Developing and implementing a pain management benchmark

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Background

- Cancer patients frequently experience pain.
- Adequate pain control is achieved in 80-90% of patients when the World Health Organization's guidelines on pain are followed; however, these guidelines are not routinely implemented in clinical practice.
- A Department of Health inpatient survey conducted at the Royal Marsden Hospital National Health System (RMH NHS) in 2002 showed that pain was inadequately controlled in a number of patients.
- A system of clinical benchmarking was established at RMH to review and improve pain management at that institution.

Methods

Planning the benchmark

- A multidisciplinary committee was established, including a physiotherapist, a complementary therapist, and a number of nurses working both in the wards and in specialized services such as practice development, pain management, and palliative care.
- The committee met over several months to develop the benchmark, with a goal of:
  - Identifying the best practice for pain management
  - Facilitating the implementation of the benchmark by support staff
  - Identifying and initiating changes in practice as a result of the benchmark
- Six key benchmark factors were established through review of the literature and local and national pain guidelines, as well as through the expertise of group members and their medical colleagues.
• **Pain assessment**: Patients have ongoing, holistic assessment of their pain with patients serving as the prime assessors of their pain, if possible.

• **Patient/family involvement and information**: Patients and their families are involved in pain management, have free access to evidence-based information, and have the opportunity to discuss any information with a registered health professional.

• **Pain management**: A comprehensive, individualized pain management plan is fully implemented and results in effective pain control.

• **Continuity of care**: Patient care is coordinated, including communication with other health care agencies to ensure seamless forward planning of pain care.

• **Training for health care professionals**: Health care professionals have up-to-date knowledge and possess clinical expertise regarding pain.

• **Patient safety and review of practice**: Patients receive safe and competent care within a culture that allows health professionals to review and reflect upon their practice.

• An evaluation form was developed to assess these six key points and was distributed to senior staff for comments and amendments.

**Implementing the benchmark**

• Members of the committee took responsibility for teaching staff how to use the pain benchmark prior to its implementation.

• Clinical units were instructed to complete the benchmark within the same two-month period.

• Different approaches were used to score the benchmark in different units; a number of units used their multidisciplinary team meeting as a forum to score one or two factors each week.

• Whenever possible, benchmarking facilitators were invited to attend these meetings.

**Results**

**Reviewing and developing practice**

• 23 clinical units completed the pain benchmark across the RMH NHS trust.

• Areas where pain practice was good included:

  • Patient involvement by the intravenous therapy team in choosing cannulation site, using topical anesthetics, using heat pads to aid venous vasodilation, promoting a relaxed atmosphere during cannulation through music, television, and aromatherapy, and ensuring high standards of staff training.

  • Promotion of non-pharmacological methods of pain relief in the rehabilitation and medical day units.

  • Pain management as a topic of patients’ information by the private patient wards.

• Areas where pain practice needed development included:
• Improvement of staff education on pain management at the ward level.
• Need for a standardized tool to assess pain, and implementation of this tool by health care providers.
• Need for regular study days for nurses to review chronic pain management.

Evaluation of the benchmarking process

• Not all clinical units could complete the benchmark in the two-month period due to busy workloads; however, the benchmark was completed by some of these units at later dates.
• Involvement of medical staff was difficult.
• Staff in some outpatients areas found the benchmark difficult to complete and did not feel it was relevant to their practice.

Authors' Conclusions

• Benchmarking pain at RMH has proved to be an effective tool for establishing best practice, reviewing practice, and identifying areas of development.
• Work should be undertaken to establish a national pain benchmark.

Discussion

This article describes an attempt to implement a system-wide assessment of pain management at the RMH NHS. The factors identified by the authors are vital areas in successful pain management. However, this particular effort was hindered by lack of participation by medical staff in the development of the benchmarks and by the failure of all clinical units to complete the benchmark, either due to time or the perception that the benchmark was not relevant to a particular unit's practice. Clearly, adequate management of pain is essential, and given the extremely subjective nature of pain, maximal involvement of the patient in his or her own pain management through patient education and self-assessment is mandatory. However, because of this subjective nature of pain, it is difficult to implement a pain benchmark that is applicable to all patients in all fields of practice. More specific pain benchmarks developed for individual units with the input of medical staff, nurses, physiotherapists, alternative medicine specialists, pastoral care, and psychiatric staff may be more useful than an all-encompassing benchmark.