

This reflective essay
is centred on pain
assessment



For the purpose of the case study I intend to use Gibbs(1998) model of reflection as this model is clear, precise allowing for description, analysis and evaluation of the experience, then prompts the practitioner to formulate an action plan to improve their practice in future(Jasper, 2003).

Wilkinson (2007) identifies assessment as the first phase of the nursing process in which a nurse uses their knowledge and skills to express human caring. It is important to choose an organised and systematic approach when caring out an assessment that enhances your ability to discover all the information needed to fully understand someone's health status (Alfaro-Le Fevre, 2004) . This can be achieved by obtaining your information from medical record and nursing charts by physical examination of the patient and also talking to patient and their families(Wilkinson, 2007). The use of objective data is more helpful in collecting information when the patient is ventilated and sedated, as they are often in the critical care setting, and this can be done by examining the patients vital sign, blood pressure, heart rate, temperature and blood results (Bulman and Schutz 2004).

I have chosen pain assessment in post- operative ventilated patient. I have worked in ICU for 4 years during this time I have nursed many post-operative ventilator patients who were on continuous infusion of sedatives and analgesics. Many of them showed signs of inadequate pain relief and associated complications. Having undertaken this module I further educated myself in this field of nursing assessment I now know, or rather have an improved knowledge base and understanding of the different aspects of pain assessment tools and recognize the possibility that I have probably nursed many more patients who were demonstrating symptoms of inadequate

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analgesia and associated complications. Given an increased awareness and knowledge I have gained through teaching, research and current literature on this topic I now, also recognise the importance of this assessment practice in particular in relation to the ventilated, non-communicated patients in ICU.

According to International Association for the Study of Pain (IASP, 1979) pain is described as unpleasant sensory and emotional experience associated with actual or potential tissue damage. Clinically pain is whatever the person says he or she is experiencing whenever he or she says it does (Mc Caffery 1979) . Appropriate pain assessment is crucial to pain management.

Patient's self-report is the gold standard of pain assessment. However pain tools that rely on verbal self-report may not be appropriate for using non-verbal ventilated sedated patients in ICU. Pain assessment tool used in our critical care setting is based on a numerical pain rating score from 0-4, a score of 0 being no pain at all and 4 being the worst pain ever experienced. There is also a visual analogue scale for patients who have difficulty communicating, they can indicate by looking at the chart and pointing at either the happy face that has no pain or a series of faces showing different stages of pain (appendix three). These tools were chosen by the specialised pain care nurses working for the trust. The tools are favoured as they provide nurses with a quick, easy assessment. They are used widely throughout the trust to provide continuity of pain assessment. Both of these tools have proved successful in practice and are supported by the literature as being reliable and accurate in practice. However they depend greatly on the patient being able to express themselves or communicate verbally with

the practitioner . Using these methods of pain assessment is not accurate on sedated patients with altered conscious level. In nonverbal patients the use of behavioural or physiological indicators are strongly recommended for detection of pain (Jacobi et al 2006).

The patient in critical care may experience pain from many sources. Along with physical pain, psychological factors such as fear, anxiety and sleep disturbances may play a significant role in patients' overall pain experience (Macintyre and Ready 2002). Urden et al (2010) states, pain can be acute or chronic, sensations are different in relation to its origin. Acute pain-duration is short corresponds to the healing process, ranges between 30 days to 6 months. Chronic pain lasts more than 3 to 6 months and can either or not associated with an illness. Somatic pain is well localised sharp, acute pain arising from skin, muscle, joints. Visceral pain refers to the deep, ill localized arising from an organ. Nociceptive pain occurs when inflammation stimulates pain receptors (Urden et al 2010). Pain experienced in critical care patients are mostly acute and has multiple origins.

Mr. Smith a 45 year old gentleman admitted to ICU following Laparotomy for small bowel perforation and faecal peritonitis. Mr Smith was cardiovascularly unstable and was unable to be extubated immediately after surgery due to secondary sepsis. He was receiving an infusion of Propofol and Fentanyl to keep him comfortable and provide analgesia. His medical notes revealed his past medical history of previous Cholecystectomy for gall bladder stones and biliary obstruction. I was assigned to nurse him on his second day in ICU.

During handover the previous staff member reported that Mr. Smith became very agitated and hypertensive soon after he was repositioned to his side.

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Mr. Smith was given a bolus dose of Propofol infusion and the rate of Infusion increased. Whilst doing the Patient assessment I noticed Mr Smith is restless and not compliant with the ventilator. Arterial Blood Gas (ABG) performed which showed Mr. Smith is hypo ventilating. Meanwhile Mr. Smith became more agitated with escalating non-compliance with ventilator and significant increase in his Mean Arterial Pressure (MAP) which was being monitored continuously by the arterial line and transducer. He was showing facial grimaces and moving his extremities restlessly. I tried to reassure him by talking to him, reorientating him to time, place and person, explaining to him that he is safe. Adam and Osbourne (2005) identifies that critically ill patients frequently require help with coping with many of the stresses like physical discomfort, isolation, fear of pain and death. By using strategies like communicate caring and understanding and provide information repeatedly and in sufficient detail for the patient etc. helps the patient to cope with the stress. But repeated reassurance and reorienting has not made any improvements in his current status.

Pain is an important problem in critical care and its detection is a priority. Pain assessment is vital to detect pain (Urden 2010). Pooler-Lunse and Price(1992) emphasises that critically ill patients who are unable to communicate effectively are at high risk of suffering from pain. Poorly controlled pain can stress the sympathetic nervous system leaving vulnerable patients at risk of complication and can compromise recovery and negatively affect both morbidity and mortality(Puntillo et al 2004, Dracup and Bryan- Brown 1995). Mr Smith was ventilated and due to the effect of sedatives his level of consciousness was altered. In critical care factors alter

verbal communication is mechanical ventilation, administration of sedative agents and the patients change in level of consciousness (Hamill-Ruth R J, Marohn L 1999 , Kwekkeboom K L, Herr K 2001, Shannon K, Bucknall T 2003). The consequences of untreated acute pain in critically ill patients include increases in catecholamine and stress hormone levels which are potential causes of tachycardia, hypertension, increased oxygen requirements and decreased tissue perfusion (Blakely and Page 2001, Hamill-Ruth and Marohn 1991). Mr Smith was increasingly hypertensive and tachycardia. Despite giving increased oxygenation Mr. Smith was hypo ventilating due to non- compliance to the ventilator.

Marshall and Soucy(2003) identifies agitation is a common problem in critically ill patients and has been shown to be associated with inadequate pain management. Agitation can have serious consequences with patients removing access lines compromising their oxygen needs by self extubating (Cohen et al 2002).

Following discussion with the nurse in charge of the shift it was apparent that Mr. Smith was showing behavioural signs of pain. There were no other obvious reasons as to why he had become compromised with his ventilation. When I approached the medical team concerning Mr. Smith's increasing agitation and non- compliance to ventilation I was instructed to give a bolus of propofol and fentanyl and to increase the rate of propofol and fentanyl until Mr Smith was deemed medically manageable. I was decided to increase Mr. Smith's ventilatory support. Following the treatment Mr Smith became much more stable, he became less tachypnoeic was synchronising with the

ventilator; his blood pressure was within acceptable limits and monitoring in sinus rhythm.

The clinician did not assess Mr Smith for signs of inadequate pain management. Unfortunately due to hypoventilation and non-compliance to mechanical ventilation, Mr Smith had to be remained on high levels of ventilation and increased levels of sedatives for the next few hours emphasising evidence by Pooler-Lunse and Price(1992), the physiological complications associated with pain including Pulmonary complications and increased cardiac workload as well as depression and anxiety and increased days of hospital stay(Desbians et al 1996). Upon further reflection I should have noted Mr Smith's agitation associated with inadequate pain relief. Had I been knowledgeable in this field Mr. Smith's agitation and physiological signs of restlessness and facial grimaces would have prompted me to carry out a detailed pain assessment. Had there been a behavioural pain assessment scale on the unit where I work that may have prompted me carry out the assessment and linked these signs as indicators of inadequate pain relief.

During my further assessment of Mr. Smith I had various thoughts and feelings which included feeling apprehensive and self-doubt regarding the decision to increase sedation and ventilator support. Whilst reviewing his past medication history I noticed that Mr Smith had been on regular analgesics which are co-codomol and paracetamol and there was no indication for their use in his notes. Fink R (2000) recognises that reviewing patient's past pain experiences and how did he or she usually react to it can be of good value when assessing pain and can help to decide treatment options , by questioning patients' family or significant other can provide us <https://assignbuster.com/this-reflective-essay-is-centred-on-pain-assessment/>

the information about patient's pain history. Later during the visiting hours Mrs Smith came to visit Mr Smith. I have given her a brief update of his condition including the changes made to his sedation and ventilation. Then I enquired to Mrs Smith about the indication of those analgesics he was on . She revealed that Mr. Smith developed back pain when he discharged to home after undergone cholecystectomy six months ago and he was prescribed those analgesics by his G. P(General Practitioner). She also mentioned that he had problems getting optimal pain relief post operatively even when he had cholecystectomy, and he would not tolerate lying on his sides. This co-related his agitation and restlessness happened when the night staff turned him to his side.

I notified these things to the ICU doctors and raised my concern that lack of adequate pain management could be the reason for Mr Smith's earlier agitation. They also agreed on this possibility and advised to change fentanyl infusion to remifentanyl and to adjust the rate of the infusion to keep Mr Smith's pain relief optimal. Remifentanyl is potent analgesics, so ensure the patient is pain free but prevents over sedating the patient, allows rapid arousal and recovery from sedation thus facilitates daily sedation holds and neurological assessment(Dhaba et al 2004). He was also prescribed regular paracetamol and Tramadol when required. It was then decided to reduce Mr. Smith's sedation as he was haemodynamically stable, he was then able to respond and started following commands. Mr. Smith was now able to communicate if he had pain or not by squeezing my hand to command.

Invasive technology can restrict the reliance on many behavioural indicators of pain (Bucknall and Shannon 2003) on the other hand it is argued that <https://assignbuster.com/this-reflective-essay-is-centred-on-pain-assessment/>

invasive lines enables constant monitoring of blood pressure (B. P) and heart rate (H. R), two commonly utilised indicators of pain and thus help to assess pain (Bucknall and Shannon 2003) . Even though Mr Smith was hypertensive and tachycardic this was presumed to be due to agitation. In a contradicting statement Bucknall and Shannon(2003) points out that the sympathetic symptoms i. e. Increasing B. P and H. R are also been found to be unreliable. Pooler-Lunse and Price (1992) emphasises that the Para sympathetic stimulation can result in less observable signs with prolonged pain, but pain intensity remains unchanged. The American Society for Pain Management Nursing (ASPMN) recommendations cited in Herr k et al (2002) emphasises that vital signs can be affected by other distress conditions, homeostatic changes and medications there for they should not be considered as primary indicators of pain. With conflicting evidence it is difficult to make decisions that best support this assessment practice.

Anand K J S, Craig K (1996), Herr K et al (2006) states that behavioural indicators are strongly recommended for pain assessment in non- verbal patients , few tools have been developed and tested in critically ill patients. The Behavioural Pain Scale (BPS) and the Critical Care Pain Observation Tool (CPOT) are suggested and supported by experts for using uncommunicative critically ill patients (Li-D, Puntillo, Sessler 2008). BPS was tested and validated exclusively in ventilated, unconscious patients (Payen et al 2001, Young G 2006, Aissaoui Y et al 2005). The Behavioural Pain Scale (BPS) includes three behaviour's 1) facial expression 2)movements of upper limbs3)compliance with the ventilator. Each behaviour is rated on a scale from 1 to 4 for a possible total score from 3 to 12. The BPS can be used

quickly (2 to 5 minutes), most clinicians were satisfied with its ease of use (Payen et al 2001). The Critical Care Pain Observation Tool (CPOT) was tested in verbal and non-verbal critically ill adults (Gelinas C 2006, 2007) its content validity supported by ICU experts including nurses and physicians (Gelinas C 2009). CPOT includes four behaviours 1) facial expression 2) body movements 3) compliance with the ventilator 4) muscle tension. Each behaviour is rated from 0 to 2 for a possible score of 0 to 8. Gelinas C and Hammond reports that feasibility and clinical utility of CPOT were positively evaluated by ICU nurses and agree it is easy to complete, simplicity to understand the usefulness for nursing practice.

My experience of using a behavioural pain scale tool is limited, however I feel that if practitioners were able to assess pain more accurately then they would be able to manage their patients pain more effectively.

Use of a behavioural pain score (BPS) evaluating facial expressions, limb movement and compliance with the ventilator has proved to be a valid reliable tool in practice. A recent study evaluating the reliability and use of the BPS consistently identified increases in pain scores after repositioning patients in the ICU. There were only small non-specific changes in the BPS after non-painful intervention of eye care (Gelinas et al 2006).

I nursed Mr Smith again 5 days later. He had since been extubated and was alert and oriented. Even though he could not remember the events when he was ventilated and sedated, he learned from his wife what had happened. He was very thankful to me for investigating the possible reason for his agitated

behaviour and prompting the doctors about this and thus provide him adequate pain relief.

Upon further reflection and evaluation of my assessment of Mr. Smith I feel there have been positive and negative aspects of the assessment. The positive aspects include- I have been able to gain further knowledge in various aspects and tools of pain assessment . By reviewing patients medical notes and gaining history from his wife I have linked his agitated behaviour and taken the possibility that these are signs of inadequate pain relief and I have managed to convince the medical team regarding this in order to act on it. Current research identifies multidisciplinary collaboration provides optimum care for the patient (Bucknall T, Shannon K 2003), this emphasises the need to perform regular, accurate pain assessment and care full documentation (Bucknall T, Shannon K 2003).

When considering the negative aspects of my assessment I feel I did not use a holistic approach instead I considered Mr. Smiths agitated behaviour as a physical problem, I was concentrated to treat the symptoms and not the patient. As described in Roper Tinney L(1989) assessment tools achieving patient centred nursing is important. I could not identify Mr. Smith's behavioural indicators of pain primarily due to my lack of knowledge about this assessment tool as well as there was no unit assessment protocol which includes the behavioural assessment scale, Unfortunately this is not isolated, it is in fact a universal problem . Camp (1998) points out that like many speciality nurse critical care nurses and physicians recognises that there basics education was insufficient for caring for patients in pain.

Accurate detection of the critically ill patient's pain is not an easy task for ICU nurses especially when the patient is unable to self-report because of mechanical ventilation or due to the effects of sedatives. Stanton (1991) argues that pain assessment and management may be significantly improved by enhancing nurses knowledge combined with improved communication of the problem. NMC(2008) emphasises that having appropriate knowledge, skills and attitude towards pain, pain assessment and its management is essential to provide optimum patient care.

Use of pain assessment tools is highly recommended by Kaiser(1992), identifies that an effective pain assessment tool as part of the documentation improves communication between patients and nurses as well as nurses and medical staff. Even though we had a pain assessment tool (0 to 4 numeric pain assessment scale) due its limitations on the use in non-communicative patients it was not contributing much in patient's pain management. The previous practitioner documented the patient's pain score is " Unable to assess " as the patient is sedated and ventilated. This highlights the inappropriate use of our pain tool currently being used in practice as a patient is unable to verbalise or communicate their pain if they are sedated and ventilated. Although today's guidelines strongly suggest that the use of a standardised behavioural pain scale to nurses who care for uncommunicative patients, further research is still needed to fully understand the behavioural and physiological responses of critically ill patients who are experiencing pain (Herr K et al 2008).

On reflection my underpinning knowledge and confidence in this area of assessment has developed tremendously. I feel that I have gained <https://assignbuster.com/this-reflective-essay-is-centred-on-pain-assessment/>

knowledge and insight into an important patient assessment, from an initial lack of sufficient knowledge I am now able to bring evidence based practice in the clinical area which will benefit the patient and my colleagues. By understanding the physiology, pain assessment tools and the complications of poorly managed pain, I will have the knowledge and skills to manage these patients. The use of sedatives and analgesics places a great deal of responsibility on critical care nurses and they must understand how the drugs work , complications of their use and how to monitor effectiveness staff must understand sedation does not equate analgesia (Ashley and Given 2003). The use of an appropriate pain assessment tool and management algorithm is essential for adequate pain management. Since undertaking this study, it is of interest to note that our practice development nurse and the specialist pain nurse for ICU , have jointly developed a behavioural pain assessment scale similar to the BPS and CPOT scale, and staffs are encouraged to use it routinely.

I feel that my action plan and recommendations are to promote the use of the pain assessment tool by educating the nurses and emphasising the importance of this assessment to improve patient outcome. The need for education to train staff on how to use the tool would take both time and money. The NHS is already under extreme financial pressures and money for training is not readily available. However if an improvement in pain management was successful then patients stay may be shorter, thus having a beneficial effect. I am also aware of the importance of not relying solely on the assessment tools but the use of both good nursing assessment and assessment tools to improve optimal patient management, shortening the

recovery time and reducing the likely hood of complications (Ashley and Given 2003). A sedated, ventilated, non-communicative patient is vulnerable and relies completely on those providing care for them but as to their family at this anxious time. Education and training will improve patient care and ultimately patient safety which is paramount. Therefore I will take the knowledge and information I have acquired back to my clinical area as I have a duty to provide a high standard of practise and care at all times (NMC 2008)