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Improving paediatric pain management: introducing the 'Pain Passport'

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ABSTRACT

The 'Pain Passport' is a novel method of improving the management of pain in children. It consists of a leaflet carried by the patient which records serial pain scores. It attempts to empower patients and prompt medical and nursing staff to evaluate the child's pain. Preliminary audit data in support of this concept are encouraging.

The timely management of children's pain is a key goal in Emergency Medicine.[1] The national 2009–2010 College of Emergency Medicine (CEM) audit indicates that pain in children is not well managed.[2] Less than 50% of children receive analgesia within 20 min of arrival/triage in the Emergency Department (ED) and only 70% are provided with pain medication after a full hour.

Previous attempts at the Royal Devon & Exeter Hospital ED to improve pain management in children have included mandatory pain-scoring at triage, nurse-prescribing and previous audit but these have had little effect in improving analgesia provision relative to CEM standards.[3]

The concept of a 'Pain Passport' has been used in a non-ED setting to involve children and their parents in pain management.[4] This is a document owned by the child and used to help put the child in charge of his or her analgesia needs. In an attempt to improve departmental management of children's pain, the Pain Passport was introduced to our department.

The ED Pain Passport had the following aims:
To improve prompt analgesia provision in children.
To empower the patient and his or her parent/guardian. They were encouraged to notify a member of staff if pain persisted while in the department.
To encourage re-evaluation of children's pain by recording multiple pain scores.

Our passport consisted of a leaflet which was provided to all children in pain (figure 1). The leaflet was given out by the reception staff or the triage nurse. The child was encouraged to carry the leaflet throughout the ED stay and show it to the treating staff. On leaving the department, the passport was scanned into the computerised notes system.

The leaflet included:

a. an explanation of pain scoring
b. Three boxes to record pain scores (with accompanying pain scales)
c. age appropriate activities: a colouring and puzzle page.

The pain-scoring charts consisted of a Visual Analogue Score and Wong-Baker FACES. Children were encouraged to complete their pain score on arrival in the ED, when seen by the doctor or nurse practitioner, and prior to leaving the department.

An audit was conducted in accordance with CEM guidance and methodology.[2] The audit office provided a weekly list of all children aged 5–15 attending the ED with a long bone fracture. This list was obtained electronically based on the clinical coding of the notes. Records were then hand-searched and cases recruited according to the CEM defined inclusion and exclusion criteria. Data were then entered into the CEM audit spreadsheet.

Following the introduction of the Pain Passport, our CEM audit data showed an improved time to analgesia in children with pain. In all, 69% of children were provided with analgesia within 20 min compared with 37% in the 2007 CEM audit (figure 2). This improvement was maintained at 30 and 60 min and performance was consistently above the national upper quartile ranges. In addition, 96% of children had a pain score recorded (previous audit 77% and national median 56%) (figure 3) and 35% had documented evidence of pain re-evaluation (previous audit 23% and national median 19%).

There are a number of limitations. The numbers of cases collected for the college audit were small (26 patients). However, we continued to collect data after the submission date for the college audit had closed, and the improvement appeared sustained. On the basis of this pilot study, we plan to introduce a permanent Pain Passport which will enable us to assess if impact is long lasting.

It may be that improved pain management in children was a consequence of raised awareness of pain and analgesia rather than due to the passport per se. However, the use of a novel patient orientated process was intended to raise the profile of paediatric analgesia and so increased awareness was a valid consequence.

The Pain Passport provides a novel strategy in an attempt to improve the management of pain in children. It aims to empower patients and carers to be involved with analgesia provision and raises the profile of paediatric pain management in the department. Its use was associated with an improvement in standards of pain management and may help improve pain scoring, the timely delivery of analgesia and reassessment of pain.

PUZZLE PAGE

Fill in the following boxes using the clues below. When you have answered them all correctly they will spell another word down the middle.

1. What is the building you are in now called?
2. What does the nurse use to measure your temperature?
3. What is the piece of material used to wrap around and protect the part you have hurt?
4. What do you say when you have hurt yourself?
5. What is the name of a small sticky bandage?
6. What is the special kind of picture called which shows our bones?
7. What is the special way of giving medicine using a needle called?
8. A medical job – they often use a stethoscope!
9. A medical job – they help number 8

H	O	S	P	I	T	A	L					
		T	H	E	R	M	O	M	E	T	E	R
						B	A	N	D	A	G	E
				O	U	C	H					
				P	L	A	S	T	E	R		
			X	R	A	Y						
				I	N	J	E	C	T	I	O	N
			D	O	C	T	O	R				
		N	U	R	S	E						

PAIN IN CHILDREN

Department of Emergency Medicine

Royal Devon and Exeter NHS
NHS Foundation Trust

INTRODUCTION

Many children attending the Emergency Department are in pain. It is important that such children are given pain-killers as quickly as possible. We can use special pain-scoring systems to try and work out how much pain a child is in. These are shown on the next page. We can then give pain relief targeted to the amount of pain the child is in. Once the pain-killing medicine has been given we need to re-assess to see if it has worked. We can use the pain-scoring systems again to work out if the child's pain has improved or not.

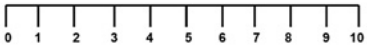
It has been shown that assessing and treating pain in children is something which is done very badly in hospitals all over the country. We want to look at a way to improve this. We think that giving children and their parents some control over the situation may help. We have therefore devised this 'pain passport'. We want you to help your child to fill-in the boxes on page 4 showing how much pain they are in when they arrive in the department. We then want you to show this to the nurses and doctors who see your child so they can give appropriate pain-killers as quickly as possible. About half an hour after the pain medicine is given we would like your child to score again how much pain they are in. We will then know if we have helped or if there is more we can do.

PAIN SCORES

FACES PAIN RATING SCALE

0 2 4 6 8 10

NUMERICAL RATING SCALE



0 1 2 3 4 5 6 7 8 9 10

PAIN SCORES

What was your pain when you arrived?

☐

What was your pain about half an hour after pain-killers were given?

☐

What was your pain when you were leaving the department?

☐

Did you find this pain passport useful?

YES / NO / NOT SURE

Figure 1 Pain scoring leaflet.

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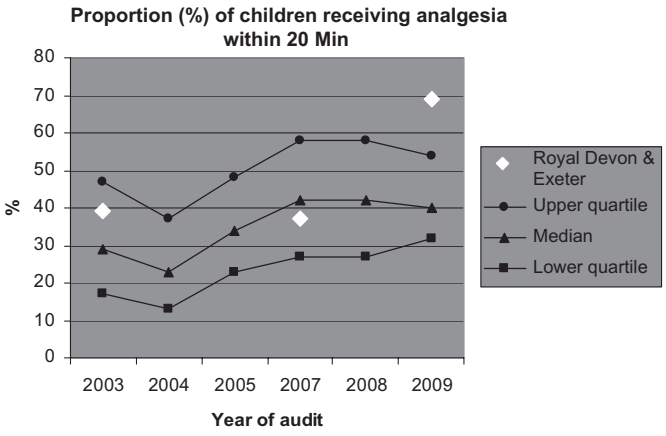

Figure 2 CEM audit data showing the proportion of children nationally receiving analgesia within 20 minutes of arrival to the ED.

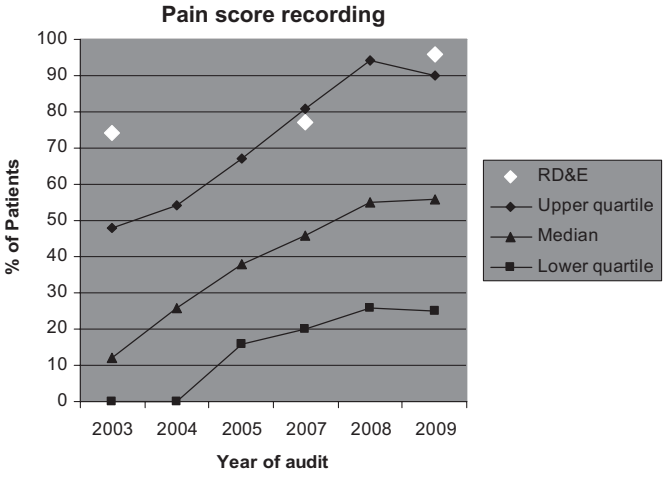

Figure 3 CEM audit data showing the percentage of children nationally who had pain scores recorded in the ED.

Contributors AA had the original idea for the 'Pain Passport' and acts as guarantor. BN supervised data collection and was the first author. SA was responsible for data collection. All authors contributed to revision of the paper.

Competing interests None.

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