Pain

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PAIN MANAGEMENT

Steps for better care and faster recovery after surgery

Nurses are vital to good pain management – and their work starts with comprehensive assessment of the patient

By Lynne Pearce

For patients having surgery, managing their pain is key to a speedy and full recovery – and nurses play a pivotal role in assessing and treating pain.

‘The impact of persistent pain after surgery is more recognised now,’ says Felicia Cox, lead nurse in pain management and head of pain services at Royal Brompton and Harefield NHS Foundation Trust in London. ‘Patient discharges were often delayed because of unrelieved pain.’

Specialist pain services are relatively new. Many were created after a 1990 Royal College of Surgeons of England report that examined post-surgery pain.

‘It recognised the need for structured acute pain services,’ says Ms Cox. ‘There had been scant provision, with nowhere having a pain team, to my knowledge.’

Yet while inpatient pain teams are now commonplace, it’s not all good news. Ms Cox is concerned about a lack of emphasis in preregistration nursing courses on understanding and managing pain.

‘I’ve had a number of student nurses who are within six weeks of qualifying, yet none could demonstrate ability to undertake a structured, multidimensional pain assessment,’ she says. ‘They
Top tips for pain management

» Take a structured approach to pain assessment, using a multidimensional tool, advises Felicia Cox, lead nurse in pain management and head of pain services at Royal Brompton and Harefield NHS Foundation Trust. ‘Don’t just look at pain intensity but its qualities and the impact on a patient’s ability to function,’ she says.

» Consider using a mnemonic to help you remember key aspects of pain assessment. For example, SOCRATES – Site, Onset, Characteristics, Radiation, Associations (any other signs or symptoms), Time course, Exacerbating or relieving factors, and Severity.

» Assess pain regularly, says Worcestershire Acute Hospitals NHS Trust senior clinical nurse specialist in acute pain control Rachael Ward, and know when to escalate. ‘Pain scoring should be done at least every time you do a set of obs,’ she says.

» Remember that pain scoring should complement what else is happening in the patient’s life, advises Antony Chuter, chair of charity Pain UK. ‘It’s about working with them to help find the pain score that’s true, without being impatient,’ he says. ‘Sometimes the temptation can be to say it’s worse than it is, because you want to be taken seriously.’

» Actively listen to what your patient is telling you. ‘And look at whether there might be a psychological or social component to their pain,’ says Ms Cox.

» Remember that an intervention doesn’t have to be medicine. ‘It can be listening, talking, being reassuring or even a hot pack,’ says Ms Cox.

» Assess and document the effectiveness of any intervention.

Also couldn’t explain how commonly-used opioids or anti-inflammatories work, or any of the precautions associated with them. It’s very disappointing.’

That experience is reflected in a survey by the British Pain Society that looked at how much time is allocated to studying pain in undergraduate curricula.

‘In some cases, nurses have less than two hours and definitely less than ten,’ says Ms Cox.

Time will tell whether the new NMC education standards, introduced this month (see page 24), will address Ms Cox’s concerns. However, one standard does make clear: ‘At point of registration, the nurse will be able to demonstrate the knowledge and skills required to identify and initiate appropriate interventions to support people with… pain’.

In 2015, in her role as chair of the RCN pain and palliative care forum, Ms Cox led the creation of a pain knowledge and skills framework. Before this, there were no UK-wide standards, competencies or frameworks for pain management nursing.

The document looks at understanding and assessing pain, management – including self-management and pharmacological – as well as service development and complex pain management.

Comprehensive introduction

Senior clinical nurse specialist in acute pain control Rachael Ward has customised some of the document for use at her workplace, Worcestershire Acute Hospitals NHS Trust.

The framework provides a comprehensive introduction for nurses who are joining the acute (perioperative) pain team, moving from band 5 to 6, and who are new to the specialty.

‘We can’t expect nurses coming into post to have done a pain course beforehand,’ says Ms Ward. ‘This guides their learning.’

Ms Ward has seen a growing focus on the importance of managing acute pain. ‘Staff are becoming much more aware, but I think there will still be an education need for a long time.’

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Rachael Ward, senior clinical nurse specialist in acute pain control, Worcestershire Acute Hospitals NHS Trust

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Part of me didn’t feel believed about my pain

For Antony Chuter, being believed by healthcare staff is key to good quality care. ‘I’ve had a whole mixed bag of experiences,’ he says. ‘Some of the worst have been when staff, including nurses, either haven’t listened or questioned whether I am in pain. When you already feel fragile, that doubt can be very hurtful.’

Mr Chuter (pictured) lives with a range of painful conditions, including osteoporosis, spondylolisthesis and inflammatory arthritis. He is chair of charity Pain UK and is former chair of the British Pain Society’s patient liaison committee.

In one incident, a consultant told him bluntly that a pain-blocking procedure hadn’t worked. ‘As he walked out, I burst into tears,’ Mr Chuter recalls. ‘Fortunately, the nurses were amazing, telling me my pain was valid. It was important because part of me didn’t feel believed.’

Patients undergoing surgery need better education about pain-relieving drugs and recovery, says Mr Chuter. ‘We need to move away from patients being sent home with a month’s supply of strong opioids,’ he says. ‘Some will follow the instructions to the letter and take them three times a day – ending up with chronic pain or addiction. ‘Opioids have their place, but use them for two or three days at most, then seek help if you’re still in pain. That message doesn’t get out there.’

Being on the receiving end of care that prioritises form-filling over listening is particularly unwelcome, he says. ‘If I’m asked “how’s your day going?” that’s the sign of a good nurse for me,’ says Mr Chuter. ‘It all boils down to feeling cared-for. There’s a sea of difference between the nurse who is just going through a checklist and those who take the time to actively listen and build a relationship.’

Her team has expanded to three, with two band 6 members. Together they provide a service that operates independently, ensuring all surgery, trauma, orthopaedic, vascular and gynaecology patients with acute pain receive the best care.

The team’s starting point is finding out whether a patient has regular pain relief – with the emphasis on regular.

Some patients are reluctant to take medication, fearing addiction or side effects. ‘They need reassurance,’ she says. Left untreated or poorly managed, there is evidence acute pain can become chronic. The charity Pain Concern says 30% of patients experience chronic post-surgery pain, ranging from mild to, in around 5% of cases, severe. It can lead to protracted recovery and discharge. Some patients who won’t move,’ says Ms Ward. ‘Even asking them to take a deep breath can be a problem.

‘That has knock-on effects clinically, such as clot formation in the legs, and chest infections, with the potential for much longer-term effects.’

Nurses may not always fully understand the impact of acute pain, she believes. ‘But if they’ve cared for patients in pain before, it heightens their awareness of the importance of relief. Nurses are vital to good pain management.’

Lynne Pearce is a health journalist