Developing and implementing a pain management benchmark

For most patients, pain is an inevitable part of the cancer journey. Pain may be acute or chronic, it may be related to the disease process or to treatments such as surgery, radiotherapy or chemotherapy. For 80–90 per cent of patients with cancer, effective pain relief could be attained using the analgesic guidelines outlined by the World Health Organization (1996). However, in routine practice this is not achieved (Portenoy and Lesage, 1999), which highlights the need to review and improve practice continuously.

In a recent Department of Health inpatient survey carried out at the Royal Marsden Hospital (DoH, 2002), a number of patients felt that their pain was not adequately controlled.

Staff decided to use the process of clinical benchmarking with the aim of reviewing and improving pain management practice in the hospital. There were four key stages:

- Planning;
- Implementation;
- Practice review and development;
- Evaluation.

Planning the benchmark The first step in the planning process was to set up a multidisciplinary working party. Although we had hoped to have representatives from a number of disciplines, time constraints and work schedules limited the number of people involved.

The final working party included a physiotherapist, a complementary therapist and a number of nurses working on wards and in specialist areas (such as practice development, pain management and palliative care). Our objectives for the working party were:

- To identify best practice for pain management;
- To facilitate the benchmarking process by supporting staff in its implementation;
- To identify and lead changes in practice across the trust that result from benchmarking.

A number of meetings were held over several months to agree best practice and to write the benchmark. This involved reviewing the relevant literature, including other pain benchmarks, and local and national pain management policies, guidelines and standards. It also involved drawing on the expertise of group members and medical colleagues.

From this review, six key factors were identified for benchmarking (Table 1). For each of these factors, we focused best practice statements on patient outcome and care rather than service availability, because in our opinion an effective patient outcome is not guaranteed by the availability of services alone.

The framework for the benchmark was based on benchmarks laid out in The Essence of Care (Department of Health, 2001). We outlined criteria/questions that could be used in the scoring process and included space for staff to document action points. We also incorporated an evaluation form for the paperwork used in the benchmarking process. This included questions such as: How did you find the instructions? Did scoring the benchmark enable you to set an action plan?

Once the benchmark was written, it was circulated to senior staff for comments and amendments.

Implementing the benchmark Before its implementation, members of the working party and senior nurses took responsibility for teaching staff how to use and score the pain benchmark. On clinical units staff were asked to complete the pain benchmark during the same two-month period so that the benchmarks could be reviewed collectively and any practice development issues affecting the whole trust could be identified.

Different approaches were used to score the benchmark— a number of units used their multidisciplinary team meetings as a forum for systematically scoring one or two factors each week. Where possible, benchmarking facilitators were invited to attend these meetings to stimulate discussion and help with the scoring process.

Reviewing and developing practice A total of 23 clinical units completed the pain benchmark across the Royal Marsden NHS Trust. The working party reviewed these benchmarks to identify good practice and areas that needed development. Benchmark findings were disseminated at the trust’s clinical practice forum.

Good practice Good practice was observed in units throughout the trust. For example, the intravenous therapy (IVT) team demonstrated high standards of care when managing pain associated with cannulation. Specific measures being used by IVT staff were:

- Involving patients in the choice of their cannulation site;
- Offering patients the use of topical anaesthetic agents to minimise pain at the puncture site;
- Using heat pads to aid venous vasodilation;
- Promoting a relaxed atmosphere during cannulation using music, television and aromatherapy oils;
- Building a therapeutic relationship with patients;
- Ensuring high standards of staff training and competence.
Other examples of good practice within the trust were found on rehabilitation and medical day units on which staff were promoting the use of non-pharmacological methods of pain relief, such as massage, relaxation and transcutaneous electrical nerve stimulation (TENS).

Making pain management a topic for the patients’ information board was also an area of good practice demonstrated by one of the private patient wards.

Areas for development At ward level, staff identified a need to improve education about pain, which they felt could be achieved through setting up ward-based journal clubs, teaching boards and focus groups. We encouraged staff to take responsibility for implementing these developments. Areas for practice development at trust-level focused on several different aspects of care.

Two specific examples were:
- **Pain assessment** Staff identified the need for a standardised tool that could be used to assess the pain felt by patients who had cancer. Although a chronic pain assessment tool existed, it was rarely, if ever, used and staff felt that it needed updating. As a direct result of this, the tool was changed to a patient-held pain assessment chart. We anticipate that when the new assessment tool is introduced into clinical practice, it will improve continuity of care because patients will bring their own assessment charts to hospital appointments. These charts will then be available for clinicians to monitor each patient’s pain, and evaluate the effectiveness of analgesic measures. The new patient-held pain assessment chart is due to be piloted throughout the trust in the next couple of months;
- **Study days** Nurses also identified the need for regular study days covering aspects of chronic pain management. To take this forward, the working party sent out a questionnaire to nurses and used the feedback to develop a programme for the study day. The first day has already been held and will be repeated on a regular basis.

**Evaluation of the benchmarking process**
The process resulted in a few challenges that need to be overcome:
- Not all clinical units could complete the benchmark within the two-month period due to busy workloads. Although this resulted in a delay in disseminating the trustwide action plans, this has not prevented developments taking place on units that completed the benchmark later;
- It was difficult to involve medical staff, even though their contribution would have been valuable;
- Staff in some outpatient areas (such as those in the radiotherapy department) found the benchmark difficult to complete, feeling it was not relevant to their specific area of practice.

Despite the challenges, the benchmarking process identified several areas of good practice. A more detailed review of these areas could help others adopt effective pain management methods.

**Conclusion**
The process of benchmarking pain at the Royal Marsden Hospital has proved to be an effective tool for establishing best practice, reviewing practice and identifying areas for development. Given the importance of pain management in primary and secondary health care settings, work should be undertaken to establish a national benchmark in accordance with the approach outlined in *The Essence of Care* (NHS Modernisation Agency, 2003).

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**TABLE 1. BEST PRACTICE STATEMENTS FOR SIX KEY PAIN MANAGEMENT FACTORS IDENTIFIED BY THE BENCHMARKING WORKING PARTY**

<table>
<thead>
<tr>
<th>FACTOR</th>
<th>BENCHMARK OF BEST PRACTICE</th>
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<tr>
<td>Pain assessment</td>
<td>Patients have an ongoing, comprehensive and holistic assessment of their pain. In cases where it is possible, patients are the prime assessors of their pain.</td>
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| Patient and/or family involvement and information | Patients and their family:  
- Are involved in the management of pain;  
- Have free access to evidence-based information;  
- Have the opportunity to discuss any information and its relevance to their individual needs with a registered health care professional. |
| Pain management                             | Patients have a comprehensive individualised pain management plan that is fully implemented. There are agreed patient/health care professional outcomes that are met, resulting in effective pain control. |
| Continuity of care                          | Patient care is coordinated and patients collaborate in the forward planning of their care. There is liaison with other health care agencies to ensure there is a seamless trajectory in the patient’s ongoing care. |
| Education and training for health care professionals | Patients have their pain managed by health care professionals who have up-to-date and relevant knowledge and possess the required clinical expertise. |
| Patient safety and review of practice       | Patients receive safe and competent care. To ensure practice improves there is a culture that allows health care professionals to review and reflect upon their practice, including accidents and clinical incidents. |