

Pain Management: A Practical Approach to Nursing Education

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ABSTRACT

This article describes a program that provides a practical approach to educating staff nurses in pain management. The content is appropriate for adult patients across all clinical specialties. Pain assess-

ment and commonly used analgesic and adjuvant medications are provided in nine educational sessions lasting 10 to 20 minute. Each presentation topic is prepared in Microsoft Power Point in three versions: slides, notes, and handouts.

Knowledge deficits in the areas of assessment and pharmacology of pain have been addressed in published practice guidelines (Agency for Healthcare Policy and Research, 1992, 1994; American Geriatrics Society Panel on Chronic Pain in Older Persons, 1998; American Pain Society, 1999a, 1999b). The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) published pain management standards that were effective in January 2001 for all patient care organizations accredited by JCAHO. These include ambulatory care, behavioral health, home care networks, home care, hospitals, long-term care, and long-term pharmacies (Berry & Dahl, 2000). Institutional compliance and education of staff are necessary components of these standards.

This article describes a complete pain management educational program that can be implemented for nursing education across all practice settings. The purpose of this program was to assist nurses in providing safe and effective pain management for patients across all specialties. Basic nursing programs do not provide sufficient lecture time dedicated to pain management in their curriculum (Graffam, 1990; Sheehan, Webb, Bower, & Einsporn, 1992). Therefore, there is a need to provide this education in clinical practice areas if patients are to receive appropriate pain relief. This program provided essential information regarding patient assessment and commonly used analgesic and adjuvant medications.

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BACKGROUND

The pain management consultation service consisting of an advanced practice nurse and a PharmD at a large New England acute care facility reviewed patterns of pain management practice during a 2-year period. Consultation alone was not sufficient to alter practice patterns throughout the institution, so staff education was deemed to be essential. An educational program called "Quick Hits" was developed out of a need to deliver information to nursing staff at the unit level in a user-friendly manner.

The first step was to query the nursing staff as to how much time they believed they could allocate to this educational offering. Most nurses indicated 10 to 20 minutes would be acceptable. Once the time issue was agreed on, the staff was provided with a list of potential content to be covered. The list was prepared after reviewing repetitive problems the pain service was called on to resolve. In essence, certain units would benefit from particular topics. For example, surgical or intensive care units would find information about parenteral and epidural analgesia particularly germane, whereas medical units would find information about oral analgesia more relevant. Nursing staff checked off which content areas they wished to learn about and added areas they believed should be included. The final content was prepared for delivery in periods of 10 to 20 minutes, and topics included:

- Pain assessment.
- Transdermal fentanyl system.
- Short-acting oral narcotics.
- Long-acting oral narcotics.
- Patient-controlled analgesia and parenteral opioids.
- Epidural analgesia.

PAIN MANAGEMENT

- Neuropathic pain.
- Use of benzodiazepines in patients with pain.
- Nonsteroidal anti-inflammatory drugs (including COX-2 inhibitors).

Each topic presentation was prepared with Microsoft Power Point and provided in three versions: slides, notes, and handouts.

IMPLEMENTATION

To achieve maximum possible attendance, each Quick Hit presentation was scheduled with the nurse manager for each unit. The nurse manager was then responsible for assigning staff to attend. The date and time for the Quick Hit educational offerings were scheduled, allowing a maximum of 30 minutes. Time scheduled varied depending on the topic. To accommodate different shifts, presentations were scheduled at 7:30 AM and 4:00 PM on the same unit. Nursing staff planning to attend the educational offering made arrangements with their support staff to monitor their patients during absences. If a patient situation arose that required nursing intervention during the presentation, the nurse was able to leave the room and quickly attend to the patient.

The educational offerings were conducted by an advanced practice nurse and a pharmacist on the scheduled unit. Rooms were assessed with regard to availability of seating and audiovisual equipment in advance of the scheduled time. Beverages and snacks were provided.

Following delivery of the material and information, 5 to 10 minutes were allowed for questions and answers. After the question-and-answer session, attendees were asked to complete a 3-item evaluation form using a scale of 0 to 10, with 0 being not adequate and 10 being the most adequate. Areas of evaluation included content, utility of materials delivered, and the amount of time allotted for the presentation. Evaluation of these components allowed the Quick Hits program to be modified and adjusted to suit the needs of each specific unit throughout the facility.

The target number of attendees per session was 10. Sessions were presented as roundtable discussions as this was the most practical style of presentation. Flip charts were used to display the visual information. For smaller groups, an 8½×11-inch version of the slides was mounted on a small flip chart, and for larger groups, the slides were enlarged and mounted on a poster-size flip chart.

When an overhead projector was available, the 8½×11-inch slide version was formatted into overhead transparencies. Most of the educational offerings

were delivered in unit conference rooms. Many of these rooms lacked an appropriate background screen for delivery from a slide projector, overhead projector, or computer/liquid crystal display projector, rendering the flip-chart presentation the most practical.

EVALUATION

One hundred thirty educational presentations covering all nine topics were conducted with the first trial of the program. Attendance at each session averaged between 5 and 10 people. Feedback and evaluations were positive.

Participants rated the content and the handout materials in the 9 to 10 point range. The most common comments regarded the time allotment. Many staff members expressed desire for additional time to learn this material, yet realized the practical value of multiple educational offerings given over short periods of time.

Practice changes were evidenced quickly. By the third week of the program, there was a decrease in the number of errors in administering analgesics, increased questioning of physician-prescribed analgesic, and improved staff satisfaction attributed to improved pain management of their patients. The new knowledge base of the nursing staff influenced the house officer physicians. They requested pain management education to be included as part of their monthly educational presentations. The pain consultation service saw a significant decrease in the repetitive problems they were called on to resolve prior to implementation of the Quick Hits program.

CONCLUSION

The rush to meet JCAHO standards for pain management has placed significant pressure on institutions to educate staff and implement proper assessment and management of pain within a narrow time frame. This educational program proved feasible even with the fiscal restraints that all organizations currently face.

Providing 130 presentations in the pilot phase required a labor intensity that would be difficult to sustain. Therefore, the entire program was provided on diskette, which included the slides, note pages, narrative, and handouts. These diskettes* were provided to each nurse manager. This allowed nurses to learn at their own convenience. The authors, therefore, needed only to be available for periodic revisions.

Wake (1987) indicated it is unrealistic to expect sig-

*For information on obtaining a copy of the diskette, contact the authors by e-mail at JayneP@concentric.net or chakdoc@aol.com.

nificant practice changes as a result of attending short-term continuing education without a practice component. Providing a diskette made it possible for the nurses to reinforce their learning over time. Once the content was established as standard, expected knowledge on each unit, concerns about loss of knowledge base through staff attrition, relocation, and rapid turnover were minimized.

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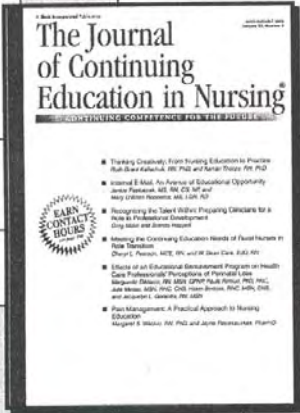
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