management are: being afraid of becoming addicted to analgesics; concerns that analgesics may not work later if the pain increases; believing the effectiveness of analgesics is limited; and fear of being seen to complain (Lorentzen et al 2012, Cogan et al 2014, Bjørnnes et al 2016). In addition, anxiety can reduce the patient’s motivation and cognitive ability to learn. Fatigue, suboptimal sleep and drug-induced drowsiness after surgery are further common barriers to learning (Ingadóttir et al 2016). Therefore, addressing patient barriers to learning is important when assessing the educational needs of patients.

Before surgery, patient education should focus on the possible barriers to effective pain management, as well as why pain relief is important, how and when to seek support with pain, and how using a pain assessment tool, such as a numerical rating scale, can support communication between the patient and healthcare professional. The available pain relief methods should be explained to the patient, with examples given of pharmacological and non-pharmacological treatments, and the patient given a choice in which pain relief methods they would prefer to use. This education should be re-enforced after surgery and preparation for discharge home commenced.

Patients have called for further education about pain management strategies after experiencing pain for longer than they expected (Sethares et al 2013) and patient education, for example about the benefits of analgesic use, may result in reduced pain following discharge home (Bjørnnes et al 2016). Patients’ concerns after surgery tend to focus on how to manage pain at home following hospital discharge, including what medication to take, how to manage or prevent associated side effects, what to do if pain persists, and when and where to seek support (Kastanias et al 2009, Mitchell 2015, Mavridou et al 2016).

The patient factors that are related to patients’ educational needs about postoperative pain management remain unclear. Neither age, gender, type of surgery or health status has been found to explain their varying educational needs (Kastanias et al 2009), and Mavridou et al (2016) found no difference in the educational needs of patients with or without previous experience of undergoing surgery, contrary to what might be expected. Therefore, assumptions about the educational needs of patients based on such patient factors are unwarranted, and assessment is the only appropriate means of determining the educational needs of each patient.

Table 2 includes examples and suggestions of possible and common content to include in patient education, based on the available evidence, divided into the six dimensions of empowering knowledge. However, the authors emphasise the importance of individualisation and exploring each patient’s priorities before teaching commences.

Planning by setting educational objectives

The second step in the education process is to set educational objectives. The healthcare professional should set the objectives of patient education with the patient, within Bloom’s domains of learning as follows (Anderson and Krathwohl 2001):

» Cognitive – for example, to improve knowledge.

» Affective – for example, to change attitudes, beliefs or values.

» Psychomotor – for example, practical skills.

Patient-focused objectives may relate to: experiential factors, such as decreasing
the patient's anxiety, depression or fear; cognitive factors, such as improving objective and subjective knowledge; or biophysiological factors, such as affecting pain intensity and pain management, or opioid use (Johansson et al 2004, 2005, Ronco et al 2012, Waller et al 2015).

Researchers have emphasised that the focus or goal of patient education should not be solely on increasing knowledge, stating that focusing on enhancing the patient's self-care skills, communication and problem-solving is likely to be more effective (Fredericks et al 2010, Commodore-Mensah and Dennison Himmelfarb 2012). Providing procedural information about pain management is not sufficient to reduce postoperative pain or to prepare patients for discharge; therefore, patient education should focus on changing the patient's pain beliefs that may be hindering effective pain management (Older et al 2010, Louw et al 2013).

It may be beneficial for healthcare professionals to consider using the Ask Me 3® educational programme, developed by the National Patient Safety Foundation (2017), to focus the patient education that will be provided. This involves encouraging patients and their families to ask the following questions to improve their understanding of their condition and what they need to do:

- What is my main problem?
- What do I need to do?
- Why is it important for me to do this?

**Implementation through teaching, using instructional methods and tools**

The third step in the education process is teaching, which involves using appropriate teaching strategies and materials to present information.

To support symptom management and self-care, patient education should be multi-sessional, individualised, culturally and gender appropriate, interactive and use multiple media, such as verbal face-to-face education, leaflets and websites (Fredericks et al 2009, 2010). It is common practice for healthcare professionals to provide postoperative pain education verbally, either in individual or group education sessions, accompanied by written material (Louw et al 2013). Patients have reported that they prefer verbal education or a combination of verbal and written information (Andersson et al 2015, Ingadottir et al 2016, Mavridou et al 2016), although they recognise the limitations of both formats.

Nurses should familiarise themselves with the advantages and limitations of the various types of teaching strategies and materials, and select those which are most suitable for the patient and the circumstances. This includes considering their own skills in using each teaching strategy. Patients have reported that nurses and other healthcare professionals differ in their skills in providing verbal face-to-face education, and how the quality of written information varies, and may not be relevant for them (Ingadottir et al 2016). This is a cause for concern and a reason for healthcare organisations to ensure that their staff have sufficient competence in this aspect of their practice.

Technology offers an increasingly wide variety of patient education methods, including the possibility of using audio and video tools, animation and hypothetical scenarios to support patient interactivity, decision-making, and foreseeing and reflecting on the consequences of their decisions, and is important in the self-care of patients (Riegel et al 2012). Examples of technology that may be beneficial to patient education include well-designed websites, computer games and mobile phone applications. They may appeal to people with low health literacy who may find it challenging to make use of written instructions, or those with visual or hearing impairments.

Patients may be reluctant to use and rely on such technology for several reasons. Factors that have been found to influence the perceptions of patients about how best to learn about postoperative pain management include trusting the source of information and motivation to learn, and patients have called for recommendations and advice from healthcare professionals about using such media in patient education (Ingadottir et al 2016). This is important
to remember when implementing novel educational methods. The authors encourage nurses to find reliable sources on the internet about postoperative pain management and pain medication that they can recommend to patients.

One example of an innovation in patient education involving the use of technology is Navimed, which is a device developed to support the self-management of postoperative pain (Mordecai et al 2016). This device enables patients to self-report pain and offers interactive self-help options, including procedural information and resources for distraction or relaxation. Another example is a simulated computer game developed to support patients to learn about postoperative pain management (Ingadóttir et al 2017).

These educational interventions may improve self-care and patient knowledge; however, further development and testing is required before their effectiveness can be determined. Table 4 outlines some of the teaching strategies and materials commonly used to provide patient education about pain management, including their advantages and limitations.

**Evaluation of the patient’s learning**

The final step in the education process is evaluating the patient’s learning. This involves determining what the patient has learned from the teaching provided. It has been emphasised in this article that providing information alone, that is one-way communication, is not enough; patient education should support patient

<table>
<thead>
<tr>
<th>Teaching strategies and materials</th>
<th>Advantages</th>
<th>Limitations</th>
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</table>
| Individual education              | » Individualised to the patient  
» Patient can be active  
» Useful to support cognitive, affective and psychomotor learning | » Time-consuming and expensive  
» Patient may forget what was said  
» Not effective on its own  
» Session times are set by the healthcare professional, which may not always be suitable for the patient |
| Self-instruction (working without direct guidance or control of a teacher) | » Patient is active  
» Self-paced  
» Supports self-directed learning  
» Timing can be suited to the patient  
» Cost-effective  
» Useful for cognitive learning | » Patient may procrastinate  
» Requires adequate patient literacy level |
| Computer game simulation           | » Patient is active  
» Can be fun, thus increasing the patient’s motivation  
» Useful to support cognitive, affective and psychomotor learning  
» Patient can practise self-care in future scenarios, at home after discharge, in a safe setting, and can receive feedback from the healthcare professional | » Requires the patient to have basic computer skills  
» Expensive to produce |
| Written information                | » Cost-effective  
» Can be tailor-made to suit individual patients  
» Convenient for patients to carry with them and refer to when necessary | » Requires adequate patient literacy level  
» Requires regular updating of content |
| Audio, visual and computer         | » Suitable for patients with low literacy levels, or visual or hearing impairments  
» Patient can be actively involved in their learning  
» Cost-effective | » Requires the patient to have basic computer skills and access to a computer |

(Adapted from Ingadóttir et al 2016, Bastable 2017)
learning – the processing of information until it becomes a part of the individual’s knowledge base.

There are several strategies that can be used to evaluate learning, which can be combined or undertaken separately. For example, patients can be invited to undertake a short test or demonstrate their skills and receive immediate feedback on what they have learned. Another recommended strategy that can easily be implemented in healthcare professionals’ everyday practice is the ‘teach-back’ method (Institute for Healthcare Improvement 2017). This is a communication technique that can be used to check that the healthcare professional has explained information sufficiently and clearly to the patient; it should be noted that this is not the same as testing the patient. By asking in a caring way for the patient to explain, in their own words, what the healthcare professional has been teaching them, the healthcare professional can check for understanding, and repeat and re-enforce the teaching if required, and check again.

**Patient education in hospitals**

Nurses may be concerned that they do not have time to provide structured patient education. One way to address this issue is by asking, ‘How can I most effectively and efficiently teach in the time I have?’ (London 2009), with a focus on providing individualised teaching that meets the patient’s specific needs (London 2009). Nurses can also use ‘teachable moments’; that is, opportunities that arise when caring for the patient to provide education about the relevant subject. With their colleagues, nurses can find appropriate website resources that they can refer patients to, and they can work in collaboration with the healthcare organisation to develop leaflets or website information about pain management that meet the common learning needs of patients.

In the UK, hospital-based acute pain services may be a valuable resource. Their expertise is in acute pain and they provide a range of services that, in some cases, includes following-up patients after discharge. Many resources for healthcare professionals and patients are available on the British Pain Society’s website (www.britishpainsociety.org).

**Case study example**

Andrew is a 65-year-old patient who underwent open heart surgery four days ago. He has type 2 diabetes and his kidney function is normal. He takes medication for cardiovascular disease, diabetes and pain. Andrew’s adherence to his medication has been suboptimal and, as a result, his diabetes is not well-managed. He states that he is ‘fed-up with all these pills’ and reports experiencing several side effects. His wife has been experiencing long-term health issues and she has a history of misusing sedatives. Andrew is experiencing pain in his sternum, which he rates as 3 on a 0-10 scale (0 being no pain, 10 being the worst pain possible) with his pain medication, which includes a weak opioid (tramadol) and paracetamol four times per day, and this treatment will continue at home. He reports that he has been experiencing constipation and fatigue. He is able to sleep for three hours during the night, but often wakes up because of his back pain. Andrew will be discharged home tomorrow.

**TIME OUT**

What would your role be as Andrew’s nurse in educating him about how to manage his pain at home? Consider the following questions:

» What would your assessment reveal about Andrew?

» What would be the likely learning objectives for Andrew?

» What teaching strategies and methods would you use for Andrew and why? What would be the main content of the education?

» How would you evaluate Andrew’s learning and assess whether the objectives of the teaching were achieved?

An example of how a nurse could discuss Andrew’s pain medication with him using the teach-back method is given in Box 1. Note that this example only concerns the use of analgesics, not the importance of pain management or other aspects of education the patient should receive.
TIME OUT 4

Practise using the teach-back method with a family member or a friend, by talking about a topic of your choice, and asking them to summarise what you have said. Practise being both the teacher and the learner. Did you manage to avoid making the learner feel they are being tested on their knowledge? How did it feel to be the learner and relay the information back to the teacher?

BOX 1. Case study example of a nurse using the teach-back method to discuss pain medication with a patient

Nurse: ‘So, Andrew. We have discussed why it is important to manage your postoperative pain. Now I want to discuss your pain medication with you. You have been prescribed two medications to assist you in managing your pain at home. These are the same medications you have been taking for the past two days here at the hospital, but the dose has decreased slightly. One of these medications is paracetamol, which is used to relieve mild or moderate pain and is often used with other pain medications when pain is severe. You have been prescribed 1g three times per day – 1g would be two 500mg tablets. Side effects associated with this drug are rare, but there is a risk of liver damage if you take more than 4g in 24 hours. The other pain medication is tramadol, which is used for moderate to severe pain, such as pain after surgery. Common side effects associated with tramadol include constipation, nausea and feeling tired. You have reported that you have experienced some of these side effects already. They should subside since the dose has been reduced and by following the bowel regimen we discussed yesterday. You have been prescribed 100mg tramadol three times per day for two days. Each tablet is 50mg so you will need to take two tablets each time. If your pain is still at 4 or below on a 0-10 scale (0 being no pain, 10 being the worst pain possible) after two days, you can reduce the dose to one tablet three times per day for three to four days. If the pain relief is satisfactory in one week from now, and your pain is diminishing, you can take the tramadol on an as required basis. You should keep taking the paracetamol until you are no longer in pain. I have written down these instructions for you. Now, I would like you to go through the pain medications to see if I have been clear. Can you please tell me, in your own words, how you will use pain medications in the next two days to relieve your pain?’

TIME OUT 5

Nurses are encouraged to apply the four themes of The Code (NMC 2015) to their professional practice. Consider how providing patient education on pain management relates to The Code.

TIME OUT 6

Now that you have completed the article you might like to write a reflective account as part of your revalidation.

References


Bjernesen AK, Rusteen T, Lie I (2016) Pain characteristics and analgesic intake before and following cardiac surgery. European Journal of Cardiovascular Nursing. 15, 1, 47-54.


1. The aim of patient education is to:
   a) Increase patients’ dependence on healthcare professionals
   b) Remind patients to take their medication
   c) Develop patients’ competence and confidence in undertaking health behaviours that are consistent with their life plans
   d) Discourage patients from making complaints about their care

   a) Assessment of educational needs
   b) Organisational policies
   c) Patient participation
   d) Improved pain relief

3. Which statement is true?
   a) Patient participation in decision-making is associated with suboptimal pain-related outcomes
   b) There has been increased emphasis on healthcare professionals deciding what patients need to know in patient education
   c) Patients should not be encouraged to undertake self-care activities to manage their pain at home
   d) There has been increased emphasis on shared decision-making in patient education

4. Which of the following is a characteristic generally associated with adult learners?
   a) Reliant on detailed instructions
   b) Goal-oriented
   c) Directed by others
   d) Inactive

5. What is the second stage of the education process?
   a) Assessment of the patient’s educational needs and potential barriers to learning
   b) Teaching
   c) Planning by setting educational objectives
   d) Evaluation of the patient’s learning

6. Which of the following is a barrier to effective patient education about pain management?
   a) Anxiety
   b) Fatigue
   c) Low health literacy
   d) All of the above

7. What are Bloom’s three domains of learning?
   a) Cognitive, affective and psychomotor
   b) Verbal, non-verbal and written
   c) Visual, audio and kinaesthetic
   d) Reading, writing and numeric

8. One limitation of using written information to provide patient education is:
   a) It is time-consuming
   b) It is expensive
   c) It is inconvenient for the patient
   d) It requires the content to be updated regularly

9. The ‘teach-back’ method involves:
   a) Encouraging the patient to work without the direct guidance or control of a teacher
   b) Asking in a caring way for the patient to explain, in their own words, what the healthcare professional has been teaching them
   c) Using a simulated computer game to support the patient’s learning about postoperative pain management
   d) Providing education to the patient and inviting them to undertake a formal test to demonstrate their learning

10. What should the nurse do if they are concerned they do not have time to provide structured patient education?
    a) Prioritise completing all clinical tasks over providing patient education
    b) Ask the patient’s family to provide patient education
    c) Focus on providing individualised teaching that meets the patient’s specific needs
    d) Provide written information only to save time

**How to complete this assessment**

This self-assessment questionnaire will help you to test your knowledge. It comprises ten multiple choice questions that are broadly linked to the article starting on page 50. There is one correct answer to each question.

- You can test your subject knowledge by attempting the questions before reading the article, and then go back over them to see if you would answer any differently.
- You might like to read the article before trying the questions. The correct answers will be published in Nursing Standard on 20 September.

Subscribers making use of their RCNi Portfolio can complete this and other questionnaires online and save the result automatically. Alternatively, you can cut out this page and add it to your professional portfolio. Don’t forget to record the amount of time taken to complete it.

You may want to write a reflective account based on what you have learned. Visit rcni.com/reflective-account

This self-assessment questionnaire was compiled by Alex Bainbridge

The answers to this questionnaire will be published on 20 September.

Answers to SAQ 908 on Safe sexual expression among older people, which appeared in the 23 August issue, are:
1. d 2. a 3. c 4. a 5. c 6. b 7. b 8. a 9. b 10. b