

Making Pain Visible: An Audit and Review of Documentation to Improve the Use of Pain Assessment by Implementing Pain as the Fifth Vital Sign

■ ■ ■ *Liz Purser, PGCert, RN,* Kelly Warfield, MSc, RN,[†]
and Cliff Richardson, PhD, RN[‡]*

■ ABSTRACT:

Pain has been promoted as the fifth vital sign for a decade, but there is little empirical evidence to suggest that doing so has affected the care of individuals suffering pain. This was a three-stage audit of pain assessment in one large teaching hospital in the Northwest of England. Stage one measured the baseline pain assessment activity on surgical and medical wards and identified that the pain assessment tool was not visible to nurses. Stage two redesigned the patient observation charts held at the end of the bed and piloted two versions for clinical utility. Version 2 which had pain assessment alongside the early warning score was adopted and introduced throughout the hospital. Stage three audited pain assessment and management 8 months after the introduction of the new charts. Pain was assessed more regularly at the stage three audit than at the baseline audit. On average, pain was assessed alongside other routine observations 70% of the time across surgical and medical wards. Medical wards appeared to improve their pain assessment using the philosophy of pain being the fifth vital sign better than surgical wards, because they assessed pain alongside routine observations in >90% of cases. Stage three identified that where a high pain score was recorded, analgesia was delivered in the majority of cases (88%). Introducing the philosophy of pain as the fifth vital sign and making pain assessment more visible on the patient observation chart improved the uptake of pain assessment. Pain management strategies were stimulated when high pain scores were identified.

© 2014 by the American Society for Pain Management Nursing

*From the *Central Manchester University Hospitals Foundation Trust; [†]High Wycombe Hospital; [‡]University of Manchester, Manchester, United Kingdom.*

Address correspondence to Cliff Richardson, PhD, RN, University of Manchester, School of Nursing, Midwifery and Social Work, Jean McFarlane Building, Oxford Road, Manchester, M13 9PL. E-mail: clifford.richardson@manchester.ac.uk

*Received January 4, 2012;
Revised July 30, 2012;
Accepted July 30, 2012.*

*1524-9042/\$36.00
© 2014 by the American Society for
Pain Management Nursing
[http://dx.doi.org/10.1016/
j.pmn.2012.07.007](http://dx.doi.org/10.1016/j.pmn.2012.07.007)*

Several studies have shown that hospitalized patients experience inadequate pain relief and report moderate to high pain scores (Cousins, Power, & Smith, 1996; Powell, Davies, Bannister, & Macrae, 2004; Shi, Langer, Cohen, & Cleeland, 2007; Sommer et al., 2008). This poor pain management incurs costs for the individual and to society. The individual costs include psychologic distress, reduced function, development of chronic pain, and reduced quality of life (Liu & Wu, 2007; Peters, Sommer, van Kleef, & Marcus, 2010). Societal effects include inability to work and increased health care costs (Peters et al., 2010; VanDenKerkhof et al., 2006).

Pain assessment is a key component of successful pain management (Breivik et al., 2008). According to Breivik et al. (2008) pain at rest and movement can be reliably assessed using tools such as the numeric rating scale or visual analog scale, especially when looking for changes in pain intensity (Breivik, Bjornsson, & Skovlund, 2000). One way that has been proposed to improve pain assessment is to regard pain as the fifth vital sign (Joint Commission on Accreditation of Healthcare Organizations, 2001; Lanser & Gesell, 2001; Lynch, 2001a; Rousseau, 2008). The premise being that if pain was assessed with the same priority as the other vital signs, which are often carried out as part of the early warning score (EWS), unnecessary suffering and pain-related complications could be avoided and patient outcomes improved (Lynch, 2001b; Merboth & Barnason, 2000).

Improving pain assessment and documentation has been shown to improve pain management (Morrison et al., 2006; Ravaud, Keita, Porcher, Durand-Stocco, Desmots, & Mantz, 2004). Providing adequate pain management is a quality issue, but studies designed to audit and research the effects of using the principle of pain as the fifth vital sign have shown mixed results. A retrospective study using electronic medical records found no improvement in pain assessment (Mularski, White-Chu, Overbay, Miller, Asch, & Ganzini, 2006). However, because the electronic device was not always available during assessments, staff were not always prompted to record pain along with other vital signs, so those results should be viewed with caution. Ravaud et al. (2004) found greater numbers of patients having pain assessed after the introduction an education program that promoted pain as the fifth vital sign. It was, however, unclear as to whether there was improved pain management alongside the increased pain assessment.

Emphasis on the importance of measuring the impact of interventions on the quality of patient outcomes is urgently required to evaluate the effects of strategies such as making pain the fifth vital sign and

whether implementing it makes a difference. The present audit was proposed initially to identify if promoting pain assessment as the fifth vital sign affected nurses' pain management behavior; however, while undertaking a preaudit review, we saw that this could not be introduced in isolation from making some other structural and contextual changes. A more complex change model was needed alongside the audit of the effects of the new philosophy for pain assessment.

METHOD

This was a three-stage audit designed by the nursing pain team to identify current pain assessment practice and to monitor the effects of introducing the principles of pain as the fifth vital sign. As the audit stages progressed, organizational learning occurred and led to the development of new observation charts and a short education program that assisted in implementing the new pain assessment philosophy. This learning led to adaptations of the final stage data collection owing to gaps identified in the first stage by the data collectors.

Each stage reviewed documentary evidence of pain assessment in one 24-hour period. The third stage reviewed analgesic administration alongside pain assessment to try to establish a link between assessment and management.

Stage one was an evaluation of current pain assessment practice. It was practice in our hospital to use the 0-10 numeric rating score to assess pain, and the audit was used to judge how widely the 0-10 score was being used. All of the patients on eight surgical and five medical wards in the hospital were selected. All of the charts held at the end of the bed were reviewed by a member of the pain team to identify baseline levels of pain assessment. The review categorized the patients and analyzed how many had their pain assessed. If pain was assessed, a count of the number of times it was assessed was taken. No judgment was made as to the necessity or accuracy of the assessment. During this process, however, it was noted that the pain assessment chart was printed on the back of the observation chart held at the end of the patient's bed. This was identified at this stage to be a potential inhibitor to the introduction of pain as the fifth vital sign, which led to the development of stage two.

Stage two took account of the results from stage one. It was a pilot of two new forms of observation chart. Both had pain assessment integrated alongside the other important patient observations rather than on the back of the chart. Version one (V1) required pain scores on movement to be plotted graphically along with temperature recordings. Version two (V2) had boxes for recording pain at rest and on movement

Download English Version:

<https://daneshyari.com/en/article/2673689>

Download Persian Version:

<https://daneshyari.com/article/2673689>

[Daneshyari.com](https://daneshyari.com)