CONTROLLING PAIN

Engaging the patient through comfort-function levels

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HOSPITALS HAVE LONG been committed to providing optimal pain relief for patients and are now further incentivized by the Hospital Consumer Assessment of Healthcare Providers and Systems requirement to survey patients’ experiences with pain control during hospitalization. However, in today’s healthcare arena, hospitals often struggle with a deficit in the provision of effective pain management. This article describes how one West Texas acute care agency took on the challenge of changing the culture of how frontline staff and the health system at large viewed patients’ pain and comfort. It discusses the methods used to alter staff perception and appreciation of pain and comfort within the patient population, and to improve comfort-function goals usage to enhance pain management.

Changing the culture

Establishing comfort-function goals requires the clinician to interact with the patient to establish a level of comfort that permits the patient to achieve appropriate functional goals based on the patient’s current health status. For example, the patient may be comfortable ambulating after surgery if his or her pain level is 3 on a validated 0-to-10 pain intensity rating scale.1

The literature speaks only briefly regarding comfort measurements. The importance of healthcare providers and patients collaborating to establish a comfort-function level isn’t clearly addressed within the literature for acute care frontline nursing staff.2

The pain-management program goal for this institution was to create an innovative initiative that would strengthen the staff’s engagement with patients for more effective pain management. Because the process of recognizing pain is critical to the establishment of effective comfort-function levels, nursing staff was tasked with engaging patients in a discussion concerning their unique comfort-function goals upon hospital admission.7 The horizontal numerical 0-to-10 scale was used to measure comfort-function goals. This scoring format was selected to mirror the 0-to-10 numerical rating scale that’s currently used to measure pain intensity in the hospital.

It was the nursing staff’s job to help each patient establish a comfort-function level appropriate for his or her clinical status. To properly establish a comfort-function goal, nurses must first describe to patients the essential activities of recovery and explain the link between pain control and positive outcomes.10 The comfort-function goals became the foundation for shifting the program’s focus from pain management to the attainment of comfort needed to achieve maximal function.

Patient-engagement challenges

Within the pain-management program, the idea of reaching the comfort-function goal was the key aspect reflecting a successful intervention. When the patient related that the pain score was equal to or less than the comfort-function goal, nurses weren’t required to provide any further pain-management intervention. For example, if a patient had established a comfort-function goal of 4 to ambulate and the current pain rating was 2, the nurse wouldn’t be required to intervene.

If the pain score exceeded the comfort-function goal, nurses were obligated to seek an intervention and to follow up within 1 hour to ensure that the intervention was successful. Using the previous example, if a patient had established a comfort-function goal of 4 to ambulate and the current pain rating was 6, the nurse would intervene with an appropriate comfort measure or measures, such as medication, back rubs, distraction therapy, or changing position. Documentation of the comfort-function goal, pain level, interventions, and follow-up were key to the effective implementation of the pain-management program.

As the program was initiated, changing the perception of the clinician along with the patient and family members was essential for success. Frequently at this institution, both nurses and patients initially set the comfort-function goal at 0. However, a comfort-function goal of 0 is often unrealistic and difficult to attain. For example, patients with preexisting pain such as severe arthritis who are undergoing surgery are unlikely to attain a comfort-function goal of 0. The comfort-function goal must be individually established based on the patient’s normal levels of function. Setting individualized, realistic comfort-function goals became a pioneering undertaking that required clinicians and patients to come to an agreement about a realistic pain rating score based on the patient’s clinical status.

Another challenge involved the documentation of the pain-management process along with
the communication of the comfort-function goals. The hospital revised its nursing pain-management program to focus on assisting patients to take the lead in establishing their unique comfort-function goals. The comfort-function goal was viewed as a dependable level of comfort the nursing staff could strive to achieve related to pain management.

An innovative nursing pain-management policy was created with importance assigned to nursing judgment. An evidence-based algorithm was implanted in the electronic health record (EHR) based on criteria found within a modified Samuels Pain Management Documentation Rating Scale (SPMDRS). Communication between healthcare providers continued to be an ongoing opportunity for improvement because ensuring that the data were effectively documented in the EHR was a challenge. Finding the best venue for conveying the comfort-function goal between shifts and frontline staff required careful thought and attention. Documentation of comfort-function goals in patient rooms, along with verifying the goals on an ongoing basis, compelled staff to be innovative.

The need to document goals, interventions, and outcomes within the EHR led to the incorporation of a modified SPMDRS, which requires extracting pain-management assessment, intervention, reassessment, and further intervention data from the medical record.11 (See Understanding SPMDRS.)

This hospital established a unique outcome measure by comparing a comfort-function goal with a pain score. The hospital used data from the EHR to measure the percentage of time the patient’s comfort-function goal was met.

Over a period of 2 years, the institution became adept at increasing the percentage of time the comfort-function goal was equal to or greater than the pain score. Prior to the use of the SPMDRS, the comfort-function goal was noted as met within the healthcare provided 53% of the time. Following the implementation of the SPMDRS, the comfort-function goal was documented as met 62% of the time. The number of times nurses documented the comfort-function goal and the pain score increased from a level of 88% to 95% over the 2-year period. The hospital realized the importance of using the comfort-function goal with the pain score to reflect the pain-management process.

Many benefits

The frontline staff at this institution are now well-versed in addressing patients as individuals with regard to providing comfort. Patient involvement in the establishment of comfort-function goals allows the focus of pain management to take the uniqueness of each patient into account. Because each patient must work with the frontline staff member to establish a realistic comfort-function goal for use during hospitalization, communication as to the expectations for pain management has improved. The comfort-function goals are documented in highly visible areas, such as on the patient message board in the room and in the patient’s medical record, so that all staff members can use the information to help the patient manage pain and discomfort. Further research is needed to validate using occurrences where the comfort-function goal is met as an outcome of pain-management efficacy.

Understanding SPMDRS

The SPMDRS has six rating levels progressing from 1 = Excellent to 7 = Very poor. This scale was incorporated to provide consistency within the evaluation of the pain-management program. The tool was determined to have interrater reliability reaching the level of .95 and an intraclass correlation coefficient of .96.11 Further investigation is needed to confirm the validity of the SPMDRS. The investigation of a pain-management program that includes correlation of the comfort-function goal with the pain scale along with a validated EHR process is key to advancing the program.

REFERENCES


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