in older patients and those with a mild/moderate cognitive impairment (Royal College of Physicians, 2007). It is suitable for patients with visual impairment.

Verbal descriptor scales
VDSs incorporate a numerical value and a description of pain intensity. The most frequently used tool for measuring POP in clinical practice is the 0–3 scale, where: 0 = no pain, 1 = mild pain, 2 = moderate pain, 3 = severe pain. The numerical value can be recorded as the fifth vital sign.

VDS scales are less sensitive to POP than the VNRS (ANZCA, 2010) but, like the VNRS, are easy and quick to teach and easy for patients to understand. Older patients and those with a mild/moderate cognitive impairment are able to use the VDS effectively, as are patients with a visual impairment (ANZCA, 2010).

Other tools
The VNRS and VDS may be difficult or inappropriate for some patients, for example unconscious/sedated patients, non-English speakers, those with learning disabilities or moderate to severe cognitive impairment. There are validated tools available for some groups of patients, for example, there are: a behavioural and/or physiological observation tool for unconscious/sedated patients (Tousignant-Laflamme, 2010); Disability Distress Assessment Tool (DisDAT) for patients with a learning disability (Regnard et al, 2007); and the Abbey Pain Scale for patients with a cognitive impairment (RCP, 2007).

REFERENCES


International Association for the Study of Pain (1994) IASP Pain Terminology. tinyurl.com/pain-terminology


Regional and local anaesthetics

Following interventions, pain intensity should be assessed again using the same tool, to evaluate the intervention’s effectiveness.

PHARMACOLOGICAL INTERVENTIONS

The World Health Organization analgesic ladder (tinyurl.com/WHO-pain-ladder-Palliative) is used in clinical practice to guide postoperative analgesic interventions.

As it was developed to guide pain relief for patients with cancer, it recommends that intervention should commence with mild analgesics, progressing to stronger analgesics as the pain intensity increases (WHO, 2007). However, POP is anticipated to be at its most severe immediately following surgery, and the intensity is expected to reduce over time as healing occurs (Büyük İlimaz et al, 2010). Its management is therefore more likely to start with strong analgesics with a subsequent reduction in the strength of analgesics until the pain has completely gone.

The WHO (2007) recommends that distinct guidelines need to be developed for acute pain. A useful analgesic guide for POP management is the descending ladder of acute pain (Bandolier, 2003), but it is not widely used in clinical practice (Fig 2).

Monitoring and management of side effects and complications following analgesic interventions is crucial.

CONCLUSION

For POP management to be effective, nurses need the knowledge and skills to select and implement appropriate assessment strategies and interventions. They must be able to evaluate these accurately and identify any problems. If this does not happen, patients will continue to experience unacceptable levels of POP and unidentified CPSP.