A lack of accountability for assessing and relieving pain has been cited as a major contributor to the undertreatment of pain in hospitalized patients.¹ The release of the Joint Commission on Accreditation of Health Care Organizations (JCAHO) pain management standards in 2001 has resulted in widespread interest in health care facilities to assess pain and implement protocols and care plans that attempt to address the needs of patients with pain. Unfortunately, many of these plans fail because they lack clear direction and do not hold clinicians accountable for relieving pain.

A simple and effective method for building in accountability for pain relief and improving patient outcomes is to establish and use comfort-function goals with patients. Establishment of a comfort-function goal requires clinicians to describe to patients the essential activities of recovery and discuss the direct link between pain control and improved outcome. Patients are then guided to identify a level of pain relief that will allow them to easily perform the essential activities. For example, a patient may decide a pain rating of 3 on a scale of 0 to 10 would allow the patient to cough, deep breathe, and ambulate postoperatively.²

Pain relief interventions during the postoperative period are implemented to achieve and maintain the patient’s comfort-function goal.³ At the time of transfer or at the end of each shift, nurses need to report to one another whether they were able to maintain this goal. The comfort-function goal provides a tangible mechanism for evaluating the health care team’s performance in terms of relieving pain and improving patient outcomes.

Teaching the Pain Rating Scale

The use of a pain rating scale is integral to the process of establishing the comfort-function goal. Therefore, the first step is to teach patients to use the facility’s pain rating scale, for example, the 0-to-10 numerical pain rating scale. Whenever possible, the scale is taught when patients are admitted to the facility. That is also the time when all patients are screened for the presence or history of pain. The preoperative teaching session provides the ideal opportunity to establish comfort-function goals with surgical patients. If patients are unable to do this preoperatively, it should be done as soon as possible postoperatively.

The patient should be taught that the pain rating scale will be used to communicate with the health care team about pain and to set goals for pain relief. They should be informed that staff will ask them regularly to rate their pain using the scale and that their reports of pain will be
taken seriously. It is particularly important to emphasize to surgical patients that until they are able to report their pain, nurses in the PACU will routinely administer analgesics in the immediate postoperative period.

The numbers on the scale can be described as representing levels of pain. Providing examples helps to clarify this concept. For example, patients can be told that a pain rating of 0 on a scale of 0 to 10 means no pain, pain ratings of 1 to 3 represent mild pain, 4 to 6 moderate pain, and a pain rating of 7 or higher means severe pain. Although most health care facilities use horizontal pain rating scales, it is important to remember that some patients may relate better to a vertical version of the scale.

Not all patients have a broad concept of the word *pain*. Tell patients that the word *pain* includes aching, hurting, pressure, and other kinds of discomfort. Asking patients to describe a type of pain they have experienced in the past will help to confirm that they understand the concept of the word *pain*. A patient who can describe experiencing, perhaps, a mild throbbing headache or a dull backache in the past probably understands the concept. Asking the patient to then select a number on the scale that rates what he/she thinks the intensity of the headache or backache was most of the time will help to determine if the patient understands how to use the scale. Next, the patient can be asked to rate that same pain when it was at its worst. Patients who are able to give a higher number when the pain was at its worst probably understand how to use the scale.

**Establishment of a Comfort-Function Goal**

Many patients will need help in establishing realistic comfort-function goals. Patients who choose a pain rating of zero probably have unrealistic expectations about the level of discomfort commonly experienced with surgery. They can be told to expect to feel pain, but that it can likely be reduced to a level that will not prevent them from performing their recovery activities well. Patients should be reminded throughout the postoperative period that they must inform staff if they are experiencing inadequate pain relief or are unable to accomplish their recovery activities.

The harmful effects of unrelieved pain should be reinforced in patients who identify high pain ratings. Studies show that pain ratings of 4 or higher interfere with function. It should be pointed out to patients that providing adequate analgesia postoperatively can reduce the stress response and improve cardiac, pulmonary, gastrointestinal, musculoskeletal, and cognitive function.

Patients who avoid analgesics or take them in insufficient amounts often have fears of addiction or adverse effects. Clinicians should assume that patients have these concerns and discuss them. The extremely low risk of addiction should be explained.

**Use of the Comfort-Function Goal to Treat Pain**

Diligent attention to achieving and maintaining the comfort-function goal is the key to achieving the best possible pain relief for postoperative patients. The goal should be documented on the same page and in close proximity to where ongoing pain ratings are documented. This will help to insure that it is used to provide direction for the treatment plan. There should be evidence in the medical record that pain ratings that exceed the comfort function goal are addressed. Pain relief interventions may include increasing the analgesic dose or adding another analgesic to the treatment plan.

Success, as well as difficulties encountered in achieving the comfort-function goal should be discussed during the transfer of care and shift report. It is used as a reference point when talking with other members of the health care
team, especially when changes in the treatment plan are suggested.

Finally, the health care facility’s quality improvement plan should include surveillance of the health care team’s achievement and maintenance of its patients’ comfort-function goals. Annual performance evaluations should include the clinician’s attention to this important aspect of care. This level of commitment to accountability for pain relief can result in a realization of the maximal benefits of pain relief, including increased patient satisfaction, improved patient outcomes, and shortened hospital stays.

Summary

A simple and effective method for holding clinicians accountable for assessing and relieving pain is the use of comfort-function goals. The comfort-function goal provides direction for both the patient and the clinician by establishing expectations of care. Pain relief interventions are implemented to achieve and maintain the patient’s comfort-function goal. The health care team’s attention to this goal can be used as a quality improvement indicator.

References

4. Joint Commission on Accreditation of Health Care Organizations (JCAHO): Hospital Accreditation Standards. Oakbrook, IL, JCAHO, 2000

CALENDAR OF EVENTS

February 22, 2003. The Annual Spring Seminar in Fresno, CA. A combined seminar with NePANA is planned for March in Las Vegas, NV. Annual Meeting and Seminar is scheduled for October 17 and 18, 2003 in Lake Tahoe, CA. Check the PANAC Web site for details on program content: www.panac.org.

April 16-10, 2003. ASPAN’s 22nd National Conference, Albuquerque, NM.