

Pain Management Practice and Guidelines in Jordanian Pediatric Intensive Care Units

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■ ABSTRACT:

Limited knowledge exists of current pain management practices and supporting guidelines in Jordanian pediatric intensive care units. To determine the current pain management practices and the availability and content of practice guidelines in Jordanian pediatric intensive care units, we conducted a cross-sectional and multisite survey of four pediatric intensive care units in Jordan. A questionnaire was developed and orally administered over the phone or in person to head nurses or their nominees to capture pain management practices and the existence and content of guidelines. All units had written pain management guidelines that included pain assessment, documentation, and management. All four units used one or more pain assessment tools. In three units, pain management was considered multidisciplinary and routinely discussed on unit rounds. In two units, continuous infusion of intravenous opioids was used as well as sedatives and neuromuscular blockers for most ventilated patients. In the two other units, continuous intravenous infusion of opioids was not used and only sedatives were administered for patients on mechanical ventilation. In two units, there were no specific guidelines on the use of nonopioid analgesics, patient-controlled anesthesia, or the management of postoperative pain. No unit used an opioid or sedative withdrawal assessment tool or had pain management guidelines on the use of topical anesthetic agents or sucrose. Pain management practices and guidelines varied across the four units, suggesting that there is an opportunity for improvement in pain management in pediatric intensive care units in Jordan.

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INTRODUCTION

In most parts of the world, pain in children is considered a public health concern (World Health Organization [WHO], 2012). In 2010, the Declaration of Montreal stated that people, including children, have the right to access appropriate

assessment and treatment of pain by adequately trained health care professionals ([International Association for Study of Pain \[IASP\], 2015](#)). However, 5 billion people have no or insufficient access to treatment for moderate to severe pain ([IASP, 2015](#)). Pain, including children's pain in pediatric intensive care units (PICUs), should be considered a high-priority issue requiring vigilance on the part of professional organizations and health care providers to ensure that optimal pain management is delivered to all patients ([Registered Nurses Association of Ontario, 2013](#)).

The [IASP \(2015\)](#) has reported that pain management is suboptimal in most parts of the world. Access to treatment for acute pain caused by trauma, disease, and terminal illness is inadequate ([IASP, 2015](#)). The availability of analgesics, particularly opioid analgesics, may be restricted, especially in low to middle income countries. In many countries, health care professionals receive little education and training about pain, and their knowledge about the mechanisms and management of pain is limited. Pain management in the PICU is no exception to these concerns as addressed by the IASP.

In the PICU, pain management can provide unique challenges. Patients in the PICU are not only critically ill with complex conditions ([Gélinas, Fortier, Viens, Fillion & Puntillo, 2004](#); [Johansson & Kokinsky, 2009](#); [Oakes, 2011](#); [Turner, 2005](#)), they are children, which makes pain management more challenging than in adults because of differences in cognitive, psychosocial, and physical development ([Srouji, Rantapalan & Schneeweiss, 2010](#)). Self-report of pain, which is widely considered the gold standard for pain assessment and management ([American Association of Critical-Care Nurses, 2014](#)), is compromised by the administration of sedative agents, neuromuscular blocking agents, mechanical ventilation, and, often, altered and changing levels of consciousness ([Gélinas et al., 2004](#); [Johansson & Kokinsky, 2009](#); [Oakes, 2011](#); [Turner, 2005](#)). However, regardless of all of these challenges, provision of appropriate and adequate analgesia is essential for all critically ill children ([Playfor et al., 2006](#)).

Untreated or poorly managed pain can negatively affect critically ill children both physiologically and psychologically ([Oakes, 2011](#); [Rennick et al., 2004](#); [Turner, 2005](#)). Postoperative pain can lead to pulmonary complications as a result of reduced chest and abdominal wall movement, leading to delays in weaning from mechanical ventilation ([Thorp & James, 2010](#)). Sympathetic nervous system responses can be increased, resulting in an increased cardiac effort and oxygen consumption, elevation of stress hormones, immunosuppression, and delays in wound

healing ([Thorp & James, 2010](#)). These consequences can delay discharge from the PICU. Pain can also result in negative psychological outcomes after discharge from the PICU. Exposure to high numbers of invasive procedures was reported as the most important predictor of negative psychological outcomes after discharge from the PICU ([Rennick et al., 2004](#)). Pediatric patients in intensive care units are exposed to large numbers of painful procedures (an average of 13 procedures per day) ([Stevens et al., 2011](#)), highlighting the need to ensure effective pain management during these multiple procedures.

The use of pain management research evidence is essential in the provision of effective pain management ([Samuels & Fetzer, 2009](#)). Yet, in critical care settings, such as the PICU, there is a wide gap between pain management evidence and practice ([Samuels & Fetzer, 2009](#)). Clinical practice guidelines (CPGs), based on best available research evidence and practice experience, are helpful tools for closing the gap between evidence and practice ([Woolf, Grol, Hutchinson, Eccles, & Grimshaw, 1999](#)). CPGs can be defined as "recommendations for clinicians about the care of patients with specific conditions" ([Shekelle, 2016](#), para. 1). CPGs can support more consistent and efficient care practices ([Graham & Harrison, 2005](#); [Woolf et al., 1999](#)). Policies provide clinicians with actions that must be taken in a particular situation ([University of Wisconsin, 2017](#)). Although both policies and CPGs are considered supporting resources that provide clinicians with practice guidelines that may be followed, following policies is considered mandatory.

Although CPGs are a strategy to improve pain care, there is a need to establish a baseline understanding if this is one of the barriers to improved pain management in a given context and to determine current practices and availability and content of CPGs that are in use. Although several studies have been conducted relating to pain management in Jordanian hospitals ([Abdallah, Majali, Stomberg & Bergbom, 2011](#); [Al Qadire & Al Khalaleh, 2014](#); [Ayasrah, O'Neill, Abdallah, Sutary, & Kharabsheh, 2014](#)), including pediatric pain management ([Batiha, 2014](#); [Finley, Forgeron & Arnaout, 2008](#); [Forgeron, Finley & Arnaout, 2005](#)), to our knowledge no previous research has assessed pain management practices and availability and content of CPGs guiding pain management in Jordanian PICUs. Nevertheless, Jordanian nurses have identified that policies and guidelines are necessary to improve pediatric pain management ([Finley et al., 2008](#)). Therefore, the aim of this study is to assess pain management practices as well as the existence and content of pain

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