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Full Length Research Paper

Evaluation of nurses' actions and opinions on pain assessment of hospitalized patients at Federal Teaching Hospital, Abakaliki

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Abstract

The study of nurses' actions and opinions during pain assessment of hospitalized patients' pain was done using cross – sectional descriptive research design. 450 nurses randomly selected from Federal Teaching Hospital, Abakaliki, Ebonyi State capital were used for the study. Questionnaire developed by the researchers whose reliability was established using test – retest technique was used as instrument. Descriptive statistics of mean and percentage were used to analyze the qualitative data. Nurses from the two hospitals were aware of the basic component of pain assessment with mean score greater than 3.00 in a five paint hedonic scale . They agreed that they assess pain routinely when other vital signs are checked, during initial health assessment, when patients complain of pain, before and other giving pain relieving drugs with mean score of 3.99, 4.17, 4.11 and 4.13 respectively. These results indicate that nurses know what to do during the pain assessment of patients in the hospital. It is recommended that nurse should be given more training to sustain their knowledge and further studies should be carried out to ascertain if they really do those things.

Key Words: Nurses' action, pain assessment, hospitalized patient, Nurses' Opinion.

INTRODUCTION

Nurses' perception of hospitalized patients' pain assessment stand absolutely essential in determining the actual pain assessment and management in improving quality of life of the patient. Although physicians order the types and doses of analgesics yet nurses are in the best position to influence patients' pain as the drugs are administered. When pain assessment is appropriately done it leads to proper pain management, quick recovery, shorter hospital stay, fewer admission and improved quality of life (Gregory 2000).

Patients' pain assessment comprised of relevant history of pains, physical examination and observation of behavioral and physiologic responses, additional investigations of biological structures, functions and documentation of pain data. It is a systematic and complex process, time consuming but a viable strategy for essential quality nursing care. It exists whenever the patient says it exist (McCoffery and Ferrel 2000).

Due to the subjective nature of pain, it is pervasively and poorly treated in most hospital setting (Smeltzer and Bare 2004) while it is one of the most common reasons people seek treatment in the hospital (McFachin 2002).

Inadequate pain assessment has been sited as the greatest barrier to pain management and this is attributed to inadequate knowledge of pain assessment. (Clark 2005, Mac Donald et al 2002, Langhlin and Tabler 2001). It was recommended by American pain society (APS) that pain assessment should be made the fifth vital sign so as to link pain assessment to routine vital sign assessment performed by nurses and its documentation is to ensure proper pain management (American Pain Society 2001, Berman et al 2008)

Knowledge is a basic factor that facilitates changes because people act based on their previous understanding about things. This means that when nurses have a good knowledge of pain their patients

Table 1: Nurses' actions during pain assessment of hospitalized patients' pain.

S/N Option	SA 5	A 4	D 3	SD 2	NOP 1	Total	- X
1. During pain assessment nurses.							
A. Collect relevant pain history from patient	200	63	24	50	83	420	3.58
B. Observe their behavioral responses	67	77	89	145	42	420	3.00
C. Observe patients' physiologic responses	186	181	40	12	1	420	4.28
D. Document patients' pain	137	143	87	50	3	420	3.86
2. Patients' pain assessment is done							
A. Routinely, whenever other vital signs are checked	147	159	79	31	4	420	3.99
B. During initial health assessment on Admission	178	164	53	23	2	420	4.17
C. When patients complain of pain	163	181	41	28	7	420	4.11
D. Before and after giving a pain relieving therapy	173	169	41	35	2	420	4.13
3. Nurses do not assess patients' pain at times in details for the following reasons.							
A. They view it exclusively as doctors' duty	110	106	68	125	11	420	2.75
B. It is time consuming	88	108	99	119	6	420	2.73
C. Is too demanding	34	80	138	150	18	420	2.91
D. Have so many patients to care for	72	86	114	139	9	420	3.17

receive a higher standard of pain assessment and management (William 2007). Pain assessment history procedure includes the nurse giving the patient chance for self reporting. The patient is asked to report the location, intensity of the pain, quality, pattern, alleviating factor, associated symptoms (Berman et al 2008). The next step involved the nurse observing the behavioral and physiological responses to the pain which include effect on activities of daily living, coping resources and effective response of the patient and the family (Mayer et al 2001). Pains are monitored actively by nurses using visual analogue scale (VAS), simple descriptive pain intensity scale, 1- 10 numeric intensity scale and Wong – Baker face pain rating scale (Soyannwo et al 2000, Hick and Von Spafford 2001, Hunter et al 2000 and Gregory 2000).

It is very important to know what actions and opinions of nurses in assessment of patient in pains. Hence this study to evaluate nurses actions and opinions during pain assessment.

METHODOLOGY

A cross sectional descriptive research design was used to study nurses actions and opinions on pain assessment of hospitalized patients. 450 nurses randomly selected from Federal Teaching Hospital in Abakaliki, Ebonyi State capital Abakaliki were used. The data were collected using questionnaire developed by the researchers and the reliability was established using test – retest technique and the spearman's product moment correlation yielded a co-efficient of 0.86.

The questionnaire was administered by researchers between December 2012 – April 2013 and data collected and analyzed SPSS version 16 – was used to analyze T-test and ANOVA of 0.05 level of significance.

RESULT

The result of nurses action during pain assessment of hospitalized patients are shown on table 1.The results show that nurses collect relevant pain history from patients, observe their behavioral/physiologic responses and document their pain response when pain assessment is undertaken, with mean scores of 3.58,3.00,4.28 and 3.86 respectively. They respectively assess patients pain routinely whenever other vital signs are checked (3.99), during initial health assessment on admission (4.17), when they complain of pain (4.11), before and after giving pain relieving therapy,(4.13). However the in depth interview guide with heads of units showed that during pain assessment they carry out the aforementioned activities but less of doing them routinely when other vital signs were being done. They did not regard pain assessment as only doctors' duty, time consuming or too demanding. These items scored 2.75,2.73 and 2.91 respectively they accepted that at times, they do not assess patients pain in detailed because they have too many patient to be cared for, and this scored 3.17 The result in table 2 shows nurses opinion of patient report of pains. The results shows that Nurses recognized that they were not the best assessors of patients pain (2.99 on 5 point hedonic scale) rather patients were the best assessors (3.88).However, nurses

Table 2: Nurses' opinion on patients' report of pain.

S/N	Assertions	SA 5	A 4	D 3	SD 2	NOP 1	Total	- X
4.	The following statements refer to nurses' opinion on patients pain.							
A.	Patient are best assessors of their Pain.	176	92	80	68	4	420	3.88
B.	Patients' verbal report is highly subjective therefore should not be relied on always.	104	117	96	98	5	420	3.52
C.	Patients at times over-report their level of pain to gain attention.	170	163	56	31	1	420	4.12
D.	Patients will be addicted to pain relief and if nurses should rely on their verbal report of pain.	118	161	84	54	3	420	3.80
E.	Management of patients' pain would be very effective when nurses accept and believe the patients' verbal report of pain.	132	164	94	28	2	420	3.94
F.	Validation of patients' pain can effectively be done with patients' verbal report of pain only.	93	119	140	62	6	420	3.55
G.	Nurses are the best assessors of Pain.	108	118	120	70	4	420	2.58
H.	Visible physiologic or behavioral signs must accompany patients' verbal report of pain to verify its existence.	146	113	102	57	8	420	3.80

assert that patients often over report their level of pain to attract attention (4.12).Majority had the fear that patients will be addicted to pain relief drugs if nurses rely on their verbal report only (3.80), hence nurses were of the opinion that visible physiologic or behavioral signs must accompany patients verbal pain report as verifiers (3.80).This seems to contradict their view that management of patients pain can effectively be done with patient verbal report only

DISCUSSION

As presented on Table 1, nurses reported that they assess patients pain routinely, whenever other vital signs are checked, during initial health assessment on admission. Nurses in addition, assess pain when patients complain of it. They also assess pain before and after administering pain relieving therapy. These findings supported Mayer (2001), that pain assessment should be done routinely as other routine vital signs, as declared by the American Pain Society to all healthcare system. Nurses were quite aware of the declaration of pain assessment as the fifth vital sign. However, the qualitative study by the research through (in-depth interview of unit heads of the nurses) revealed that (100%) of nurses do not assess pain routinely when other vital signs are being done. This could be, that despite the awareness of the respondent on the declaration of pain as fifth vital sign, they did not practice it, especially when they had many patients to care for, as indicated in table 2 (item 9d). In other words they are quite aware of the right things that should be done during pain assessment but do not do it in practice. This assertion is based on the varied findings from the two instruments used. It revealed a gap in their awareness and what they practice. This clearly portrayed one of the weaknesses of using only questionnaire in eliciting information from the respondents.

Responding to the reasons that made nurses not to assess patients' pain in details, they opined that at times they may have so many patients to care for. This agrees with the findings of Ellen et al (2009) who identified workload as one of the greatest barrier to pain assessment. Despite this perceived barrier most of the nurses in this study did not accept that pain assessment is time consuming and too demanding (2.73). It is important that nurses accepted carrying out pain assessment as their legitimate duties because they know its importance. Their rejecting pain assessment as being time consuming implied that nurses are indeed aware and accepted that to ensure quality nursing care, that pain assessment should remain one of their core duties in the hospital irrespective of the burden of work on them. The findings agree with MacCaffery and Ferrel (2000) observations that pain assessment may be complex and strenuous to the assessor but that it remains a viable strategy for essential healthcare. Asterin (2003) stated that since assessment and documentation of other vital signs are done by nurses, likewise pain assessment should equally be carried out by the nurses.

Findings on nurses' opinion on patients report verbal report of pain, Table 2 (Item 4) showed that respondents accepted that patients are the best assessors of their pain and that effective validation of patients' pain would be done with patient's verbal pain report. This findings disagree with McMillian et al (2000) who found that 5% of the nurses indicated that their estimated of patients' pain more valid than the patients' own. Most conscious patients always made verbal report of their pain,

directing the nurses on the direction where their pains were felt. Gregory (2006) also pointed out that patients are the best assessors of their pain and not nurses. McCaffery et al (2000) also pointed out that pain as a subjective experience was what the patient said it was, and existed wherever the patients said it did exist. It is not for nurses to doubt patients' report of pain. Respondents on the other hand felt that patient's verbal report of pain is highly objective and that patients could a time over report their pain to attract attention. This seems to contradict their afore stated response on patient being the best assessor of their pains. This revealed that despite their awareness on pain assessment, they still don't believe patients' report in practice. This attitude to patients' pain report is at variance with American Pain Society, (2005) that it is the responsibility of the patients to complain or prove that they are in pain, while the onus lies on the nurses to accept the patients' pain report. Peter and Water-Watson (2002) also stated that nurses appear to distrust patients' self –report of pain which suggests that they may have their own bench mark of what is acceptable, when and how patients should express pain. These nurses were of the view that patients would be addicted to pain reliefing drug if nurses should rely on their verbal pain report. These are perceptual misconceptions often based on ignorance. Despite the nurses' good awareness on pain and what should be done during pain assessment they still fear that patients should be addicted to pain relieving drugs if they should attend to them according to their pain report. This revealed clearly the indispensable nature of nurses' perception in pain assessment.

It could be concluded from the study that nurses take right action in the hospitalized patients' pain assessment and despite the heavy workloads, nurses still take time to assess pains in hospitalized patients. Nurses also agreed that effective validation of patients' pain is done with patients' verbal pain report.

It is recommended that nurse managers should ensure that patients' pain assessment be done routinely as other vital signs unconditionally. Intensive training programme should be organized for nurses to update their knowledge of pain assessment.

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