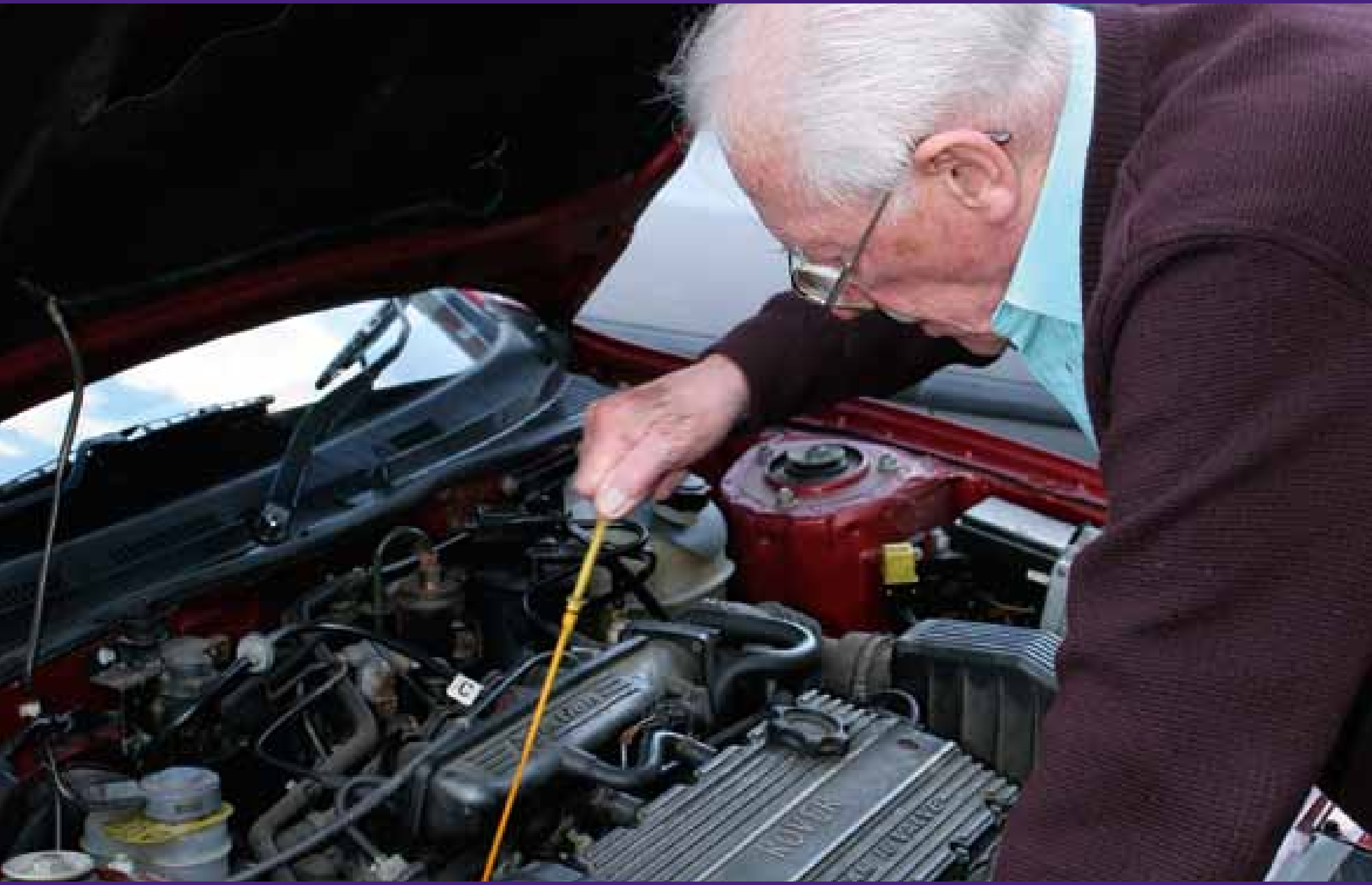
Essence of Care 2010

Benchmarks for the Prevention and Management of Pain



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Description	Essence of Care 2010 includes all the benchmarks developed since it was first launched in 2001, including the latest on the Prevention and Management of Pain. All the benchmarks have been reviewed to reflect the current views of people requiring care, carers and staff	
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Essence of Care 2010

BENCHMARKS FOR THE FUNDAMENTAL ASPECTS OF CARE

Benchmarks for the Prevention and Management of Pain

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Contents

Best Practice – General Indicators

The factors and indicators for each set of benchmarks focus on the specific needs, wants and preferences of *people* and carers. However, there are a number of general issues[1] that must be considered with every factor. These are:

People's experience

- *People* feel that care is delivered at all times with compassion and empathy in a respectful and non-judgemental way
- The best interests of *people* are maintained throughout the assessment, planning, implementation, evaluation and revision of care and development of services
- A system for continuous improvement of quality of care is in place

Diversity and individual needs

- Ethnicity, religion, belief, culture, language, age, gender, physical, sensory, sexual orientation, developmental, mental health, social and environmental needs are taken into account when diagnosing a health or social condition, assessing, planning, implementing, evaluating and revising care and providing equality of access to services

Effectiveness

- The effectiveness of practice and care is continuously monitored and improved as appropriate
- Practice and care are evidence-based, underpinned by research and supported by practice development

Consent and confidentiality

- Explicit or expressed valid consent is obtained and recorded prior to sharing information or providing treatment or care

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[1] Also see Department of Health (2010) NHS Constitution The NHS belongs to us all. Department of Health: London accessed 07 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113645.pdf

- *People*’s best interests are maintained where they lack the capacity to make particular decisions.[2]
- Confidentiality is maintained by all staff members

People, carer and community members’ participation

- *People*, carers’ and community members’ views and choices underpin the development, planning implementation, evaluation and revision of personalised care and services and their input is acted upon
- Strategies are used to involve *people* and carers from isolated or hard to reach communities

Leadership

- Effective leadership is in place throughout the organisation

Education and training

- Staff are competent to assess, plan, implement, evaluate and revise care according to all *people*’s and carers’ individual needs
- Education and training are available and accessed to develop the required competencies of all those delivering care
- *People* and carers are provided with the knowledge, skills and support to best manage care

Documentation

- Care records are clear, maintained according to relevant guidance and subject to appropriate scrutiny
- Evidence-based policies, procedures, protocols and guidelines for care are up-to-date, clear and utilised

Service delivery

- Co-ordinated, consistent and accessible services exist between health and social care organisations that work in partnership with other relevant agencies

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[2] Mental Capacity Act 2005 accessed 25 November 2008 at http://www.legislation.gov.uk/ukpga/2005/9/contents

- Care is integrated with clear and effective communication between organisations, agencies, staff, *people* and carers
- Resources required to deliver care are available

Safety

- Safety and security of *people*, carers and staff is maintained at all times

Safeguarding

- Robust, integrated systems are in place to identify and respond to abuse, harm and neglect[3]
- All agencies working with babies, children and young *people* and their families take all reasonable measures to ensure that the risks of harm to babies, children's and young *people*'s welfare are minimised.[4]

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[3] Department of Health (2010) Clinical Governance and Adult Safeguarding – An Integrated Approach Department of Health: London accessed 30 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh.digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112341.pdf

[4] Department of Health (2006) Safeguarding Children. A Summary of the Joint Chief Inspector's Report on Arrangements to Safeguard Children Department of Health: London accessed 30 May 2010 at http//www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103428

Benchmarks for the Prevention and Management of Pain

Agreed person-focused outcome

People and carers experience individualised, timely and supportive care that anticipates, recognises and manages pain and optimises function and quality of life

Definitions

For the purpose of these benchmarks, **pain** is:

> *whatever the person experiencing pain says it is, existing whenever the person communicates or demonstrates (voluntarily or involuntarily) it does (adapted from McCaffrey M. 1968)*[5]

and

> *an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage (Merskey and Bogduk 1994.)*[6]

The above definitions incorporate the concept of pain as a subjective and complex experience and include acute, chronic, intermittent, temporary, long term, acute on chronic etc pain and pain experienced at the end of life.

For the purpose of these benchmarks, **acute pain** is:

> *pain of less than 12 weeks duration or pain that occurs during the expected period of healing*

For the purpose of these benchmarks, **chronic pain** is:

> *pain of more than 12 weeks duration or pain that continues after the expected period of healing*

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[5] McCaffrey M (1968) Nursing Practice Theories Related to Cognition, Bodily Pain and Man-Environment Interactions University of California at Los Angeles Students' Store;Los Angeles

[6] Merskey H and Bogduk N (eds) (1994) Classification of Chronic Pain (2nd Edn) p210 International Association for the Study of Pain Task Force on Taxonomy. ISAP Press;Seattle WA

For the purpose of these benchmarks, **pain** management is:

> *any intervention designed to prevent or alleviate pain and/or its impact, such that quality of life and ability to function are optimised*

Since pain is complex, managing pain requires a holistic approach. Therefore, physical (including function), social, psychological, and spiritual aspects of pain need to be considered as part of assessment, care planning, implementation, evaluation and revision of practice and care.

For simplicity, ***people requiring care*** is shortened to *people (in italics)* or omitted from most of the body of the text. ***People*** includes babies, children, young people under the age of 18 years and adults. ***Carers*** (for example, members of families and friends) are included as appropriate.

The term ***carers*** refers to those who 'look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid' (Carers UK, 2002). Please note, within these benchmarks it is acknowledged that the term 'carer' can include children and young *people* aged under 18 years.

The term ***staff*** refers to any employee, or paid and unpaid worker (for example, a volunteer), who has an agreement to work in that setting and is involved in promoting well-being.

The ***care environment*** is defined as an area where care takes place. For example, this could be a building or a vehicle.

The ***personal environment*** is defined as the immediate area in which a person receives care. For example, this can be in a person's home, a consulting room, hospital bed space, prison, or any treatment/clinic area.

Agreed person-focused outcome

People and carers experience individualised, timely and supportive care that anticipates, recognises and manages pain and optimises function and quality of life

Factor	Best practice
1. Access	*People* experiencing pain, or who are likely to experience pain, and carers receive timely and appropriate access to services to manage pain
2. *People* and carer participation	*People* (where able), carers and staff are active partners in the decisions involving pain management
3. Assessment	*People* have an ongoing, comprehensive assessment of their pain
4. Care planning, intervention, evaluation, review and prevention	*People's* individualised care concerning pain is planned, implemented, continuously evaluated and revised in partnership with *people*, staff and carers
5. Knowledge and skills	*People*, carers and staff have the knowledge and skills to understand how best to manage pain
6. Self-management	*People* are enabled to manage their pain when they wish to, and as appropriate
7. Partnership working	*People*, carers and appropriate agencies work collaboratively to enable *people* to meet their pain management needs
8. Service evaluation and audit	Services are regularly reviewed and evaluated by *people*, carers, providers and commissioners for effect, breadth and equity

Factor 1

Access

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People and carers do not have access to timely and appropriate pain management

BEST PRACTICE

People experiencing pain, or who are likely to experience pain, and carers receive timely and appropriate access to services to manage pain

Indicators of best practice for factor 1

The following indicators support best practice for the prevention and management of pain:

a. *general indicators (see page 4) are considered in relation to this factor*

b. up-to-date information about pain management and services, and how to access them, is readily available in all care environments and (where applicable) given in advance of care. Information is provided in a suitable format and in plain language

c. appropriate and timely pain management and services are accessible for *people* with pain or anticipated pain (such as pain following surgery), and their carers. This includes interventions, resources, equipment, personnel and space to provide care, as well as urgent pain management when required

d. *people* and carers are enabled to access pain management services when managing further episodes of pain

e. commissioning organisations ensure that *people* have access to a full range of pain management services

f. a single point of access leads to appropriate pain management services that are co-ordinated

g. information concerning access to complementary therapies and services, and the evidence base for their use and possible effects, are available to *people*

h. there is equality of access to services for all *people* with pain or anticipated pain. This includes interventions, resources, equipment, personnel and space to provide care

i. *add your local indicators here*

Factor 2

People and carer participation

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People and carers are not given the opportunity to be involved in managing pain

BEST PRACTICE

People (where able), carers and staff are active partners in the decisions involving pain management

Indicators of best practice for factor 2

The following indicators support best practice for the prevention and management of pain:

a. *general indicators (see page 4) are considered in relation to this factor*

b. *people* are facilitated and supported to be partners in decisions involving their pain management. This includes *people* with special needs, specific cultural needs and/or those who are vulnerable. Advocates are used where appropriate[7]

c. *people's* and carers' decisions about managing pain are based on an understanding of choices and opportunities

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[7] National Institute for Mental Health in England (2008) Independent Mental Health Advocacy. Guidance for Commissioners. National Institute for Mental Health England: London accessed 07 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_097681.pdf
Department of Health (2002) National Standards for the Provision of Children's Advocacy Services Department of Health: London accessed 06 September 2010 at http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_4017049

d. *people* and carers are listened to, treated with respect and can discuss their concerns openly with staff. Where appropriate, *people* and carers are consulted separately

e. *people's* and carers' needs, views and preferences are sought actively (where possible) and incorporated into a realistic, appropriate pain management plan

f. *people*, carers and staff develop and agree a realistic, appropriate pain management plan

g. *people*, carers and staff understand the pain management plan

h. *people* and carers are involved in evaluation of their pain management plan

i. *add your local indicators here*

Factor 3

Assessment

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People have an inadequate pain assessment

BEST PRACTICE

People have an ongoing, comprehensive assessment of their pain

Indicators of best practice for factor 3

The following indicators support best practice for the prevention and management of pain:

a. *general indicators (see page 4) are considered in relation to this factor*

b. any health or social services encounter includes an enquiry about pain that leads to an appropriate referral as required

c. *people*'s pain management needs are identified on initial contact and as required

d. staff are competent to recognise when a person is experiencing pain, whether or not that person is able to describe the pain and/or its severity[8]

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[8] For example, with reference to guidance such as RCN (2009) **The Recognition and Assessment of Acute Pain in Children Update of Full Guideline** RCN: London accessed 21 June 2010 at http://www.rcn.org.uk/__data/assets/pdf_file/0004/269185/003542.pdf

e. staff are competent to assess pain and ascertain (where possible) the underlying cause of pain, or are able to refer onwards as appropriate

f. an evidence-based tool appropriate to the needs of *people* and their condition(s) is used to assess pain (including severity). This includes the use of, for example, standard and/or self-report data collection tools (where possible) and observation scales. Observation of behavioural expression or a report from a carer or advocate may be used where there are communication difficulties or to accommodate different cognitive levels

g. evidence-based information concerning pain assessment and management is accessible to *people* and carers in a suitable format and in plain language

h. physical (including function), social, psychological and spiritual aspects of *people's* pain and health profile are assessed (where possible) using evidence-based tools

i. the assessment process recognises *people's* and carers' perspectives, opinions and expectations of pain and its management

j. *people's* pain experiences and (where appropriate) previous treatment are included in the assessment, for example, whether the pain is acute, chronic, intermittent, temporary, long term and/or whether the pain has been treated palliatively etc

k. assessment includes consideration of the use, interactions and side effects etc of medications

l. the impact of strategies to manage pain are assessed. For example, on other treatments, or existing or long terms conditions

m. assessment of pain and management strategies by *people*, carers and staff is ongoing and is collaborative, and reviewed as appropriate. For example, pain is observed regularly along with other vital physiological measurements (that is, pain is one of the 'vital signs')

n. *add your local indicators here*

Factor 4

Care planning, implementation, evaluation, review and prevention

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People do not have a plan of care

BEST PRACTICE

People's individualised care concerning pain is planned, implemented, continuously evaluated and revised in partnership with people, staff and carers

Indicators of best practice for factor 4

The following indicators support best practice for the prevention and management of pain:

a. *general indicators (see page 4) are considered in relation to this factor*

b. planning, implementing, evaluating and revising care is a collaborative process that involves *people* and their carers or advocates (as appropriate), as well as all relevant members of staff

c. pain management plans are evidence-based[9] and reflect all the components of *people's* care including recognising the individual's experience of pain and expectations of pain relief, the agreed level of pain relief and function to be achieved, and/or the coping strategies required

d. a documented rationale for the pain management plan is in place

e. interventions, such as medication to prevent, reduce or remove pain, are provided promptly and the results evaluated. This includes the need to employ distraction methods for *people* and/or prescribe in anticipation of pain

f. access to a range of pain management interventions and services, such as psychological care and care at the end of life, is facilitated as appropriate

g. *people* and carers can initiate a review of pain management strategies as they require

h. *people* hold their own pain management records where appropriate

i. safety issues in relation to pain management, including the use of medication, risk of self-harm, increased risk of suicide, are addressed

j. staff are competent and plan, implement, evaluate and revise care and demonstrate a professional attitude to *people* who require their pain to be managed

k. *add your local indicators here*

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[9] For example, using guidance developed by the National Institute for Clinical Excellence such as NICE (2010) **Neuropathic Pain**. **The Pharmacological Management of Neuropathic Pain in Adults in Non-Specialist Settings** accessed 13 July 2010 at http://www.nice.org.uk/nicemedia/live/12948/47949/47949.pdf
Marie Curie Palliative Care Institute Liverpool (2009) **The Liverpool Care Pathway for the Dying Patient (LCP) Core Documentation. LCP generic document version 12, Supporting documentation** accessed 27 April 2010 at http://www.mcpcil.org.uk/pdfs/LCP%20V12%20Core%20Documentation.pdf

Factor 5
Knowledge and Skills

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People, carers and/or staff have inadequate knowledge and skills to manage pain effectively

BEST PRACTICE

People, carers and staff have the knowledge and skills to understand how best to manage pain

Indicators of best practice for factor 5

The following indicators support best practice for the prevention and management of pain:

a. *general indicators (see page 4) are considered in relation to this factor*

b. timely, individualised, correct and evidence-based information about *people's* pain and pain management and coping strategies, is provided, where appropriate, to enable *people* and/or carers to participate equally in decisions about the most appropriate package for managing pain

c. information concerning management strategies for pain, including complementary therapies, pain relieving injections and medicines etc, is available, together with a summary of the evidence base and an indication in which clinical conditions the treatments are effective.

d. information concerning assistance available when *people* cannot care for themselves (or carers cannot provide care), or in an emergency, is provided to *people* and carers

e. education and training needs of *people* and carers are assessed and learning outcomes are identified and met

f. *people* and carers are provided with ongoing, individualised evidence-based education and training to meet their pain management needs and preferences

g. the views and expectations of *people* and carers are used to inform the education and training programmes of *people*, carers and staff. This includes the use of *people's* testimonies such as in the Expert Patient Programme (DH 2008)

h. staff education includes the prevention of pain as well as the complexity and impact of pain on the social, physical, spiritual, emotional, psychological and economic well-being of *people* and carers

i. staff attitudes to *people* in pain and pain management are assessed and education put in place to ensure understanding of *people's* perspectives

j. commissioners have the knowledge and skills to commission a clinically and cost effective service for *people* with pain and their carers

k. *add your local indicators here*

Factor 6

Self-management

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

People have no opportunity to manage their own pain

BEST PRACTICE

People are enabled to manage their pain when they wish to, and as appropriate

Indicators of best practice for factor 6

The following indicators support best practice for the prevention and management of pain:

a. *general indicators (see page 4) are considered in relation to this factor*

b. all means are explored to enable *people* to manage their pain if they wish to do so, including consideration and support of *people's* and carers' capacity and capability

c. *people* are offered the opportunity to manage their pain, and/or its impact on their lives, to an acceptable level

d. *people* and carers have the opportunity to attend education programmes or sessions to enable them to manage pain

e. self-management plans are developed in partnership with *people*, carers and staff

f. ongoing assessment and review of self-management plans is evident

g. the organisation identifies and removes barriers to *people* managing their pain

h. *people* and carers are provided with up-to-date information about external resources, such as peer support groups and networks, Royal Colleges, the British Pain Society and web based services[10]

i. up-to-date evidence-based information is provided ont a range of resources and how to access them. This includes information about, for example, medication and technological, mechanical and electronic methods of pain management, or complementary therapies (as appropriate)

j. *people* and carers are enabled to use methods of pain control (where appropriate)

k. staff support is provided when requested for *people* and carers to manage pain

l. monitoring and assessment takes place for *people* who are administering medicines to themselves

m. the risk of harm to *people* and carers who are managing pain is assessed and revised to meet individuals' needs, including the need for good management of medicines

n. *add your local indicators here*

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[10] Web services such as http://www.healthtalkonline.org; http://www.patientopinion.org.uk/ or NHS Choices at http://www.nhs.uk/aboutnhschoices/aboutnhschoices/termsandconditions/pages/patientfeedback.aspx

Factor 7

Partnership working

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

Health and social organisations do not provide an integrated service and do not liaise with other relevant agencies

BEST PRACTICE

People, carers and appropriate agencies work collaboratively to enable people to meet their pain management needs

Indicators of best practice for factor 7

The following indicators support best practice for the prevention and management of pain:

a. *general indicators (see page 4) are considered in relation to this factor*

b. co-ordinated, continuous, consistent, multidisciplinary, multidimensional and accessible services exist between health and social care organisations within different environments that work in partnership with, for example, employers, voluntary organisations and schools, Royal Colleges, the British Pain Society, as appropriate and as agreed. A key worker co-ordinates continuing management and care

c. joint planning to facilitate *people's* desired outcomes is evident

d. opportunities exist for *people* and carers to participate in joint planning across agency boundaries, for example, as in the case of rehabilitation or end of life care

e. there is prompt and accurate information sharing between all involved in the management of care whilst meeting *people's* needs and ensuring confidentiality is demonstrated

f. an assessment and joint care review are undertaken by all relevant staff prior to *people* moving to another service and/or environment

g. joint documentation is utilised in the management of pain across agency boundaries (where appropriate)

h. *add your local indicators here*

Factor 8

Service evaluation and audit

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

POOR PRACTICE

No service evaluation is carried out

BEST PRACTICE

Services are regularly reviewed and evaluated by people, carers, providers, and commissioners for effect, breadth and equity

Indicators of best practice for factor 8

The following indicators support best practice for the prevention and management of pain:

a. *general indicators (see page 4) are considered in relation to this factor*

b. services that support *people* with pain and their carers are systematically reviewed and published at least annually and as required. Service review should include availability, access, quality, timeliness, and continuity of services; appropriateness of services for local health care needs; recorded pain scores; cost effectiveness and clinical effectiveness; staff attitudes; and an analysis of information obtained from complaints, letters, *people's* interviews, the national Patient Satisfaction Survey and Patient Advice and Liaison Services

c. risk is assessed and reassessed within an appropriate time frame

d. risks, incidents, complaints and concerns are recorded, monitored, analysed and the information used to improve care

e. a written evaluation of pain services is provided annually by staff and commissioners

f. *add your local indicators here*

Notes

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