



Original article

A review of postoperative pain assessment records of nurses[☆]

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1. Introduction

Pain, one of the most common postoperative symptoms, develops at moderate and severe levels in approximately 30 to 80% of the patients. (Ay & Alpar, 2010; Rizalar & Özbaş, 2016; Sommer et al., 2008; Wu & Raja, 2011). Pain disturbs organ functions and leads to delayed recovery, thus it may extend the length of hospital stay (Coluzzi et al., 2015). The first step to take the pain under control is an appropriate pain assessment (Ayasrah, O'Neill, Abdalrahim, Sutary, & Kharabsheh, 2014). The main goals of pain assessment are to determine pain intensity, to decide the dose and type of analgesic drug, and to assess the efficacy of the administered drug. Surgical nurses have important tasks to achieve the stated goals (Yüceer, 2011).

The patient should be actively involved in the pain assessment, a valid and reliable pain assessment scale should be used, the severity, quality and location of pain should be questioned periodically (i.e. once every 2 h). Also, appropriate analgesia should be determined according to the type, severity of pain and medical condition of the patient and pain assessment should be repeated after every analgesic administration. Pain should be assessed during rest and movement, and reassessed after analgesic interventions (pharmacological and non-pharmacological). Then, all of the obtained data should be recorded in the observation forms of nurses and shared with the medical team (Anesthesia Practice Guidelines, 2006; Joint Commission Requirements, 2007). These data also provide important information for the medical team about the efficacy of analgesia and the cause of pain (Yüceer, 2011). However in Turkey, recording pain assessment and treatment are not considered as the main steps of postoperative pain management nursing intervention (Yüceer, 2011; Bas Gürarşlan et al., 2016). Therefore, we consider that pain management records are insufficient to provide information to health care professionals to control the pain and analgesia.

The International Pain Committee recommend recording pain assessment, since it enables pain control and facilitates follow-up (Gordon et al., 2008; Gordon et al., 2016; Joint Commission Requirements, 2007). However, several studies have shown that the nursing records about pain assessment are inadequate (Ayasrah et al., 2014; Dalton

et al., 2001; Gordon et al., 2008; Idvall & Ehrenberg, 2002; Liu et al., 2016; Mędrzycka-Dąbrowska, Dąbrowski, Basiński, & Małecka-Dubiela, 2016). Ayasrah et al. reported that pain assessment was recorded only in 35% of 301 medical records and re-assessment after analgesia was performed only in 37% (Ayasrah et al., 2014). In a study by Idvall and Ehrenberg examining the medical records of 172 patients, although 73% of the nurses registered the records in accordance with the guidelines, 50% reports ($n = 86$) did not contain location of pain, approximately 88% lacked the quality of pain, while a pain scale was not used in 40% (Idvall & Ehrenberg, 2002). In a study by Rafati et al. only 6% of the records included the quality of pain and no pain scale was used in the assessment (Rafati, Soltaninejad, Aflatoonian, & Mashayekhi, 2016).

Previous findings have suggested that why ineffective pain management and inadequate pain records are still the topics to be worked on. They have also indicated that hospital administration and nurses do not pay enough attention to the records of pain assessment (Abdalrahim, Majali, & Bergbom, 2008; Gordon et al., 2008; Gunningberg & Idvall, 2007; Liu et al., 2016; Mackintosh-Franklin, 2017) The protocols of pain assessment and management to be used in hospitals are needed, since no standard guide for assessing postoperative pain is developed in Turkey. Since the missing pain records are considered as obstacles in front of pain management, awareness related to the topic should be increased in nurses and the current situation should be revealed. In our study, we aimed to examine the postoperative pain assessment records of nurses.

2. Materials and methods

2.1. Type of study

The aim of this retrospective and descriptive study is to examine postoperative pain assessment records of nurses.

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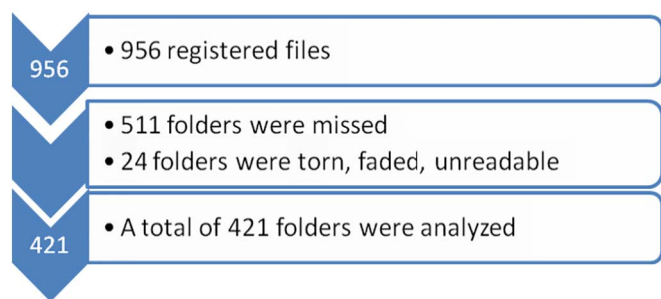


Fig. 1. The population and sample of study.

2.2. Location of study

The study was conducted in Cukurova University, Faculty of Medicine, Balcali Hospital with a total capacity of 1200 beds, Health Application and Research Center, General Surgery clinic. This clinic where patients are followed postoperatively has 74 beds and 24 nurses. Eight nurses work in the day shift and four work in the evening and nightshifts.

2.3. Study population and sample

The study population included the nurse observation forms of 956 patients who were hospitalized for surgery between January 2014 and January 2015 in Cukurova University Faculty of Medicine, Balcali Hospital, Health Application and Research Center, General Surgery clinic. Of these files, 511 were unable to be reached and 24 was not included in the sample group, as it was either torn or unreadable (Fig. 1). As a result, the sample of the study consisted of the nurse observation forms of a total of 421 patients older than 18 years of age who underwent surgery under general anesthesia and who were hospitalized at least 48 h postoperatively.

2.4. Data collection instruments

The questionnaires and nurse observation forms were used to collect data in the study. The questionnaire was developed by the researchers after literature review (Anesthesia Practice Guidelines, 2006; Gordon et al., 2008; Idvall & Ehrenberg, 2002; Joint Commission Requirements, 2007; Yüceer, 2011) The questionnaire consisted of two parts including the data about patient (i.e., age, sex, comorbidities) and the data regarding pain assessment. The section contained the data for pain assessment included, the characteristics of pain, the pain scale used, the type of analgesia (pharmacological/non-pharmacological analgesia), the route of administration and the frequency of pain assessment after analgesia were also questioned. The other form which was the nurse observation form included the recorded patient data (diagnosis, chronic diseases, vital findings, or treatment applied) and the nursing interventions for diagnosis and treatment.

2.5. Data collection

The data were collected by two researchers who did not work as nurse at the hospital. These researchers examined the nursing observation forms of the patients with in the sample group in the room of the archive section of the hospital. They were supposed to evaluate 30 records per week. Depending on the type of surgery, some patients were discharged after 48 h after surgery (i.e., laparoscopic cholecystectomy, inguinal hernia repair, breast mass excision, and thyroidectomy). In these cases, the nurse observation forms including the first 48 h were evaluated. The evaluation of each file that met the inclusion criteria took about 10 min. The files and forms that did not meet the study criteria (unread, faded, or lost,) were excluded from the study. The data

of our study were based on the hospital statistics and the documentation of data base department.

2.6. Evaluation of data

Statistical analysis was performed using SPSS version 20.0 software (IBM Corp., Armonk, NY, USA). The descriptive data were expressed in numbers and percent distributions.

2.7. Ethical aspect of study

The ethical approval was obtained from Cukurova University, Faculty of Medicine, Non-Interventional Ethics Board (Decisionno:16; Date:05.06.2015) and a written permission was received from the chief physician of Cukurova University, Faculty of Medicine, Balcali Hospital (27/04/2015-5054/18649120-302.08.01).

3. Results

Demographic data of nurses working in clinics was obtained from staff records in the clinic and the number of nurses was found to be 24. The mean age of the nurses was $27,8 \pm 6,8$ years, 83.3% of them were female, 54,1% of them were under graduate/graduate and their mean of working period was 6.5 ± 4.5 years.

The mean age of the patients was 46.03 ± 15.4 and there was a chronic disease in 33% of them. The most frequently performed surgery was colorectal surgery (63.7%) (Table 1).

The nursing observation forms of in total 421 patient files were examined in the study. When the first 48-hour postoperative records were reviewed, it was detected that no information regarding pain assessment (severity, location, type, duration, and pain assessment scale) was recorded in any patient (Table 2).

The highest rates (70.8%) of pain therapy-related records (pharmacological and non-pharmacological) were registered with in the first 2 h in the postoperative period. The analgesia record rate was detected to be below 42% after 24 h. It was determined that the most commonly administered and recorded analgesic was diclofenac sodium, the least administered analgesic was pethidine HCl and the most frequently used and recorded route of administration was intramuscular route. Also, there was not any record related to non-pharmacological pain therapy (massage, hot-cold application, and positioning) in the nurse observation forms (Table 3).

4. Discussion

Pain assessment records, including the characteristics of pain and the patient's analgesic response, guide the medical team for providing effective pain management. In our study there was no record related to

Table 1
The demographic and surgery-related data of the patients ($n = 421$).

		<i>n</i>	%	Meant \pm SD (min-max)
Age		–	–	46.03 \pm 15.4 (15–87)
Gender	Male	196	46.6	–
	Female	225	53.4	–
Chronic Disease (DM, HT etc)	Yes	139	33.0	–
	No	282	67.0	–
Surgery type	Colorectal surgery	268	63.7	–
	Breast-thyroid surgery	61	14.5	–
	Hernia surgery	45	10.6	–
	Upper GIS surgery	34	8.1	–
	Others (splenectomy, drainage of abscess etc.)	13	3.1	–
Total		421	100	–

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