Department of Pain Management

Student nurse pack

Aim

To gain knowledge and experience of the services provided by the acute and chronic pain management team.

Learning outcomes

During the placement the student will be able to:

- Discuss differences between acute and chronic pain experiences
- Relate patients' acute and chronic pain experiences to individual plans of evidence-based care
- Appreciate the roles of the multiprofessional team within pain management
- Identify an area of their practice where they could improve pain management and develop an action plan

Student Nurse Timetable

	AM	**PM**
Monday	Orientation to department Nurse led clinic TENS	Dr Bhansali Follow up clinic
Tuesday	PACU / HDU	Dr Hui follow up/ Pain assessment
Wednesday	Theatre list – Theatre 3	New Patient clinic
Thursday	Acute pain Dr Farquharson clinic Amantadine	HDU/ Nurse led Clinic TENS
Friday	Xray Facets. Angio Suite	Consultant clinic Self directed study and reflection

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To be reviewed by: Learning Environment Manager and Nurse Practitioner

Introduction to Department of Pain Management

Out-Patient Suite 6

Chesterfield Royal Hospital NHS Foundation Trust

This is an introduction to the Pain Management Department, based at Chesterfield Royal hospital. We are part of the Critical Care Directorate.

The Department aims to help patients who are experiencing acute and/or chronic non-malignant pain. We are an integrated acute and chronic pain management team. Our work regularly involves assessing and planning pain management for inpatients on the wards. As well as our patient clinics for chronic pain management, we offer training sessions in a variety of pain relief methods, such as epidurals, intrathecal opioids, and entonox for ward nurses.

We aim to create an atmosphere for students that is stimulating, supportive and educational. You will have the opportunity to develop new skills and knowledge in assessing, managing and evaluating patients experiences of pain, such skills will benefit your future practice.

Our team is made up of 6 Consultant anaesthetists:

- Dr D. Farquharson Chronic pain
- Dr . R. Bhansali Chronic pain
- Dr J. Hui Chronic pain
- Dr I. Makkison Chronic pain
- Dr J. Cort Acute pain

Clinical Psychologists

- Dr Nielie Ho

Nurse Practitioner

- Linsay Taylor

Staff Nurses

- Melissa Bulloch
- Donna Siddon
- Maria Walder

Health Care Assistant/Housekeeper

- Julia Wood

Receptionists

- Jayne Kennedy
- Julie Watson

Our hours of work are Monday to Friday, 9-5pm, with each day bringing a different mixture of patients with acute and/or chronic pain. We have all ages of patients, from 18 years upwards. You will have the opportunity to observe both nurse-led clinics and consultant-led clinics.

Please wear your uniform during the allocation.

You will be given the use of a small locker for security of your possessions whilst on placement. Please ensure the key is returned on the final day. (Friday).

The multi-professional team is supported by health care assistants and other secretarial/clerical staff who have a valuable part to play in communicating information to patient's GP's and other departments within the hospital.

Whilst on your placement you will be allocated a mentor and given a timetable to allow you to observe the wide variety of clinics and treatments provided in Suite 6, X-ray departments, cardiac catheter department, theatres and recovery, and ward based patients.

It may be helpful to consider forming some objectives prior to your allocation. For instance, looking at how pain is assessed, what are the differences between acute and chronic pain or any other aims or interests that you want to find out more about?

Some examples of treatments that you may be able to observe are:

- Amantadine infusion
- TENS (Trans electrical nerve stimulation)
- Epidural injections
- Facet joint injections
- Regional nerve blocks
- Trigger point injections

Please bring your Placement book as a testimony of learning will be written by your mentor at the end of the week where objectives met will be documented.

It would be useful to familiarise yourself with common types of drugs used for patients experiencing non malignant types of pain.

Examples of these drugs include:

- Non-opioids – NSAID's (Non steroidal anti inflammatory)
  Paracetamol
- Weak opioids – Codeine
  Tramadol
- Strong opioids – Diamorphine
  Morphine
  Fentanyl
  Methadone
- Local anaesthetics – Levobupivacaine
  Bupivacaine
  Lignocaine
- Antidepressants – Amitriptyline
- Anticonvulsants – Gabapentin
  Carbamazepine

Chronic pain conditions require regular dosing for extended periods, many drugs will need to be given for the lifetime of the patient

It would be useful to study the doses used, the routes given, side effects and contraindications. This work can be discussed with your mentor during your allocation.

You are welcome to contact us prior to your allocation to discuss any queries that this information may raise – Telephone 01246 512286 or Bleep 092.

What is acute pain

How do we treat it

Acute pain is usually associated with an obvious cause or explanation. It is usually rapid in onset and variable in intensity from mild, moderate to severe. Examples of acute pain include post-operative pain, trauma, cholecystitis, renal colic, burns or labour pain. However, acute pain can be experienced without any physical disorder, for example headaches.

The International Association for the Study of Pain (1979) defines acute pain as:

> "pain of recent onset and probable limited duration"

Many other factors will shape the experience of acute pain (Paige and Cioffi 1992). These include:

> Fears, anxiety, sleep disruption, illness, age, previous experiences, the response of health care staff, personality, drugs and analgesia, culture.

Merskey and Bogduk (1994) state that the limit between acute developing into chronic pain is three months. However, more recently Carr and Goudas (1999) revealed that acute pain might rapidly evolve into chronic pain. They use the example of the pain intensity of herpes zoster pain developing into chronic post herpetic neuralgia pain. Another example states how heel lancing in newborn infants causes weeks of local sensitivity to touch. This study also discusses how biological and psychological foundation for long term persistent chronic pain are in place within hours of injury.

A point to remember, people may experience pain in different ways. Compare the acute labour pain experienced by some mothers who require strong opioids, and other women who can give birth with very little or any analgesia.

As professionals caring for such patients, we can provide an explanation, using terms and language that are familiar to the patient. The nurse can administer analgesic drugs and monitor their effectiveness. Documentation is vital to record progress and alert members of staff to any problems developing.

Effective pain control depends on the knowledge and skills and the values of health professionals who have to identify, prevent and treat the pain. Assessment of pain is essential to determine the site, severity and effectiveness of treatment. Verderhus, Eide, Natvig (2006)

As pain is a sensation and very difficult to quantify, accurate assessment needs to practiced and recorded.

This is made simpler in the hospital setting by grading the pain as:

- None 0
- Mild 1
- Moderate 2
- Severe 3

and is found and documented on the observation chart.
Other scoring systems can be used but this is our standard at the Royal hospital NHS Trust. It is important to remember that severity score is just one element of pain assessment.

Time out

What other factors are required to complete an assessment of pain?

Where can you document pain assessment whilst caring for a patient on the ward?

Consider how do you describe pain – try the example of a "headache"?

How does the headache make you feel?

Can you visualise the pain, or state how intense the pain feels, using a numerical score between 0-3?

Open ended questioning needs to be used when asking patients about any pain – try using what when why how as a structure to guide your questions.

For example:

Where is the pain, what does it feel like, how long has it been painful?
What drugs have been given or omitted?
Is there anything else that has helped reduce the pain?
Other resources used – change of position, equipment, referral to Pain team?

Routes of analgesia

Many routes are available for analgesic medication:

- Oral
- Intravenous
- Subcutaneous
- Epidural
- Intrathecal
- Rectal
- Topical
- Inhalation

Time out

Consider and list the advantages and disadvantages of each route of analgesia

It is recognised that untreated acute pain, coupled with the physiological response, known as the stress response, can have a number of adverse consequences on the bodies other systems. Macintyre, Ready (1996).

Cardiovascular

Rises in heart rate, blood pressure, increased myocardial oxygen demands, altered blood flow (patients skin becomes pale), possible deep vein thrombosis

Respiratory

Decreased deep breathing and cough, sputum retention, infection, hypoxia. Pulmonary changes are most noticeable on the 1st or 2nd day after surgery and may take 2 weeks or more to return to normal.

Gastrointestinal

Pain will lead to delays in gastric emptying and bowel motility.

Urinary

Urinary retention may occur. Many drugs used in acute pain are excreted via the renal system. If a patient has reduced urine output, caution will be necessary when giving analgesic drugs especially opioids.

Musculoskeletal

Muscle spasm may reduce respiratory function and immobility will increase the possibility of deep vein thrombosis.

Endocrine/metabolic

Pain is believed to play a part in the activation of the “stress response”, resulting in the release of a number of hormones. These changes can lead to hyperglycaemia, increased coagulation, impairment of wound healing and immune function. Sodium and water retention may occur.

Effective analgesia can partially reverse some of the harmful effects shown above and will help early mobilisation and recovery of the patient.

Time out

Choose two of the body systems listed and describe how you could prevent pain becoming worse, using simple measures.

Guidelines produced by the Royal College of Surgeons and the Royal College of Anaesthetists (1990) clearly state:

- To assess and document pain routinely, at the same time as other observations – pulse, blood pressure, respiratory rate.
- Treat pain as early as possible.
- Select the treatment according to the patient’s clinical need and response – using a s/c route for analgesia when the patient may be able to take oral analgesia.

In summary, acute pain management is vital for patient’s recovery, and can significantly reduce the incidence of complications and shorten hospital stays.

References

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Paige, D and Cioffi, A.M. (1992) Pain assessment and measurement p70. *In* Sinatra, R. Hord A. H. Ginsberg B. Preble L.M. Acute Pain – Mechanisms and Management. Mosby. Missouri.

Royal College of Surgeons of England, the Royal College of Anaesthetists. (1990). Report of the working party on pain after surgery. London. Royal College of Surgeons.

Vederhus B. J. Eide G.E. Natvig G.K. (2006) Psychometric testing of a Norwegian version of the premature infant pain profile. An acute pain assessment tool. A clinical validation study. *International Journal of Nursing practice.* Vol 12, (6), December 2006. p334-344.

Overview of Chronic Pain

Patients referred are experiencing on-going chronic non-malignant pain.

The service consists of an out-patient clinic, taking referrals from GPs, Consultants from other specialities within the Trust, Physiotherapy Extended Scope Practitioners and Consultants from outside the Trust.
Medical and nursing staff may also require advice on chronic pain management with hospital in-patient's who may have complex pain management regimes.

Resources

This brief overview of chronic pain provides an opportunity, through self-directed learning, to investigate and reflect on what chronic pain is, common chronic pain syndromes, the impact of chronic pain on patients' lives and treatment options available.

Information can be found in resource files and books throughout the department. Also, speak to staff, doctors, nurses and health care assistants about their experiences and views on caring for people with chronic pain.

Chronic non-malignant pain

In 1986, the International Association for the Study of Pain (IASP) defined pain as:

'an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage'

The IASP define chronic pain as:

'pain without apparent biological value that has persisted beyond normal healing time (usually taken to be three months)'

Bonica (1990) suggested that chronic pain was:

'pain that persists a month beyond the usual course of an acute disease or a reasonable time for an injury to heal, or, that it is associated with a chronic pathologic process that causes continuous pain, or the pain recurs at intervals for months or years'.

Many patients report that chronic pain has a severely limiting effect on their quality of life, causing high levels of disability and enormous demands on the health care system (NHS Quality Improvement Scotland 2006).

Acute pain may serve as a warning or protection against serious harm, but chronic pain serves no useful purpose. In some chronic pain syndromes, the

stimulus for the pain is constant or intermittent, for example, pressure on a nerve from a prolapsed inter-vertebral disc or pressure or tumour.

Time out
What are the definitions of acute pain and chronic pain?
Consider the differences between the two

Patients are usually referred to the pain clinic when they have been thoroughly investigated and no cause has been found for their pain. Although a precise diagnosis of the cause of the pain may not be possible, it is important that all reasonable investigations are carried out. Sometimes, a diagnosis is made but surgery is either inappropriate, impossible or has failed, and pain management is the only option left.

Some patients complain of pain without any obvious tissue damage or disease. The pain is still very real to the patient, even though there may be a psychological element. Chronic pain touches every aspect of the patient's life, affecting their physical and mental health, and their families and relationships (Rowbotham 2000).

The pain clinic offers a multi-disciplinary approach to pain management, using a wide range of treatments, with the emphasis on improving quality of life not providing a 'cure'.

It is important that patients are involved and encouraged to take a pro-active role in their treatment programme, to prevent them developing a passive role, expecting everything to be done 'to' or 'for' them. It is vital that patients are able to take control of their pain in order to achieve maximum quality of life.

Common chronic pain syndromes

Chronic pain syndromes can be broadly divided into two groups though patients often complain of more than one type of pain:

Nociceptive pain includes complaints such as:

Back and neck pain
Musculo-skeletal pain (eg. fibromyalgia)
Headaches
Osteoarthritis
Rheumatoid arthritis
Post-operative and post-trauma pain
Chronic pelvic and visceral pain

Neuropathic pain includes complaints such as:

Post-herpatic neuralgia
Phantom limb pain
Trigeminal neuralgia
Complex regional pain syndrome
Painful peripheral neuropathies (eg. diabetic neuropathy)

Time out
Select two of the above and look in detail at the possible treatment for a patient presenting with that chronic pain syndrome

Assessment of pain

Pain assessment is vital when planning the care of patients in pain. Without the initial assessment, it is impossible to measure the effectiveness of treatments. This becomes more difficult in an out-patient setting where patients will not be reviewed for months. New patients are assessed initially by a nurse specialist or doctor.

Effective communication skills are vital when assessing patients who may have been in pain for many years. Patients may be reluctant to discuss these complex issues. It is important to develop trust with the patient so that they feel able to discuss all elements of their pain and the impact it has on their quality of life. This will also help to ensure that the patient is able to take an active role in their treatment plan, and are more likely to be concordant in it.

Time out
Consider the information that the nurse or doctor will need to discuss with the patient when taking a history in order to effectively plan a pathway of care for a patient in the pain management department

Treatments

The care pathway for chronic pain patients is multi-modal and tailored to the individual's needs. It will include many of the treatments summarized, and is constantly evaluated and changed according to the response of the patient.

Pharmacology

Pharmacology may include simple analgesia, such as paracetamol, and or opioids, with or without adjuncts such as non-steroidal anti-inflammatory

drugs, anti-depressants and anti-convulsants. Various combinations of drugs can be prescribed to meet the individual patient's needs.

Non-steroidal anti-inflammatory drugs
Include diclofenac, ibuprofen. They decrease the production of prostaglandins.

Paracetamol
The mode of action of paracetamol is not fully understood. It is known to reduce prostaglandin concentrations in the brain and is an effective analgesic and anti-pyretic agent.

Opioids
Include morphine, codeine, oxycodone, buprenorphine, fentanyl, tramadol. Opioid use in patients with chronic pain must be closely monitored by specialists.

Anti-depressants, anti-convulsants, and other drugs
Neuropathic pain does not respond well to standard analgesia, but it does respond to drugs that were not originally intended for use in pain management.

Anti-depressants
Include amitriptyline, dothiepin, seroxat. Anti-depressants do have analgesic effects for which they are prescribed in small doses. However, patients with chronic pain do sometimes become clinically depressed, and anti-depressants are prescribed to improve mood.

Anti-convulsants
Include, gabapentin, pregabalin, carbemazipine, and sodium valproate. The exact function of some of these drugs in pain management is still unclear. However, they do stabilise nerve membranes which has the effect of 'damping down' symptoms of neuropathic pain.

Miscellaneous drugs
Include anti-spasmodics, such as baclofen and sedatives, such as diazepam (short term use only). These drugs are useful in reducing muscle spasm and the pain this causes.

Capsaicin
Used topically as a cream called Axsain, the active agent in this treatment is chilli peppers. It is licensed for use in post-herpatic neuralgia and painful diabetic neuropathy.

Time out
Choose a drug from each of the categories of drugs, and investigate it's use in chronic pain. Include it's mode of action, doses, indications for

use, contra-indications and side effects

Invasive treatments

If the pain is identified as mechanical, such as nerve compression, invasive techniques may be of benefit. However it must be made clear to the patient that this is not a cure. These techniques are highly invasive and are normally reserved for use if less invasive treatments have had no effect.

The procedures involve injection of steroids and or local anaesthetics, or injection of chemicals around nerves.
Procedures used in this hospital are facet joint injections, caudal epidurals, lumbar epidurals, guanethidine blocks, stellate ganglion blocks, chemical sympathectomies.

Time out
Choose one invasive procedure and investigate it's use in the treatment of chronic pain. Include the type of pain it is used to treat, related anatomy and possible risks and benefits to the patient

Complementary therapies and psychology

In chronic pain management, it is vital to formulate a treatment plan that will encompass the patient as a whole instead of a collection of symptoms. Complementary therapies and psychology involve the use of touch, relaxation and sensory stimulation and contact with the therapist that the patient with chronic pain has often been deprived of.

Psychological therapies

Psychological factors in patients living with chronic pain affect both biochemical and neurophysiological aspects of pain mechanisms (Price 1999). Psychology must therefore be accepted as a vital area of the treatment of chronic pain as it may enhance the efficacy of other treatments (Wasan et al 2005).

Psychological therapies are aimed at enabling the patient to adopt ways of thinking and behaving that help them to manage their pain more effectively and enhance their quality of life when living with chronic pain.
They include, education, cognitive behavioural therapy, diversion, relaxation techniques, stress management and guided imagery.

Time out
Investigate the ways in which patients with chronic pain, and their families and friends, can adapt their behaviour and lifestyle to enable them to improve and maintain their quality of life

Complementary therapies

Many types of complementary exist and many people with chronic pain will source these therapies. Evidence suggests that there has been an increase in the use of complementary therapies for chronic pain (Haetzmann et al 2003). Complementary therapies must not be seen as a substitute for pharmacology or other conventional treatments. Careful assessment must be made to ensure that any complementary therapies used are both safe and appropriate for the patient.

Therapies used for pain management include acupuncture, reflexology, reiki, transcutaneous electrical nerve stimulation (TENS), aromatherapy, massage.

Time out
Choose one of the complementary therapies mentioned above. Investigate it's origins, mechanism of action, evidence base and possible risks and benefits for patients

References

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Haetzmann M., Elliott AM., Smith BH., Hannaford P., Chambers WA. (2003) *Chronic pain and the use of conventional and alternative therapy.* Family Practice. 20 (2) 147-173

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Psychology
In
Pain Management

The philosophy of treatment focuses on helping patients to take responsibility for their pain and helping them to cope with it using a variety of strategies. Many factors such as personality types, culture, and the meaning and the circumstances of the pain interact to produce the overall chronic pain experience.

The aim of psychological management is one of changing the patient's perception, so that rather than considering themselves to be suffering from chronic pain, they consider themselves to be well and coping, therefore taking responsibility for the maintenance of their own health. The Clinical Psychologist team is integral part of the multiprofessional team helping patients develop their individual coping strategies, on a one to one or group basis.

Emotionally distressed patients tend to focus on negative events and stressors in their life, including their pain. This can exacerbate their experience of pain causing a stress-pain cycle. Negative thoughts and emotional distress can lead to increased muscle tension, with greater pain levels and further distress reinforcing the stress-pain cycle.

Cognitive-behavioural strategies have emerged as effective non-pharmacological interventions for the management of different types of pain. These strategies range in complexity from simple distraction, music therapy, relaxation and guided imagery to hypnosis.

Distraction

This is about taking patients' minds off their pain. Distraction is used to focus their attention on a stimulus, other than their pain. There are three types of distraction.

- **Imaginative inattention** – a strategy where patients imagine doing something pleasant such as walking, going on a family outing, or floating on water.
- **Mental distraction** – where a person carries out some mental activity such as counting, reciting a poem or praying.
- **Behavioural distraction** – the person actually does something that they find pleasant such as watching TV, stroking an animal, reading a book, smelling an essential oil or talking with friends.

Music Therapy

Music has been used with great success to switch patients' attention away from their pain. The most effective type of music at decreasing anxiety and inducing relaxation is music with a slow steady rhythm and low frequency tones. Music has been shown to be effective at ameliorating pain across a number of settings including postoperative, oncology, coronary care and during childbirth. We often use music therapy during acupuncture treatments to aid the patients' relaxation throughout the session.

Focusing

Focusing consists of a number of cognitive coping techniques that are very different from those used in distraction. A patient imagines the pain as something that can be controlled, for example viewing the pain as heat radiating from an oven and then imagining that turning the oven off can control it.

Reframing

Essentially the patient is taught to replace negative thoughts and beliefs with more positive ones. This approach is particularly useful for patients with chronic pain who experience feelings of helplessness and have a tendency to personalise and dramatise negative life events.

Relaxation

There is evidence, which demonstrates the relationship between pain, muscle tension and anxiety. If patients are instructed how to use relaxation exercises their pain levels can be reduced. Some relaxation techniques are very brief and simple to use, for example yawning or deep breathing exercises. Patients can focus their attention in a systematic manner to gain a sensation of warmth in various parts of their body, for example, the thought of lying on a beach with the sun on your face. Progressive muscle relaxation is a process of systematically focusing on various muscle groups, tensing then relaxing each group in a stepwise fashion.

Guided Imagery

This is a technique that involves using one's own mind to create a mental image, which distracts attention away from the pain experience. Patients are encouraged to imagine they are somewhere pleasant, for example walking barefoot in a forest, they can feel the coolness of the floor, hear the leaves rustling in the breeze, smell the wild flowers and see the beauty all around them. Relaxation exercises are often used in conjunction with guided imagery to enhance the overall effect.

	Objective	Content
Induction	Orientation to the department	• Introduction to members of the team and layout of department. To include fire exits, procedures and emergency equipment • Discussion of aims and learning outcomes • Structure of the week using timetable • Explanation of learning packs and timescale
Acute pain	To gain insight and experience in: ❖ Role of acute pain team ❖ Communication within the team and other teams Trust wide. ❖ Pain assessment and documentation ❖ Methods used – PCA, PCEA, SDITO, oral and others as opportunity allows ❖ Drugs commonly used ❖ Holistic care and assessment of patient's with acute pain	• Accompany nurse specialist and consultant on acute pain round • Discussion with multiprofessional team, understand how referral process works • Visit PACU to observe acute post operative pain assessment and management in action • Observations required for patients receiving drugs to manage acute pain. • Routes, doses required, side effects, pharmacology advantages and disadvantages for types of drugs commonly used. • Tools available and how to document pain assessment • Factors affecting patient's experience of pain. • Identification of acute on chronic pain, the treatment and effect on recovery.

	Objective	Content
Chronic pain	To gain insight and experience in: • Assessment of pain in the outpatient setting • Communication within the team and with patients, their carers and families • Types of pain and pain syndromes, for example: Fibromyalgia Multiple sclerosis Neuropathic Musculoskeletal Visceral Migraine • Care pathways and interventions for patients with chronic pain • Documentation and communication with GP's and other community practitioners	• Discussion of referral process for patients • Work with the team in clinic to ensure patient flow, privacy, dignity and safety in clinic. Following prevention and control of infection policy • Accompany doctor and nurse for an assessment of pain in the outpatient setting. Discussion of psychosocial, pathology, physiology, pharmacology in management of pain. • Discussion and participation of interventions – TENS, acupuncture, lifestyle, psychology and health promotion using patient information leaflets • Discussion and observation of medical treatment and invasive procedures such as caudal epidural injections, facet joint injections, trigger point injections in clinic setting. • Attend x-ray, cardiac catheter suite and operating theatre sessions to observe patients having invasive procedures

Department of Pain Management
Student Nurse Placement Evaluation Form

University base:

Current Module: **Date:**

What knowledge have you gained from this placement?	**What did you enjoy/find most useful about this placement?**	**What would you change about this placement?**
Please comment on the approach and style of your mentor. Please include positive aspects and areas for development. Thank you.		

Notes

Chesterfield Royal Hospital NHS
NHS Foundation Trust

Department of Pain Management

Student Nurse Training Pack

Name:_____