THE CHRONIC PAIN NURSE IN LANCASTER: A PILOT STUDY

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INTRODUCTION

In 1996, two factors combined to shape the present work of the nurse practitioner in chronic pain. Firstly, the tide of change within the NHS carried "skill mix" to a position of prominence in many specialties and the time was right to explore the role of nurse practitioner in chronic pain management within the department of anaesthetics. Secondly, I had an enforced change of career. Whilst employed as a Sister on the Intensive Care Unit (ICU) at the Royal Lancaster Infirmary, I tested positive to methicillin resistant staphylococcus aureus (MRSA) after caring for an MRSA-infected patient. This subsequently proved difficult to treat, and my sixteen-year career as an intensive care nurse ended for what seemed like the foreseeable future. What follows is a description of a job in evolution which, as there are no footprints to follow, is necessarily quite personal.

A CHANGE OF DIRECTION

For some time the subject of pain has been of special interest to me, although in 1996 my primary interest was in acute pain. No longer being allowed to work in the ICU, one secondment led me to the Department of Pain Management. During an interim period whilst my longterm future was still uncertain, I became involved in several areas:

- I undertook an audit of pain relief following day case surgery. The findings from this have resulted in changes in analgesia prescribing practice, and in the way in which information regarding analgesia is presented to patients. Once the changes have been fully implemented we hope to demonstrate an improved quality of pain relief and satisfaction for day case patients
- I was responsible for compiling a resource package on epidural analgesia and its administration, including a hospital policy and procedure prior to implementing a ward-based epidural service. This was followed by several inhouse training days for ward staff run by myself and the Acute Pain Nurse, Lee Jolly.
- I attended the consultant-led Pain Management Clinics to provide patients with and instruct them in the use of transcutaneous electrical nerve stimulation (TENS), following which the patient is loaned a machine for a trial period. With improved monitoring, regular review and follow up, the patient waiting time to receive a TENS trial (following medical consultation) fell from five months to nothing.

The chronic pain experience – the beginnings

Attending these clinics in late 1996 I gained further insight into the subject of chronic pain and soon became aware how often it can encompass every aspect of a person's life. I

quickly realised how complex the subject is, but how challenging, potentially rewarding and sometimes mentally exhausting it could be.

APPOINTMENT OF A CHRONIC PAIN NURSE – A ONE-YEAR PILOT STUDY

From 1 August 1997 I was appointed to the position of Chronic Pain Nurse for an initial period of one year. The post evolved as a result of a successful proposal by Lancaster Acute Hospitals NHS Trust to the Regional Health Authority to obtain funding to conduct a twelve-month pilot study to explore and develop the nurse's role within a pain management service, with particular reference to the workload of the two consultant anaesthetists, Drs Vickers and Severn. This proposal was submitted in response to a Scoping Study undertaken for the National Health Service Executive⁽¹⁾ at a time when there was a national shortage of trained anaesthetists ready to take up consultant posts. It concluded, amongst other things, that "*there is obvious scope for the adjustment of professional roles within the anaesthetic service . . .*", but that "*NHS trusts should be encouraged to avoid ad hoc developments which involve significant adjustment of professional roles*". Following a directive from Region, it is hoped that the Research & Development (R & D) Department at Lancaster University will undertake an independent evaluation of the post and present the findings to an external audience, including the funders. This may have wider implications for other such positions nationwide. It is proposed that the evaluation of the pilot project be based upon the activities I undertake.

THE PRIMARY AIM OF THIS PILOT PROJECT: TO EASE CONSULTANT WORKLOAD

How might this objective be achieved?

- i) The Chronic Pain Nurse could perform repetitive tasks, eg psychometric questionnaires
- ii) The nurse assumes responsibility for taking a history and gathering other relevant data
- iii) Patients could see a nurse for drug reviews. The nurse could use drug algorithms to adjust medication using the agreed policy. Telephone follow-ups could often replace an outpatient visit. Two studies^(2,3) in rheumatology clinics, with which pain management clinics can perhaps be compared, showed that most patients attending rheumatology clinics do not need to see a doctor.

Secondary benefits

(a) To the patient:

- improved management, eg monitoring and safety of treatments, increased compliance (drugs/TENS)

- shorter waiting times for new appointments
- improved access to information, advice, support and guidance, which will help to decrease patients' anxiety about treatments
- increased satisfaction through information received and empathy experienced. Since patients are usually more willing to confide in a nurse, the nurse can significantly improve the communication of patients' needs to other team members
- reduced visits to the GP
- continuity of care throughout the treatment package

(b) To the trust:

- shorter waiting times for new appointments
- increased throughput (greater capital generated)
- improved quality and raised awareness of the pain management service. Satisfaction identified via patients to fundholders
- reduction in capital lost from misplaced equipment through improved monitoring of equipment loans
- reduced expenditure elsewhere. Fewer patient referrals to other specialties (treatment shopping), fewer visits to GPs, reduced drug bill due to the rationalisation of therapy (more national research required)

(c) To the nurse:

- *career development*: an opportunity to be innovative, to develop skills and to gain a higher qualification. There is, however, currently no set standard for the specialist nurse in the pain setting
- *job satisfaction*: to be part of a multi-disciplinary team making a valuable contribution towards an improved quality of life to those patients limited by pain and discomfort (whilst recognising that cure is often impossible), to care for and help patients help themselves, and to support them and their families.

The first six months

A significant part of the first six months in post has been spent gaining the appropriate background knowledge relevant to the job. This has included liaison with other members of the pain team, networking with other pain management services throughout the country, personal study, attending meetings, lectures, short courses and so on. I have spent some days visiting and observing practice at the pain services of the following hospitals: Chesterfield, Blackpool and Royal Preston.

HOW THE POST HAS DEVELOPED SO FAR

• Patient assessment

I now see and assess new patient referrals in clinic prior to the medical consultation. This involves obtaining demographic details, a pain history, past treatments and medications and if these were of any help, any other medical history, psychosocial and family history, psychometric tests, such as Mod Zung and MSPQ, and a disability score.

• Drug reviews

With the aid of drug algorithms I monitor patients' newly-prescribed drug treatments for efficacy, outcome and safety in

Figure 1 An example of a drug algorithm: Amitriptyline

order to optimise compliance. Examples of drugs used are amitriptyline, (see Figure 1) lamotrigine, carbamazepine and gabapentin. Although these are not licensed drugs for use in chronic pain, they are recognised as being effective in the management of some painful conditions. Response is very individual so drug doses are carefully monitored to achieve maximum analgesic effects with the minimum of side effects.

• Written information for patients

To support the verbal information given in clinic I have produced leaflets on:

- various drug treatments, such as amitriptyline and carbamazepine
- a variety of the pain-relieving procedures performed as day cases, for example facet joint injections, epidurals and paravertebral injections.

• TENS

Where TENS machines are offered as part of a patient's pain management, I advise on their use and electrode placement, etc. Records of issue, efficacy and outcome are monitored.

• Written information for ward staff

For ward staff caring for the chronic pain patients admitted as a day case I have compiled an information file on the common procedures undertaken by the two pain specialists.

• Day case procedures

Prior to day case pain-relieving procedures such as epidural or facet joint injections I visit patients to provide reassurance, to clarify and explain what will happen, the anticipated

outcome, possible side effects and what is expected of the patients afterwards. Post procedure I will check the patients to monitor the effects and check on their well-being.

● **Telephone follow-up**

With the patients' permission I have recently started to make contact by telephone approximately two days following a daycase procedure to check progress. When appropriate some patients, especially the elderly, are contacted soon after commencement of any new drug therapy to check for adverse side effects or problems.

● **Telephone helpline**

Patients are told they may contact me at any time during working hours by telephone for advice or to discuss any problems with treatments. If I feel it is necessary I will arrange an outpatient appointment with myself or the consultant in charge of their care. They are also given the Pain Management Secretary's telephone number in case they need to make contact regarding an appointment attendance.

● **Patient records, outcomes, audit**

More recently I have become keen to establish a database of patients seen by the Pain Management Service. This is primarily to improve record keeping and improve efficiency, to monitor outcomes and assess efficacy of treatments, etc. With as much patient detail as possible entered on computer, it is hoped to provide a useful tool for ongoing audit purposes, both locally and nationally.

● **Domiciliary visits**

At present these are made on an occasional, discretionary basis.

● **Resource person**

As other professional colleagues become aware of my existence, including those in primary care, I am increasingly approached for information relating to chronic pain issues.

HOW I SEE MY ROLE AND PLANS FOR THE FUTURE

This is a new position, which I have found both challenging and stimulating. I am grateful for the encouragement,

guidance and ongoing support of my two consultants. Like so many nurses in similar positions, not having had previous training in the field much of my learning has had to be self-directed. Working as part of a multidisciplinary team I find there are several areas to cover: clinical, educational and research. Clinical and educational responsibilities are for the patients, myself and colleagues. It is important that I keep up to date with current developments and research, applying them clinically and being a resource for others. Chronic pain is an important growth area of research. To enhance my knowledge of effective pain management and develop my academic skills, I began the ENB N53 course in April with a view to progressing to higher levels of pain-related study in the future – perhaps even an MSc.

The time ahead is an exciting one. Now that the trust merger plans are going ahead, further expansion of the pain service could be a possibility. It would be a huge asset to have greater input from psychological and physiotherapy services, which could provide functional rehabilitation and facilitate changes in patients' lifestyles. For pain management to be effective I believe the multidisciplinary approach is the best way forward and one in which a nurse has an important place. I feel the pain service at the Royal Lancaster Infirmary has preempted some of the recommendations of the recently published audit commission report "Anaesthesia Under Examination"⁽⁴⁾ by the work it already undertakes. I hope this will increase the chances of the permanent employment of a Chronic Pain Nurse in Lancaster after 1 August 1998. Watch this space . . . !

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