Where there's a will, there's a way!

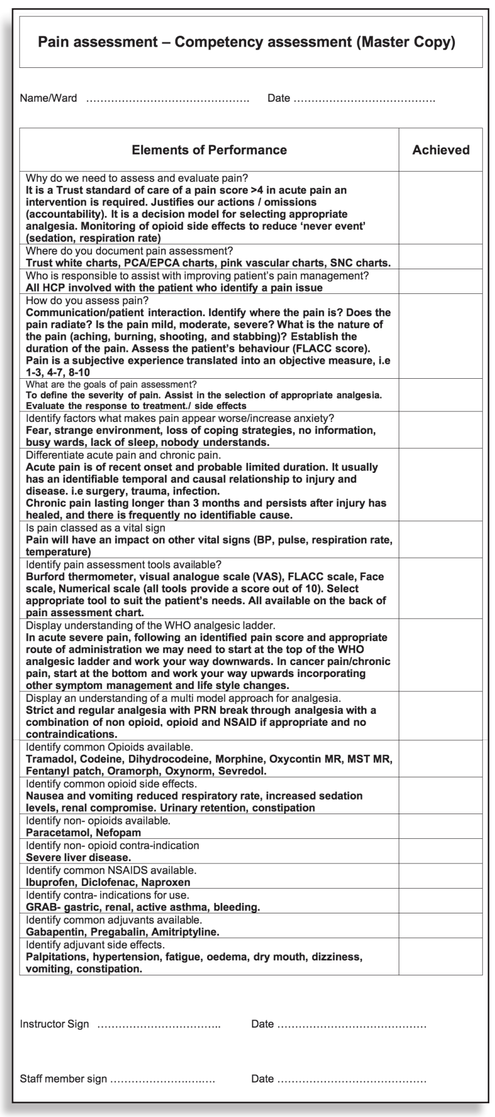
Faye Travis - Pain Management Sister
Denise Everett - Specialist Pain Nurse
The James Cook University Hospital,
Middlesbrough, UK.

South Tees Hospitals NHS
NHS Foundation Trust

Introduction

National and local targets can influence the importance of ensuring safe and effective practice is embedded into areas where pain management techniques are utilised. Currently, pain management training is not a high priority corporately, due to high volumes of other mandatory training. This is consequently resulting in previous classroom teaching being poorly attended. Education and training delivery is a major role of the pain management team, causing much frustration when clinical staff are not able to attend.

Major concerns around patient safety were identified due to the lack of training delivered. To address this problem, a new way of delivering this essential training was developed and introduced. This involved developing a competency framework for the pain techniques used (PCA, EPCA, pain assessment, IV morphine, Entonox) for the inpatient pain team to deliver at ward level to all clinical staff on a regular basis.



Pain assessment – Competency assessment (Master Copy)

Name/Ward ..... Date .....

Name/Ward ..... Date .....

Elements of Performance	Achieved
Why do we need to assess and evaluate pain? **It is a Trust standard of care of a pain score >4 in acute pain an intervention is required. Justifies our actions / omissions (accountability). It is a decision model for selecting appropriate analgesia. Monitoring of opioid side effects to reduce 'never event' (sedation, respiration rate)**	
Where do you document pain assessment? **Trust white charts, PCA/EPCA charts, pink vascular charts, SNC charts.**	
Who is responsible to assist with improving patient's pain management? **All HCP involved with the patient who identify a pain issue**	
How do you assess pain? **Communication/patient interaction. Identify where the pain is? Does the pain radiate? Is the pain mild, moderate, severe? What is the nature of the pain (aching, burning, shooting, and stabbing)? Establish the duration of the pain. Assess the patient's behaviour (FLACC score). Pain is a subjective experience translated into an objective measure, i.e 1-3, 4-7, 8-10**	
What are the goals of pain assessment? **To define the severity of pain. Assist in the selection of appropriate analgesia. Evaluate the response to treatment./ side effects**	
Identify factors what makes pain appear worse/increase anxiety? **Fear, strange environment, loss of coping strategies, no information, busy wards, lack of sleep, nobody understands.**	
Differentiate acute pain and chronic pain. **Acute pain is of recent onset and probable limited duration. It usually has an identifiable temporal and causal relationship to injury and disease. i.e surgery, trauma, infection.** **Chronic pain lasting longer than 3 months and persists after injury has healed, and there is frequently no identifiable cause.**	
Is pain classed as a vital sign **Pain will have an impact on other vital signs (BP, pulse, respiration rate, temperature)**	
Identify pain assessment tools available? **Burford thermometer, visual analogue scale (VAS), FLACC scale, Face scale, Numerical scale (all tools provide a score out of 10). Select appropriate tool to suit the patient's needs. All available on the back of pain assessment chart.**	
Display understanding of the WHO analgesic ladder. **In acute severe pain, following an identified pain score and appropriate route of administration we may need to start at the top of the WHO analgesic ladder and work your way downwards. In cancer pain/chronic pain, start at the bottom and work your way upwards incorporating other symptom management and life style changes.**	
Display an understanding of a multi model approach for analgesia. **Strict and regular analgesia with PRN break through analgesia with a combination of non opioid. opioid and NSAID if appropriate and no contraindications.**	
Identify common Opioids available. **Tramadol, Codeine, Dihydrocodeine, Morphine, Oxycontin MR, MST MR, Fentanyl patch, Oramorph, Oxynorm, Sevredol.**	
Identify common opioid side effects. **Nausea and vomiting reduced respiratory rate, increased sedation levels, renal compromise. Urinary retention, constipation**	
Identify non- opioids available. **Paracetamol, Nefopam**	
Identify non- opioid contra-indication **Severe liver disease.**	
Identify common NSAIDS available. **Ibuprofen, Diclofenac, Naproxen**	
Identify contra- indications for use. **GRAB- gastric, renal, active asthma, bleeding.**	
Identify common adjuvants available. **Gabapentin, Pregabalin, Amitriptyline.**	
Identify adjuvant side effects. **Palpitations, hypertension, fatigue, oedema, dry mouth, dizziness, vomiting, constipation.**	

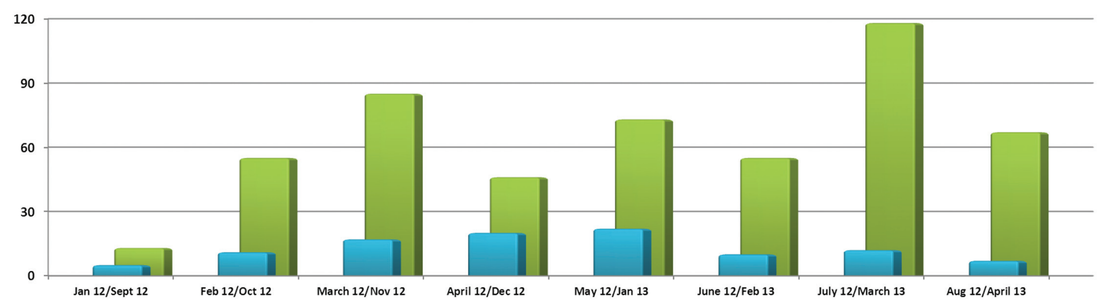
Instructor Sign ..... Date .....

Staff member sign ..... Date .....

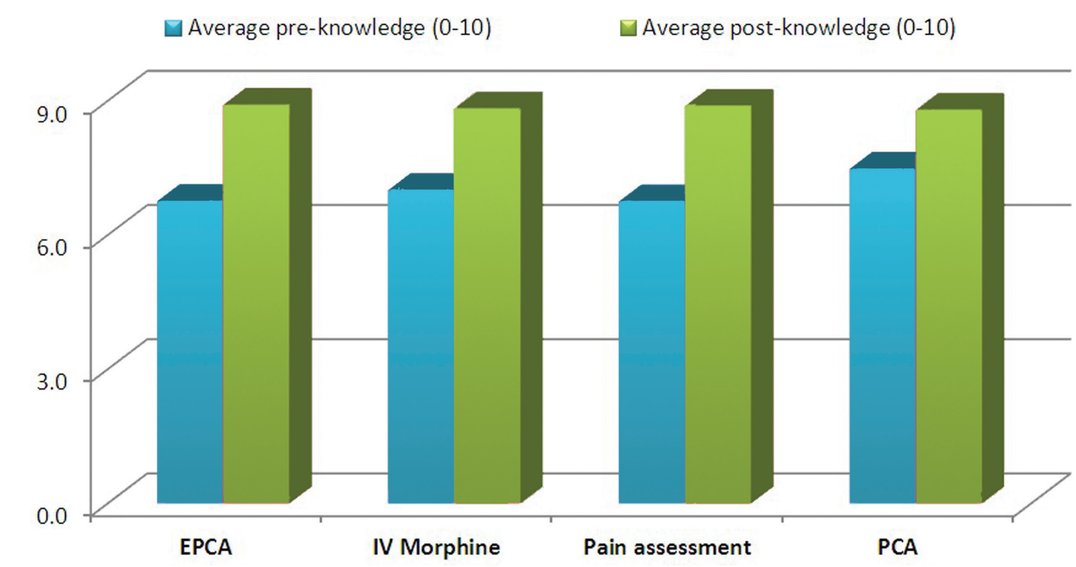
This resulted in significant attendance differences and with improved knowledge on pain management techniques and pain assessment. Utilising the competency checklist proved to be less time consuming when teaching the staff, making it realistic to teach in a busy ward environment.

Results

Classroom vs ward-based attendance



Knowledge comparison



Conclusion

Where there's a will, there's a way!

Since ward based teaching has been introduced, ward staff have an improved level of knowledge and patient safety has improved. Overall, incidents have reduced and pain management has improved within the ward environment.

together we do the amazing

MICB4302