The Christie NHS Foundation Trust

Nursing Forms: Pain Assessments

Electronic pain assessment forms

When patients are admitted to The Christie they undergo a full review of nursing needs. This includes an assessment of pain. When the clinical team identifies a patient is experiencing pain a series of pain specific assessments are completed to ensure the correct treatment/monitoring is applied. With the new electronic nursing forms, these pain assessments are now automatically triggered whenever pain is identified at various points in the patient care pathway whether this is on first admission, at the shift change over or during the surgical care pathway. The type of assessment that is triggered is dependent upon the pathway event and/or trigger type (Fig 1).

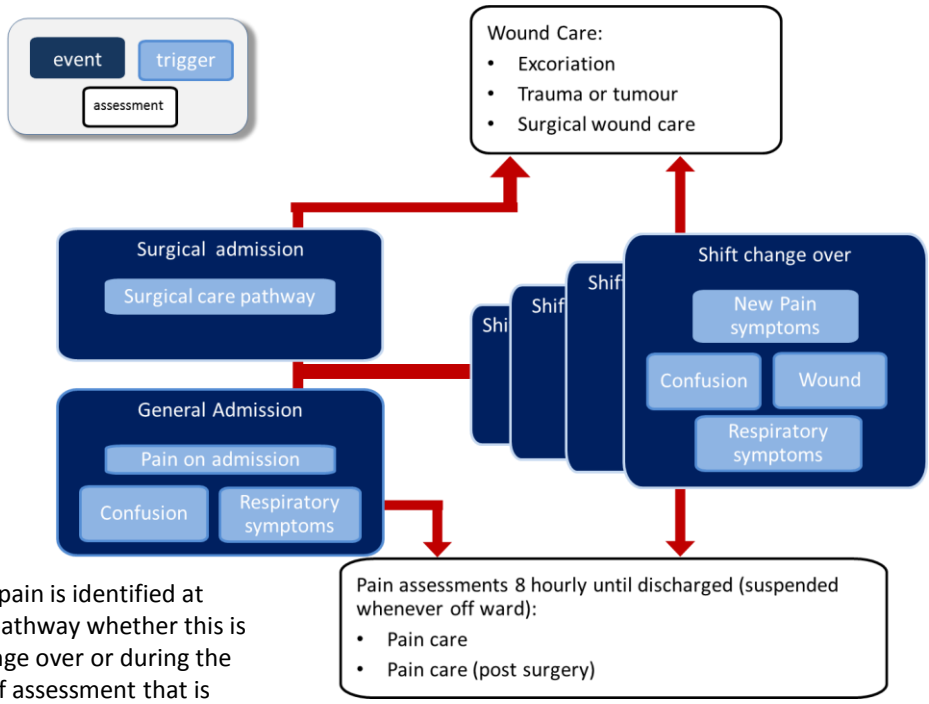


Fig. 1. Event and Trigger points for pain assessments along the inpatient care pathway

Assessing pain: general admissions

450 patients were admitted to The Christie over a period of 30 days February to March 2015. Of these, 265 (59%) were emergency admissions and 185 planned or routine admissions. Patients admitted via the emergency route were slightly older than those admitted via the planned route (Fig 2), median age for emergency admissions being 61 years compared to 57 years for planned admissions. Patients admitted via the emergency route were more likely to have pain on admission (46%) compared with planned admission patients (13%). 65 patients (25%) admitted via the emergency route had pain recorded as a reason for admission.

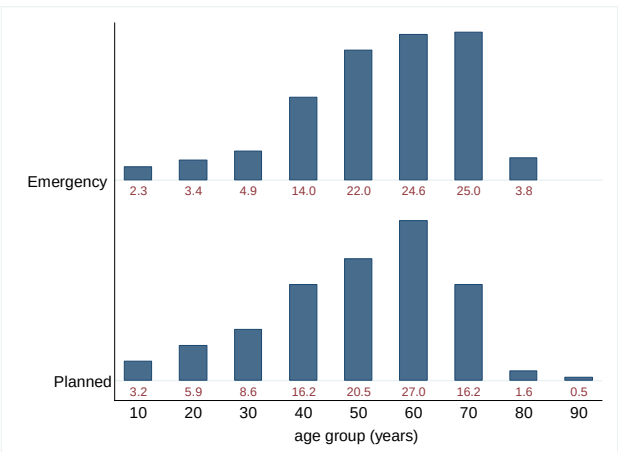


Fig. 2. Age distribution of patients admitted by type of admission. Numbers under the bars are % of patients in that age group for each type of admission.

Assessing pain: during inpatient stay

Patients are assessed for pain routinely throughout their stay. Of the patients admitted during our analysis period, 199 required a pain care assessment at some point during their stay. Forty-three of these were planned admissions, 156 emergency admissions . Pain assessment requirements also varied by diagnosis (Fig 3).

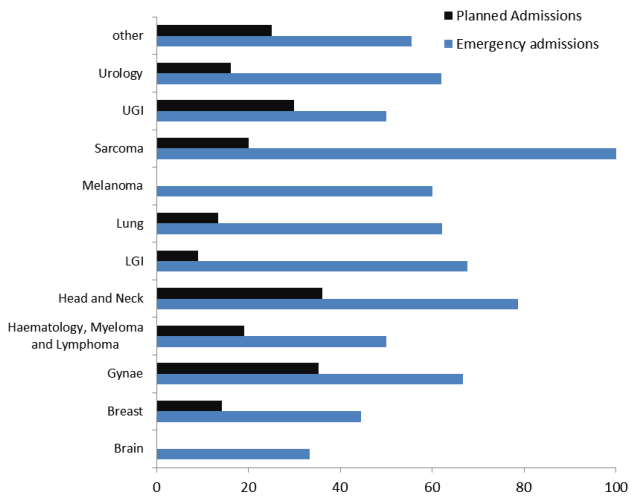


Fig. 3. Percentage of patients requiring a pain assessment by type of admission and diagnosis.

Assessing pain levels

Pain care assessments are conducted every 8 hours. As part of this assessment patients are asked to score the intensity of pain most commonly experienced since the last assessment, on a scale of 0 (no pain) to 10. For patients admitted as an emergency and as a planned admission during this period the median pain score was 3. The most severe pain score reported for each patient was 7. Figure 4 shows how pain scores changed over time for emergency and planned admission patients. The general pattern was for pain to diminish or stabilise from first assessment to the last assessment. At each assessment pain levels are compared to the previous assessment to establish how pain levels are being managed. The majority of patients were recorded at their last assessment to have pain levels stabilised (58%). For 13% pain levels had decreased and for 26% pain had been completed resolved (Fig 5).

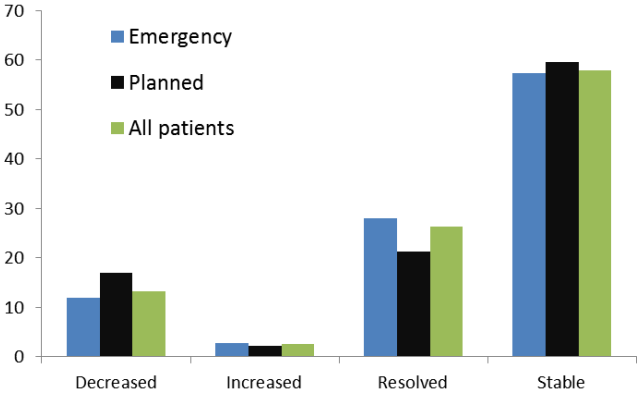


Fig. 5. Pain management at last assessment.

Assessing pain: surgery admissions

105 patients were admitted for surgery (non ERAS) over a period of 30 days February to March 2015. Just under half of patients admitted for surgery were female (48%). Median age for admitted patients was 62 years. 67% of the admissions were for non-day case surgery, 31% were day case admission for surgery under general anaesthetic as a day case and 2% for surgery under local anaesthetic . Four of the 105 admitted patients reported pain on admission, all being reported as long term pain.

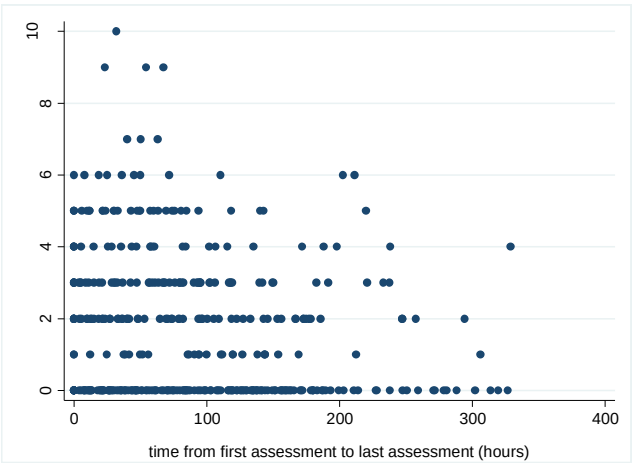
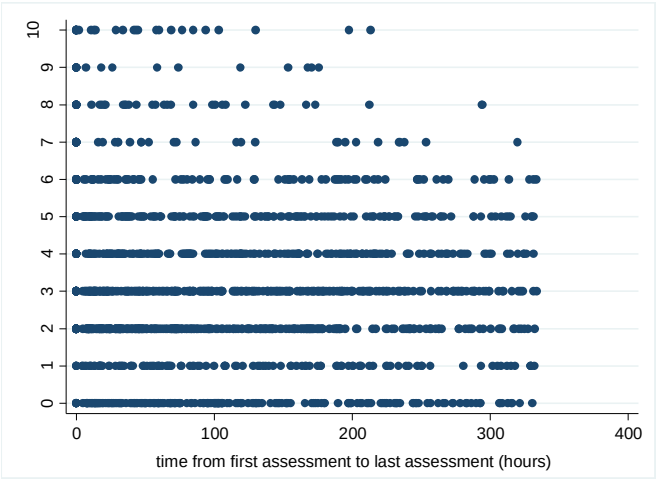


Fig. 6. Patient reported pain intensity for surgery admissions. Scale is 0 to10 with 0 = no pain. Pain assessments are done every 8 hours. Time has been calculated from the first assessment on admission to the last assessment (up to 14 days post admission).

Assessing pain: post surgery care

30 surgery patients required at least one post surgery pain assessment following surgery. These pain care assessments are also conducted every 8 hours until the patient leaves the ward. Median pain score for surgery patients admitted during this period was 1. The median most severe pain score reported for each patient was 6. Figure 6 shows how pain scores changed over time for surgery patients. Again the general pattern was for pain to diminish or remain stable from first assessment to the last assessment.

Emergency



Planned

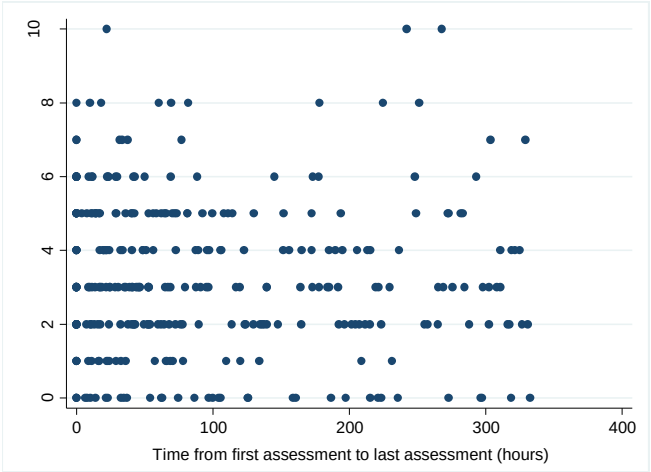


Fig. 4. Patient reported pain intensity for patients admitted via the emergency and planned admission routes. Scale is 0 to10 with 0 = no pain. Pain assessments are done every 8 hours. Time has been calculated from the first assessment on admission to the last assessment (up to 14 days post admission).