



Healthcare Professionals' Perceptions of the Use of Pain Scales in Postoperative Pain Assessments

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ABSTRACT

Aim: To describe how healthcare professionals perceive the use of pain scales in postoperative care.

Background: Pain scales are important but not an obvious choice to use in postoperative care. No study has explored how healthcare professionals experience the use of pain scales.

Methods: An explorative design with a phenomenographic approach was used. The sample consisted of 25 healthcare professionals. Semistructured interviews were performed.

Results: Four descriptive categories emerged - the use of pain scales facilitated the understanding of postoperative pain, facilitated treatment, demanded a multidimensional approach and was affected by work situations.

Conclusions: Healthcare professionals described that pain scales contribute to the understanding of patient's postoperative pain. It is important to ensure patient understanding and be aware about variations in pain ratings. Dialogue and observations are necessary to be certain what the ratings mean to the patient. The use of pain scales depends on patient's needs and organization.

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1. Introduction

An investigation of postoperative pain normally begins with a screening followed by a more thorough assessment if patients are in pain (e.g., including questions on location and duration of the pain). Pain is however a subjective experience that can be hard to communicate, both between patient and staff, as well as between staff with different professions. It is therefore recommended in guidelines that patient's self-report of pain should be screened by using a valid pain scale (Gordon et al., 2005). The extent to which pain scales are used (Abdalahim, Majali, & Bergbom, 2008, Ene, Nordberg, Bergh, Gaston-Johansson, & Sjöström, 2008) and how assessments of postoperative pain are performed are explored only in a few studies (Klopper, Andersson, Minkinen, Ohlsson, & Sjöström, 2006, Manias, Bucknall, & Botti, 2004). The results indicate that the use of pain scales

such as numeric rating scale (NRS), visual analogue scale (VAS) or verbal scale (VS) is not an obvious choice.

The implementation of validated pain scales has been difficult in clinical settings despite educational programs (Ene et al., 2008). Screening for the presence of pain, without using pain scales still occurs and is instead based on the patient's appearance and behavior, what they express and how much pain "it usually is" after a certain type of surgery. Age, sex or ethnicity is taken into consideration (Klopper et al., 2006), and changes in vital signs such as pulse rate, blood pressure and respiratory rate are also used (Richards & Hubbert, 2007; Clabo, 2007).

Quality of care is related to a well-functioning communication between healthcare professionals (Havens, Vasey, Gittell, & Lin, 2010), and pain scales are described as improving the screening of patient's pain and communication between healthcare professionals and patients (Gordon et al., 2005). The nurse's performance in screening for postoperative pain is mainly focused in research because they are described as playing an important role in postoperative pain management (Dihle, Bjölseth, & Helseth, 2006, Schafheutle, Cantrill, & Noyce, 2004). No studies describing the enrolled nurse's or physician's use of pain scales have been found. However, in Sweden enrolled nurses perform much of patient's daily care including screening for pain, but they are not trained to distributing drugs to patients. Further, according to Hartog, Rothaug, Goettermann,

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Zimmer, and Meissner (2010) the physician's competence in this area is necessary to obtain a well-functioning pain management. To contribute to a better understanding on how pain scales can provide an improved communication around pain, the aim of this study was to describe how healthcare professionals perceive the use of pain scales in postoperative care.

2. Methods

2.1. Design, method description and setting

With permission from the Regional Ethics Committee for Human Research in Linköping, Sweden, an explorative design with a phenomenographic approach was chosen. The goal with phenomenography is to explore variations in people's perceptions of the surrounding world (e.g., how they perceive, understand and remember various aspects of a phenomenon). It is substance-oriented (searching for the underlying structure of variance) and differentiates between two types of description: the first order perspective (i.e., the real facts that can be observed), and the second order perspective (i.e., how the person perceives something). Phenomenography uses the second order perspective (Marton & Both, 1997). Phenomenology on the other hand aims to find the essence of a phenomenon (Holloway & Wheeler, 2006).

The study was performed in one university and three county hospitals in the south of Sweden. Healthcare professionals of different professions working with postoperative care in orthopedic and general surgery wards were asked to participate. In Sweden physicians, nurses and enrolled nurses have knowledge about pain screening, but it is mainly performed by nurses. National guidelines recommend pain screening using NRS, VAS or a verbal scale; frequency of assessments is, however, not specified. Three of the included hospitals had routines according to the national guidelines (i.e., performing screenings at least every fourth hour using pain scales). The fourth hospital used assessments based on expressions, appearances and behaviors of the actual patient. All hospitals used electronic patient records.

2.2. Participants

A purposeful sample of healthcare professionals with clinical experience of pain scales in postoperative care was selected. The physicians were all performing both surgery and ward rounds, while the selected nurses and enrolled nurses performed daily care duties. The selection was based on variation in age, sex, profession and employment on a surgical or orthopedic ward. One physician and one enrolled nurse declined participation, without giving reasons. Characteristics of the participants ($n = 25$) are shown in Table 1 (downgrading of Table 1).

2.3. Data collection

According to the phenomenographic tradition semi-structured interviews (Marton & Both, 1997) were conducted. An interview guide (Table 2) was designed by the research team which had long experience of postoperative pain and phenomenography. The guide was based on recommendations from the American Pain Society (Gordon et al., 2005). Before the interviews the importance of

Table 1
Socio-demographic characteristics of healthcare professionals ($n = 25$).

Sex; male, female	6/19
Age; years, range	23–63
Profession, enrolled nurses, nurses, physicians	6/15/4
Years of experience in postoperative care; 1–5, 6–10, >10	8/6/11
Employment: orthopedic, general surgery	17/8

Table 2
Interview guide used in the data collection with healthcare professionals ($n = 25$).

What does the patient's pain mean to you as a health professional?
How do you perceive the importance of assessment with a pain scale the first postoperative days?
How do you perceive your responsibility/role in pain assessment?
How do you perceive the patients responsibility/role in pain assessment?
How do you perceive pain assessment in relation to action/pain treatment?
How do you perceive assessing pain several times a day?

telling self-perceived experiences and concrete examples to avoid superficial descriptions from what is heard from other healthcare professionals was stressed. Probing questions such as “could you explain more” were used. Two pilot interviews were performed. Since the guide worked well the pilot interviews were included in the data analysis. The interviews took place in a quiet room on the ward where the participant was employed and lasted up to 40 minutes; they were audiotaped and transcribed verbatim. The number of interviews from the three professions reflects the proportion of users of pain scales at the included units. The main researcher who has long experience of postoperative pain management performed all interviews between June and November 2012 (downgrading of Table 2).

2.4. Data analysis

Data analysis was conducted according to the phenomenographic tradition described by Sjöström and Dahlgren (2002) (Table 3). The main researcher carried out the data analysis with continuous reflections on each step from the other members in the research team until consensus was established (downgrading of Table 3).

3. Findings

An overview of the findings and quotations in relation to all perceptions is presented in Table 4.

3.1. The use of pain scales facilitated the understanding of postoperative pain

3.1.1. Pain scales facilitated the discovery of pain

Pain scales were perceived being useful in detecting pain in patients who for various reasons, i.e., tiredness after anesthesia and fear of unnecessary interruptions, did not tell healthcare professionals about their pain. Frequent screenings for pain were described as necessary to detecting pain early. An interval of 3 to 4 hours was expressed too long the first day after surgery, especially for those patients who did not report pain.

Table 3
Phenomenographic data analysis according to Sjöström and Dahlgren (2002) as used in the present study.

1. Familiarization. The 25 interviews containing 242 pages (A4) were read several times to become familiar with the data and obtain a sense of the whole.
2. Compilation. Answers from all responders on a certain topic were compiled into statements. A total of (420) significant statements corresponding to the aim of this study were identified.
3. Condensation. The individual statements were reduced.
4. Grouping. Groupings were made on similar statements. Totally there were 17 pre-perceptions found that distinctly differed from one another.
5. Comparison. Including statements in the perceptions were thoughtfully read to ensure similarities within the perception and differences between the perceptions.
6. Naming. Perceptions and the emerged descriptive categories were discussed and named with an adequate level of abstraction to emphasize their essence.
7. Contrastive comparison. The obtained descriptive categories were compared in terms of similarities and differences. Finally 4 descriptive categories and 13 perceptions were found, Table 4.

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