Nurses’ and doctors’ knowledge of pain after surgery


Abstract

Aim To analyse the links between levels of acute pain management knowledge, perceptions of clinical skills and the acute pain management education history of doctors and nurses working in orthopaedics and general surgery in an acute hospital.

Method Questionnaires were sent to 101 doctors and nurses. Eighty two were returned. Questions were derived from an abridged version of McCaffery and Ferrell’s (2002) Nurses’ Knowledge and Attitudes Survey Regarding Pain, acute pain literature and the trust’s clinical standards and protocols.

Results The results identified the most useful sources of acute pain management education and who accessed these; barriers to good acute pain management, other than a lack of education; differences between doctors and nurses in standards of education, levels of perceived competence and knowledge in assessment, pharmacology and analgesic delivery systems.

Conclusion Staff and patient misconceptions, inadequate sources of learning and professional traditions continue to affect the quality of acute pain management. However, progress has been made in the trust to overcome these factors through collaborative practice, review of education programmes and specific practice development initiatives.

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Keywords

Pain and pain management; Pain: post-operative

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Knowledge and competency are not only influenced by the quality of training and culture of the clinical environment, but also by the practitioner’s background and the socialisation process which underpins personal values, beliefs and attitudes towards the meaning and management of pain. Despite knowing what is ‘best practice’, professionals have been found to give allegiance to their own personal beliefs and work-based attitudes (Argyris and Schön 1989). In other words, while practitioners might claim to respect the definition ‘pain is what the patient says it is and exists when they [sic] say it does’ (McCaffery 1965), in reality they continue to make their own judgements of the patient’s pain experience (McCaffery and Pasero 1999). Hawthorne and Redmond (1999) uncovered a plethora of myths and misconceptions about pain management which are based on beliefs, attitudes and traditions rather than proven evidence.

The study

Aim From the literature it appears that, despite the ideals of professionalism, education and the establishment of acute pain services, some practitioners lack knowledge of pain management and have misconceptions of pain behaviours and pain relief methods, which are not conducive to high-quality care. The RCoA (2000) recommends that nurses should achieve 100 per cent in a knowledge test related to the management of patients in pain, including a test of misconceptions. Such a test was conducted as part of this study, which aimed to examine doctors’ and nurses’ knowledge, education and confidence about pain after surgery.

Objectives were set that provided a framework for the collection and analysis of data. These were to:

- Establish the demographics of the sample.
- Identify sources of acute pain education and ratings of their adequacy.
- Identify significant barriers that might limit good acute pain management practice.
- Measure levels of perceived competence in acute pain management clinical skills.
- Test acute pain management knowledge.
- Ascertain any links between perceived competence and tested knowledge with education history.

Method A structured questionnaire was designed to identify professional demographics and educational input, barriers to acute pain management, perceived competence in clinical skills and to test
knowledge using an abridged version of McCaffery and Ferrell's (1999) validated questionnaire which was annotated to trust standards (Box 1). McCaffery and Ferrell (2002) permit replication of their work with local annotations and/or additions. Knowledge test questions were formatted as closed questions, each with only one correct answer (true or false and multiple choice).

A pilot questionnaire was administered as a validity check to colleagues working in acute pain, research and education. The study's objectives were outlined and deficiencies in the layout and wording were identified. Some questions were repetitive or irrelevant; alterations were made and questions were refined in response to this feedback.

**Sample**

A convenience sample was taken from one of the three acute hospitals in the trust. It consisted of 101 permanent, trained doctors and nurses from three orthopaedic and two surgical wards. The sample was purposefully selected to coincide with the end of the junior doctors' six-month appointments, when they should have had greatest knowledge of the trust's standards. Gynaecological medical staff (who followed a different syllabus to the RCS 2001) and locum/flexibank/agency staff whose demographic characteristics were deemed too varied and thus may have biased the results, were excluded from the sample. The response rate was 81 per cent (n=82).

**Ethical considerations**

As there were no vulnerable subjects ethics approval was not sought. A proposal outlining the study's method of enquiry was registered and scrutinised for scientific worthiness by the trust's research and development (R&D) department through a process of peer review and supervision. It lent itself to what is known as a 'grey area project' involving both audit and research approaches. The audit elements of this study compared actual acute pain management knowledge with expected standards of knowledge (as cited in the trust's acute pain management handbook and as learning outcomes of in-house training). The research elements generated new information from the analyses of relationships between knowledge, perceptions and acute pain management education. Research governance was monitored by two supervisors: one academic and the other from R&D.

Questionnaires were distributed by hand in sealed envelopes with guidelines on the purpose and objectives of the study. Participant anonymity was assured. In an attempt to reduce bias the respondents were requested not to disclose, discuss or reproduce the questions with anyone else to ensure that the respondents' answers were not influenced by others. Confidentiality of the respondents' answers and reassurance that no individual would be identified in the results had to be reinforced halfway through data collection by a follow-up letter because it became apparent that some respondents felt they could be identified from specific demographic data, for example, the sample contained only one grade G nurse for each ward and some overseas staff could be identified by the country they trained in. These data were later grouped by Statistical Package for Social Scientists (SPSS) into UK or non-UK.

The involvement of key personnel was vital if the study was to lead to improvements in clinical practice. The project aim, objectives and method were discussed at divisional meetings of surgeons, pain link nurse forums and with ward managers of the respective wards under study. An internal facilitator was co-opted for nursing staff in each ward and for medical staff as per directorate. The internal facilitator distributed the questionnaires and monitored receipt of their return. Respondents were provided with an envelope addressed to the project lead (SC) for completed questionnaires to safeguard anonymity. The internal facilitators followed up any non-respondents and acted as communication links with the author. The internal facilitators dealt with confidentiality and interpretation queries on the meaning of 'jargonistic' words such as 'efficacious' and 'noxious' (not picked up in the pilot); monitored responses and generally upheld the value of taking part.

**BOX 1**

**Content topics in the questionnaire**

- Professional demographics
- Educational input and sources of learning
- Adequacies of education
- Perceived barriers to effective clinical practice
- Perceived clinical skills in: assessment, managing opioid-related respiratory depression, managing opioid-related nausea, using combination analgesia, patient-controlled analgesia and the intramuscular algorithm
- Knowledge test of patient assessment: misconceptions and beliefs, patient factors, and monitoring tools
- Knowledge test of pharmacology: opioid administration, adjuvant analgesia, management of side-effects and misconceptions
- Knowledge test of analgesic drug delivery systems: protocol knowledge

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Data analysis  To demonstrate their level of knowledge, the percentage of correct answers achieved by each respondent was calculated. Quantitative analysis of central tendencies and cross-comparisons was calculated against educational input, professional occupation and whether they trained in the UK or not. Qualitative, Likert-type scales were designed to rate and rank opinions to identify the strength of feelings from a higher to lesser degree, that is, poor to excellent; strongly disagree to strongly agree; not competent to expert in questions related to sources of learning, perceived barriers and perceived skills respectively.

SPSS enabled a numerical coding framework to be applied to these scales for analysis, including cross-comparisons. A tally of the frequency of ticks against specific ‘sources of learning’ enabled the total amount of educational input by each clinician to be scored.

Results

The sample of 101 consisted of all the general surgery and orthopaedic trained nursing and medical staff employed by the hospital, and therefore the 81 per cent (n=82) who responded were deemed representative. Of those who responded, 73 per cent had trained in the UK, but few of the junior doctors had.

Knowledge test  Nursing staff (n=49) fared better than doctors (n=33) in the knowledge test scores. Nurses were more knowledgeable than doctors specifically in assessment and analgesic delivery systems, whereas doctors were more knowledgeable in pharmacology (Figure 1). The non-UK trained staff (n=17) scored worse than UK-trained staff in the knowledge test but 20 respondents did not state country of training. Lower test scores were also evident in wards where fewer staff had been sent on the trust’s acute pain management course (Table 1).

Examples of some significantly low knowledge scores are illustrated in Table 2. In general doctors and nurses were found to make their own judgements regarding assessment of the patient’s pain experience, despite the fact that both groups perceived themselves to be skilled in pain assessment (Figure 2).

Many staff thought non-steroidal anti-inflammatory drugs (NSAIDs) should never be given to asthmatics, despite only 10 per cent of these patients being sensitive to NSAIDs (O’Brien and Bagby 1985). Nearly half thought that respiratory depression rather than nausea is the most common side effect of morphine. They also were not aware that morphine has a shorter half life than naloxone. One third of respondents were overly concerned about opioid use and associated addiction and respiratory depression. This was reinforced by a statistically significant finding of opioid phobia among staff (Table 3).

Perceived skills and education  Clinical skills confidence scores were greater in nurses than doctors. Nurses felt more confident in pain assessment, managing patient-controlled analgesia (PCA) and morphine algorithms, using combined analgesia and managing side effects (Figure 2). The more education the nurses had, the greater their perceived confidence in clinical skills. However, that was not the case for doctors, who had less skills confidence despite having more educational input (Table 1).

Knowledge and education  Most staff felt that they were inadequately trained. The worst source of learning rated was pre-registration/undergraduate programmes with junior staff relying on induction lectures and training offered by the trust to provide education on acute pain management. Working with the acute pain service, using link nurses and audit were identified as valuable practice-based learning sources. There was a slight increase in nurses’ knowledge on wards that had received more educational input, those who had attended the trust’s acute pain management course and those who had trained in the UK (Table 1).

Barriers in the clinical setting  Practitioners identified barriers to good acute pain management which were statistically significant. Organisational concerns over staff being too busy were legitimate. Other significant barriers included inadequate staff knowledge, staff opioid phobia and patients’ reluctance to take analgesics (Table 3).
Discussion

Limitations The pilot group, which consisted of expert pain practitioners and senior staff, could have been better selected to represent the sample group. For example, they were familiar with the terminology in the questionnaire, whereas some of the respondents were unclear. Issues about anonymity and language were identified – particularly for those respondents whose first language was not English. However, this was picked up and addressed in most cases by the internal facilitators.

The stand-alone case study approach was deemed contextually valid as it provided realistic measures to a given population at a certain point in time and therefore was useful in informing local education and practice development plans. Further studies that attempt to compare the results with another group by replicating this approach would be limited in their reliability as a result of a constantly rotating workforce, changes in service provision and educational opportunities.

Knowledge The knowledge test results, which averaged 71 per cent, clearly fall short of the 100 per cent pass standard recommended by the RCoA (2000). This result is consistent with previous studies. While the practitioners under study were from only one of the three main hospitals in the trust, their characteristics were not exceptionally different from other studies. A 100 per cent pass rate may be unrealistic given the international background of the workforce, barriers in the clinical setting and the lack of mandatory status concerning evidence of competency. The poor results of the non-UK group could be attributed to their educational background, and/or cultural background with different beliefs about the meaning of pain and/or that their first language might not have been English (required to fully understand the questionnaire). Whatever the reason, these staff members should be equally knowledgeable in pain assessment and pharmacology as UK-trained staff.

The knowledge of pharmacology that was tested related to analgesic types, dosages and time intervals. The study findings support concerns already identified in the literature that suboptimal, irregular treatment of patients’ pain still exists. Interestingly, while most practitioners

<table>
<thead>
<tr>
<th>Group</th>
<th>Average education input (mean)</th>
<th>Those who felt adequately educated (%)</th>
<th>Skills perception score (mean)</th>
<th>Acute pain management course attended (%)</th>
<th>Knowledge test (%)</th>
<th>Assessment (%)</th>
<th>Pharmacology (%)</th>
<th>Delivery systems (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical ward 1 (n=10)</td>
<td>5</td>
<td>5(50)</td>
<td>12.56</td>
<td>6(60)</td>
<td>72</td>
<td>70</td>
<td>62</td>
<td>68</td>
</tr>
<tr>
<td>Surgical ward 2 (n=11)</td>
<td>4</td>
<td>4(36)</td>
<td>16.55</td>
<td>4(36)</td>
<td>64</td>
<td>71</td>
<td>61</td>
<td>61</td>
</tr>
<tr>
<td>Orthopaedic ward 3 (n=7)</td>
<td>4.7</td>
<td>1(14)</td>
<td>13.86</td>
<td>1(14)</td>
<td>69</td>
<td>81</td>
<td>57</td>
<td>68</td>
</tr>
<tr>
<td>Orthopaedic ward 4 (n=12)</td>
<td>5.8</td>
<td>10(83)</td>
<td>16.58</td>
<td>10(83)</td>
<td>78</td>
<td>77</td>
<td>71</td>
<td>86</td>
</tr>
<tr>
<td>Orthopaedic ward 5 (n=9)</td>
<td>6.7</td>
<td>4(44)</td>
<td>14.78</td>
<td>6(67)</td>
<td>80</td>
<td>78</td>
<td>73</td>
<td>81</td>
</tr>
<tr>
<td>Nurses (n=49)</td>
<td>5.2</td>
<td>24(49)</td>
<td>15.08</td>
<td>27(55)</td>
<td>73</td>
<td>76</td>
<td>65</td>
<td>73</td>
</tr>
<tr>
<td>Orthopaedic doctors (n=13)</td>
<td>5.8</td>
<td>1(8)</td>
<td>10.97</td>
<td>3(23)</td>
<td>71</td>
<td>63</td>
<td>83</td>
<td>66</td>
</tr>
<tr>
<td>Surgical doctors (n=20)</td>
<td>5.8</td>
<td>9(47)</td>
<td>15.08</td>
<td>2(10)</td>
<td>68</td>
<td>63</td>
<td>70</td>
<td>66</td>
</tr>
<tr>
<td>Doctors (n=33)</td>
<td>5.8</td>
<td>10(32)</td>
<td>10.97</td>
<td>5(15)</td>
<td>69</td>
<td>63</td>
<td>75</td>
<td>66</td>
</tr>
<tr>
<td>UK (n=45)</td>
<td>5.6</td>
<td>18(39)</td>
<td>11.08</td>
<td>18(40)</td>
<td>74</td>
<td>75</td>
<td>69</td>
<td>73</td>
</tr>
<tr>
<td>Non-UK (n=17)</td>
<td>6.8</td>
<td>6(35)</td>
<td>10.88</td>
<td>6(35)</td>
<td>63</td>
<td>54</td>
<td>66</td>
<td>69</td>
</tr>
</tbody>
</table>
felt confident and skilled in managing patients with respiratory depression and nausea (when receiving opioids and combination analgesia), this was not borne out by a good level of evidence-based knowledge.

Doctors lacked confidence in managing patients on patient-controlled analgesia (PCA) and the intramuscular algorithm, and they scored lower than nurses in related knowledge test questions. Combined with inadequate knowledge of pharmacology (especially naloxone) and pain assessment, it is not unsurprising that Carr (2000) found analgesic delivery systems were not fully optimised for the patient’s benefit.

**Education** The percentage of nurses who responded correctly to the knowledge test about assessment was marginally greater than doctors. This is perhaps because assessment forms a greater part of their everyday practice, or perhaps because they may have received better education in this area. Questions are raised about educational resources and quality rather than quantity because nurses, who had greater attendance on specialist courses than doctors (such as the trust’s acute pain management course), scored higher. Pre-registration/undergraduate level was rated the worst source of learning; junior staff clearly rely on induction lectures and training opportunities offered by the trust.

**Values, beliefs and attitudes** The differences between what staff believe they do regarding assessment and what they actually do, is congruent with Argyris and Schön’s (1989) work and reinforces the need to measure or audit performance periodically. Numerous studies have implicated inadequate assessment and inadequate use of analgesics as the reasons for patients experiencing pain unnecessarily. Knowledge of cultural differences and the impact of psychosocial factors, such as anxiety and loss of role, are important but are probably not as essential as acknowledging that the patient’s self-report using a pain rating scale is the best way to measure pain. Coping strategies – communicating with relatives, walking, going out for a cigarette or even sleeping – may cause patients with severe pain to look as if they are not in pain; the reality is that these behaviours are a distraction and are invalid as predictors of pain intensity when compared with the patient’s self-report.

Adequate opioid doses may be withheld because of misconceptions, ignorance and fears over addiction or respiratory depression. Studies

<table>
<thead>
<tr>
<th>Knowledge test (n=82): significant results</th>
<th>True</th>
<th>False</th>
<th>Percentage (number) correct</th>
<th>NR*</th>
</tr>
</thead>
<tbody>
<tr>
<td>The most common side effect of morphine is respiratory depression</td>
<td>X</td>
<td>48 (39)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>There are no studies that show that pethidine is more efficacious than morphine</td>
<td>X</td>
<td>54 (42)</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Observable changes in vital signs should be relied on to verify a patient’s statement that he or she has severe pain</td>
<td>X</td>
<td>68 (54)</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Patients may sleep in spite of severe pain</td>
<td>X</td>
<td>67 (54)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Beyond a certain dosage of morphine, further increases in dosage will not increase pain relief</td>
<td>X</td>
<td>45 (34)</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Morphine has a shorter half life than naloxone</td>
<td>X</td>
<td>70 (52)</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Non-steroidal anti-inflammatory drugs must never be given to asthmatics</td>
<td>X</td>
<td>60 (49)</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>The recommended route of administration of opioid analgesics to patients with brief, severe pain of sudden onset, for example, trauma or post-operative pain is (mark one): a) [X] intravenous b) [ ] intramuscular c) [ ] subcutaneous d) [ ] oral e) [ ] rectal</td>
<td>65 (52)</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The incidence of addiction resulting from treatment of post-operative pain with opioid analgesics is (mark one): a) [X] less than 1 per cent b) [ ] 1-5 per cent c) [ ] 6-25 per cent d) [ ] more than 25 per cent</td>
<td>67 (55)</td>
<td>–</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The percentage of patients who over-report the amount of pain they have is (mark one): 0 [X] 10 [ ] 20 [ ] 30 [ ] 40 [ ] 50 [ ] 60 [ ] 70 [ ] 80 [ ] 90 [ ] 100 [ ]</td>
<td>5 (4)</td>
<td>–</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* NR = non-respondents
have shown that it is rare (less than 1 per cent) for patients to become addicted when given opioids for acute pain (McCaffery and Pasero 1999). Carr (2000) found post-operative opioids were frequently prematurely discontinued, suggesting a lack of knowledge. Her work is supported by the results of this study.

**Progress**

Results of the study were presented to ward staff, managers, educationalists, divisional meetings of doctors and at a pain link nurse forum. A poster was also created to disseminate the main findings. Attitudes and practices have been changing over the past year based on recommendations for improvement to benefit staff and patients (Box 2).

**Progress in staff development**
The trust’s acute pain management course makes a positive difference not only to knowledge levels but also to confidence in acute pain management skills, which were greater in the nursing group. While an RCoA (2000) 100 per cent pass rate is too ambitious, in theory there should be no room for error with the goal of optimum comfort and minimal pain. An increase in attendance on the trust’s acute pain management course has followed and the course has now been awarded five postgraduate continuing medical education points from the RCoA which is attracting more medical staff. Links with the local university have been established with acute pain service involvement on post-registration courses but further work needs to be done to address pre-registration curricula. There is also a need to train nursing auxiliary/healthcare assistants (HCAs) because they are closely involved in patient care and monitoring. Competencies have been written for HCAs and formal training programmes are being considered. APS practitioners are being invited to the medical staff’s divisional education meetings to give presentations at mandatory induction days. Further, junior medical staff are undergoing a radical review of training in their foundation years. The results of this audit have influenced programme planners to include acute pain management training.

Specific clinical competencies in pain assessment, analgesia administration, PCA, epidurals, entonox, intravenous bolus opioids,
the IM algorithm and transcutaneous electrical nerve stimulation have been agreed which act as yardsticks for staff to measure their performance against and enable practitioners to plan their own learning strategies. Strategies range from formal courses to work-based learning such as rounds with the APS, visits to recovery and independent study supported by useful sources of learning provided by the APS (references, websites and networks). The trust executive is considering mandatory evidence of clinical competency.

The key to high quality, knowledgeable acute pain management is not only well-designed courses but also targeted clinical practice training. Cultural myths and misconceptions need to be dispelled. Success is not about new drugs, modern delivery systems or daily acute pain team rounds. Existing tools can do the job if doctors and nurses are educated in both the clinical area and the classroom, and take responsibility for providing quality care, particularly in relation to patient assessment and opioid administration.

Daily decisions regarding standard acute pain management (based on definitive guidelines or protocols, that is, discontinuing PCA or an epidural infusion) are now routinely being made by competent nurses rather than waiting for the traditional doctors’ round or acute pain team round. APS practitioners are now more available to help meet the needs of complicated cases such as patients with severe chronic pain and/or opioid tolerance, addiction or dependency problems. They are also able to focus more on teaching, monitoring, research and audit, and facilitating specific practice development initiatives in new areas such as radiology, obstetrics, paediatrics and accident and emergency.

A multidisciplinary acute pain development group representing nurses (link nurses), medical staff, pharmacy and physiotherapy meets twice yearly with the APS to share local initiatives, case studies, research, strategic information and problems in practice to ensure that local needs are being addressed, national initiatives are disseminated and misconceptions dispelled.

**Progress in patient care** The introduction of pre-printed prescription stickers at the hospital

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**TABLE 3**

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Doctors agreed % (n=33)</th>
<th>Nurses agreed % (n=49)</th>
<th>Percentage difference of opinion</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients' lack of understanding</td>
<td>71 (23)</td>
<td>80 (39)</td>
<td>9</td>
<td>0.45</td>
</tr>
<tr>
<td>Nurses' reluctance to administer analgesics</td>
<td>34 (11)</td>
<td>24 (12)</td>
<td>10</td>
<td>0.49</td>
</tr>
<tr>
<td>Patients do not say when they are in pain</td>
<td>66 (22)</td>
<td>78 (38)</td>
<td>12</td>
<td>0.32</td>
</tr>
<tr>
<td>Nurses' perceived lack of knowledge</td>
<td>64 (21)</td>
<td>47 (23)</td>
<td>17</td>
<td>0.22</td>
</tr>
<tr>
<td>Medical staff reluctance to prescribe analgesics</td>
<td>24 (8)</td>
<td>46 (22)</td>
<td>22</td>
<td>0.87</td>
</tr>
<tr>
<td>Inadequate staff knowledge</td>
<td>81 (27)</td>
<td>57 (28)</td>
<td>24</td>
<td>0.04*</td>
</tr>
<tr>
<td>Staff too busy</td>
<td>66 (22)</td>
<td>40 (20)</td>
<td>26</td>
<td>0.05*</td>
</tr>
<tr>
<td>Staff opioid phobia</td>
<td>53 (17)</td>
<td>26 (13)</td>
<td>27</td>
<td>0.03*</td>
</tr>
<tr>
<td>Patients' reluctance to take analgesics</td>
<td>30 (10)</td>
<td>67 (33)</td>
<td>37</td>
<td>0.02*</td>
</tr>
</tbody>
</table>

*Statistically significant (0.05 or less)
has reduced staff time and improved the standard of prescribing, ensuring regular multimodal analgesia, rescue analgesia for breakthrough pain, and anti-emetics and naloxone for opioid side-effect management. Assessment documentation has also improved with the production of unique ‘three-in-one’ patient monitoring charts for PCA and epidural infusions to guide practitioners on prescribing protocols, assessment, management and discontinuation requirements and side effects. These are kept at the patient’s bedside.

Improving the patient’s experience, contributing to his or her acceleration in recovery is at the centre of the APS philosophy and service profile. Encouraging patients to be more involved in their pain management both in hospital and at home will help to ensure that their expectations match their experiences. An audit of patient information is currently being planned.

Conclusion

To improve knowledge it is essential that healthcare professionals question their own beliefs and attitudes, accept their responsibilities for evidence-based acute pain management practice and be empowered to do so. The right sort of education can prepare them to execute tasks effectively but this depends on clinical practice settings developing positive cultures that uphold common professional values. The involvement and collaboration of staff has been fundamental to the achievements in acute pain management in the hospital setting. Progress, it is concluded, is not a result of education alone.

References


International Association for the Study of Pain (1993) Pain Curriculum for Nursing Education. IASP newsletter September/October 4-6.


IMPLICATIONS FOR PRACTICE

- Nurses and doctors continue to have misconceptions about opioid administration, which may result in doses being withheld from patients.
- Nursing and medical staff require improved standards of education and training in acute pain management.
- Patients should be encouraged to become more actively involved in their pain management both in hospital and at home.