Introduction

Pain assessment in critical care areas is a challenge, since patients are often incapable of self-reporting pain. This may be due to a variety of reasons, including: sedation, mechanical ventilation, paralysis and metabolic abnormalities [1]. In this patient population, the Intensive care society (ICS) [2] and the European federation of Critical care nursing associations (EFCCNA) [3] encourage the use of behavioural pain scales to assess pain. When utilised they decrease the incidence of pain and reduce the duration of mechanical ventilation, improving patient outcome.

In our institution there is currently no assessment tool specifically used for evaluating pain in unconscious patients in the level 3 care areas. Instead the only tools presently used are a numeric rating scale and a visual analogue scale. Both of these lack validation in the critical care environment in patients who are unable to self-report. Moreover, they depend not only on the nurses’ knowledge and skill in utilising the tool, but the subjective beliefs of the nurse regarding the patient experience. This is problematic, given that there is a plethora of evidence to demonstrate that nurses (and doctors) routinely underestimate the subjective experience of the patient as regards pain [4].

The aim of this exploration was to review the current practice of pain assessment in the level 3 areas of the Trust. This consists of 2 adult intensive care units (AICUs) and 2 post anaesthetic care units (PACUs). In addition, we hoped to assess the necessity of implementing a validated pain assessment tool in these areas.

Methods

Institutional approval was gained from the Royal Brompton and Harefield NHS Foundation Trust Clinical governance committee. Data was collected over a period of 3 weeks for all patients who were unable to self-report pain, admitted to the 2 ICUs and 2 PACUs. The electronic recording system used routinely in these areas was interrogated retrospectively as regards to nursing documentation of pain assessment.

Data from the last 24 hour period of any patient’s time in the level 3 areas were inspected for pain scores. In addition we assessed the tool used; usually numeric rating scale (NRS) or visual analogue scale (VAS), with intensity from 0-10. We further examined the written nursing record for any signs of assessment of pain.

Results
A total of 44 patients (n=44) were assessed over a period of 3 weeks. 71% (n=31) of the patients had no pain assessment. Of the remaining 29%, 4 patients were assessed by nurses using numeric or analogue scales, and in all cases a rating of no pain was documented. All these patients were sedated and some paralysed. A further 9 had descriptions about pain assessment in nursing notes. This included statements such as: â€˜no grimacingâ€™, â€˜patient appeared comfortableâ€™.

Conclusion

Despite the fact that validated pain assessment tools are available for patients unable to self-report pain (e.g. Behavioural pain scale, Critical-care pain observation tool) [5,6], only a small minority of our level 3 cohort had any form of pain assessment undertaken by nursing staff. Where this did occur, it utilised only unsupported notes, or tools (such as NRS or VAS) that are not valid in this group. This reflects a similar finding amongst medical staff in ICUs within our region [7].

We conclude from this, that we need to educate both medical and nursing staff in our Trust as regards pain assessment within level 3 areas. This will need to include knowledge of the relevant pain assessment tools, for both verbal and non-verbal patients. Furthermore we will need to plan training sessions to equip our medical and nursing staff, and allied health professionals, with the skills to recognise which tools are appropriate for each patient, and how best to utilise them.

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