Essence of Care 2010
Benchmarks for the Prevention and Management of Pain
<table>
<thead>
<tr>
<th><strong>Document Purpose</strong></th>
<th>Best Practice Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ROCR Ref:</strong></td>
<td><strong>Gateway Ref:</strong> 14641</td>
</tr>
<tr>
<td><strong>Title</strong></td>
<td>ESSENCE OF CARE 2010</td>
</tr>
<tr>
<td><strong>Author</strong></td>
<td>DEPARTMENT OF HEALTH</td>
</tr>
<tr>
<td><strong>Publication Date</strong></td>
<td>1ST OCTOBER 2010</td>
</tr>
<tr>
<td><strong>Target Audience</strong></td>
<td>PCT CEs, NHS Trust CEs, Care Trust CEs, Foundation Trust CEs, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, PCT PEC Chairs, Special HA CEs, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs, Universities UK, RCN, RCM, AHPF, SHA Lead Nurses, SHA AHP Leads, Patient Organisations</td>
</tr>
<tr>
<td><strong>Circulation List</strong></td>
<td>PCT CEs, NHS Trust CEs, Care Trust CEs, Foundation Trust CEs, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, PCT PEC Chairs, Special HA CEs, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs, Voluntary Organisations/NDPBs, Universities UK, RCN, RCM, AHPF, SHA Lead Nurses, SHA AHP Leads, Patient Organisations</td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td>Essence of Care 2010 includes all the benchmarks developed since it was first launched in 2001, including the latest on the Prevention and Management of Pain. All the benchmarks have been reviewed to reflect the current views of people requiring care, carers and staff</td>
</tr>
<tr>
<td><strong>Cross Ref</strong></td>
<td>Essence of Care 2001, Communication, Promoting Health and Care Environment</td>
</tr>
<tr>
<td><strong>Superseded Docs</strong></td>
<td>Essence of Care 2001 Gateway No. 4656 and 8489</td>
</tr>
<tr>
<td><strong>Action Required</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Timing</strong></td>
<td>N/A</td>
</tr>
</tbody>
</table>
| **Contact Details** | Gerry Bolger  
CNO Directorate - PLT  
5E58, Quarry House  
Quarry Hill, Leeds  
LS2 7UE  
01132546056  
www.dh.gov.uk |
| **For Recipient's Use** | |
Essence of Care 2010

*BENCHMARKS FOR THE FUNDAMENTAL ASPECTS OF CARE*

Benchmarks for the Prevention and Management of Pain
Contents

Best Practice – General Indicators 4

Factor 1
Access 10

Factor 2
People and carer participation 12

Factor 3
Assessment 14

Factor 4
Care planning, implementation, evaluation, review and prevention 16

Factor 5
Knowledge and skills 18

Factor 6
Self-management 20

Factor 7
Partnership working 22

Factor 8
Service evaluation and audit 24
Best Practice – General Indicators

The factors and indicators for each set of benchmarks focus on the specific needs, wants and preferences of people and carers. However, there are a number of general issues\(^1\) that must be considered with every factor. These are:

**People’s experience**
- People feel that care is delivered at all times with compassion and empathy in a respectful and non-judgemental way
- The best interests of people are maintained throughout the assessment, planning, implementation, evaluation and revision of care and development of services
- A system for continuous improvement of quality of care is in place

**Diversity and individual needs**
- Ethnicity, religion, belief, culture, language, age, gender, physical, sensory, sexual orientation, developmental, mental health, social and environmental needs are taken into account when diagnosing a health or social condition, assessing, planning, implementing, evaluating and revising care and providing equality of access to services

**Effectiveness**
- The effectiveness of practice and care is continuously monitored and improved as appropriate
- Practice and care are evidence-based, underpinned by research and supported by practice development

**Consent and confidentiality**
- Explicit or expressed valid consent is obtained and recorded prior to sharing information or providing treatment or care

People’s best interests are maintained where they lack the capacity to make particular decisions.  
Confidentiality is maintained by all staff members

People, carer and community members’ participation

People, carers’ and community members’ views and choices underpin the development, planning implementation, evaluation and revision of personalised care and services and their input is acted upon

Strategies are used to involve people and carers from isolated or hard to reach communities

Leadership

Effective leadership is in place throughout the organisation

Education and training

Staff are competent to assess, plan, implement, evaluate and revise care according to all people’s and carers’ individual needs

Education and training are available and accessed to develop the required competencies of all those delivering care

People and carers are provided with the knowledge, skills and support to best manage care

Documentation

Care records are clear, maintained according to relevant guidance and subject to appropriate scrutiny

Evidence-based policies, procedures, protocols and guidelines for care are up-to-date, clear and utilised

Service delivery

Co-ordinated, consistent and accessible services exist between health and social care organisations that work in partnership with other relevant agencies

---

Care is integrated with clear and effective communication between organisations, agencies, staff, people and carers

Resources required to deliver care are available

**Safety**

- Safety and security of people, carers and staff is maintained at all times

**Safeguarding**

- Robust, integrated systems are in place to identify and respond to abuse, harm and neglect

- All agencies working with babies, children and young people and their families take all reasonable measures to ensure that the risks of harm to babies, children’s and young people’s welfare are minimised.

---


Benchmarks for the Prevention and Management of Pain

Agreed person-focused outcome

*People* and carers experience individualised, timely and supportive care that anticipates, recognises and manages pain and optimises function and quality of life.

Definitions

For the purpose of these benchmarks, **pain** is:

> whatever the person experiencing pain says it is, existing whenever the person communicates or demonstrates (voluntarily or involuntarily) it does (adapted from McCaffrey M. 1968)\(^5\)

and

> an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage (Merskey and Bogduk 1994.)\(^6\)

The above definitions incorporate the concept of pain as a subjective and complex experience and include acute, chronic, intermittent, temporary, long term, acute on chronic etc pain and pain experienced at the end of life.

For the purpose of these benchmarks, **acute pain** is:

> pain of less than 12 weeks duration or pain that occurs during the expected period of healing

For the purpose of these benchmarks, **chronic pain** is:

> pain of more than 12 weeks duration or pain that continues after the expected period of healing

---

\(^5\) McCaffrey M (1968) Nursing Practice Theories Related to Cognition, Bodily Pain and Man-Environment Interactions University of California at Los Angeles Students’ Store; Los Angeles

\(^6\) Merskey H and Bogduk N (eds) (1994) Classification of Chronic Pain (2nd Edn) p210 International Association for the Study of Pain Task Force on Taxonomy. ISAP Press; Seattle WA
For the purpose of these benchmarks, **pain** management is:

> any intervention designed to prevent or alleviate
> pain and/or its impact, such that quality of life
> and ability to function are optimised

Since pain is complex, managing pain requires a holistic approach. Therefore, physical (including function), social, psychological, and spiritual aspects of pain need to be considered as part of assessment, care planning, implementation, evaluation and revision of practice and care.

For simplicity, **people requiring care** is shortened to **people** (*in italics*) or omitted from most of the body of the text. **People** includes babies, children, young people under the age of 18 years and adults. **Carers** (for example, members of families and friends) are included as appropriate.

The term **carers** refers to those who ‘look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid’ (Carers UK, 2002). Please note, within these benchmarks it is acknowledged that the term ‘carer’ can include children and young **people** aged under 18 years.

The term **staff** refers to any employee, or paid and unpaid worker (for example, a volunteer), who has an agreement to work in that setting and is involved in promoting well-being.

The **care environment** is defined as an area where care takes place. For example, this could be a building or a vehicle.

The **personal environment** is defined as the immediate area in which a person receives care. For example, this can be in a person’s home, a consulting room, hospital bed space, prison, or any treatment/clinic area.
**Agreed person-focused outcome**

*People* and carers experience individualised, timely and supportive care that anticipates, recognises and manages pain and optimises function and quality of life

<table>
<thead>
<tr>
<th>Factor</th>
<th>Best practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Access</td>
<td><em>People</em> experiencing pain, or who are likely to experience pain, and carers receive timely and appropriate access to services to manage pain</td>
</tr>
<tr>
<td>2. <em>People</em> and carer participation</td>
<td><em>People</em> (where able), carers and staff are active partners in the decisions involving pain management</td>
</tr>
<tr>
<td>3. Assessment</td>
<td><em>People</em> have an ongoing, comprehensive assessment of their pain</td>
</tr>
<tr>
<td>4. Care planning, intervention, evaluation, review and prevention</td>
<td><em>People’s</em> individualised care concerning pain is planned, implemented, continuously evaluated and revised in partnership with <em>people</em>, staff and carers</td>
</tr>
<tr>
<td>5. Knowledge and skills</td>
<td><em>People</em>, carers and staff have the knowledge and skills to understand how best to manage pain</td>
</tr>
<tr>
<td>6. Self-management</td>
<td><em>People</em> are enabled to manage their pain when they wish to, and as appropriate</td>
</tr>
<tr>
<td>7. Partnership working</td>
<td><em>People</em>, carers and appropriate agencies work collaboratively to enable <em>people</em> to meet their pain management needs</td>
</tr>
<tr>
<td>8. Service evaluation and audit</td>
<td>Services are regularly reviewed and evaluated by <em>people</em>, carers, providers and commissioners for effect, breadth and equity</td>
</tr>
</tbody>
</table>
Factor 1
Access

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document

### POOR PRACTICE
*People* and carers do not have access to timely and appropriate pain management

### BEST PRACTICE
*People* experiencing pain, or who are likely to experience pain, and carers receive timely and appropriate access to services to manage pain

### Indicators of best practice for factor 1

The following indicators support best practice for the prevention and management of pain:

a. *general indicators (see page 4) are considered in relation to this factor*

b. up-to-date information about pain management and services, and how to access them, is readily available in all care environments and (where applicable) given in advance of care. Information is provided in a suitable format and in plain language

c. appropriate and timely pain management and services are accessible for *people* with pain or anticipated pain (such as pain following surgery), and their carers. This includes interventions, resources, equipment, personnel and space to provide care, as well as urgent pain management when required

d. *people* and carers are enabled to access pain management services when managing further episodes of pain
e. commissioning organisations ensure that people have access to a full range of pain management services

f. a single point of access leads to appropriate pain management services that are co-ordinated

g. information concerning access to complementary therapies and services, and the evidence base for their use and possible effects, are available to people

h. there is equality of access to services for all people with pain or anticipated pain. This includes interventions, resources, equipment, personnel and space to provide care

i. add your local indicators here
Factor 2

People and carer participation

Please note that this benchmark must be used in conjunction with the How to use Essence of Care 2010 document

Indicators of best practice for factor 2

The following indicators support best practice for the prevention and management of pain:

a. general indicators (see page 4) are considered in relation to this factor

b. people are facilitated and supported to be partners in decisions involving their pain management. This includes people with special needs, specific cultural needs and/or those who are vulnerable. Advocates are used where appropriate

c. people’s and carers’ decisions about managing pain are based on an understanding of choices and opportunities


d. *people* and carers are listened to, treated with respect and can discuss their concerns openly with staff. Where appropriate, *people* and carers are consulted separately

e. *people’s* and carers’ needs, views and preferences are sought actively (where possible) and incorporated into a realistic, appropriate pain management plan

f. *people*, carers and staff develop and agree a realistic, appropriate pain management plan

g. *people*, carers and staff understand the pain management plan

h. *people* and carers are involved in evaluation of their pain management plan

i. *add your local indicators here*
**Factor 3**

**Assessment**

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010* document.

**POOR PRACTICE**

*People* have an inadequate pain assessment

**BEST PRACTICE**

*People* have an ongoing, comprehensive assessment of their pain

**Indicators of best practice for factor 3**

The following indicators support best practice for the prevention and management of pain:

a. *general indicators (see page 4)* are considered in relation to this factor

b. any health or social services encounter includes an enquiry about pain that leads to an appropriate referral as required

c. *people’s* pain management needs are identified on initial contact and as required

d. staff are competent to recognise when a person is experiencing pain, whether or not that person is able to describe the pain and/or its severity

---

e. staff are competent to assess pain and ascertain (where possible) the underlying cause of pain, or are able to refer onwards as appropriate

f. an evidence-based tool appropriate to the needs of people and their condition(s) is used to assess pain (including severity). This includes the use of, for example, standard and/or self-report data collection tools (where possible) and observation scales. Observation of behavioural expression or a report from a carer or advocate may be used where there are communication difficulties or to accommodate different cognitive levels

g. evidence-based information concerning pain assessment and management is accessible to people and carers in a suitable format and in plain language

h. physical (including function), social, psychological and spiritual aspects of people’s pain and health profile are assessed (where possible) using evidence-based tools

i. the assessment process recognises people’s and carers’ perspectives, opinions and expectations of pain and its management

j. people’s pain experiences and (where appropriate) previous treatment are included in the assessment, for example, whether the pain is acute, chronic, intermittent, temporary, long term and/or whether the pain has been treated palliatively etc

k. assessment includes consideration of the use, interactions and side effects etc of medications

l. the impact of strategies to manage pain are assessed. For example, on other treatments, or existing or long terms conditions

m. assessment of pain and management strategies by people, carers and staff is ongoing and is collaborative, and reviewed as appropriate. For example, pain is observed regularly along with other vital physiological measurements (that is, pain is one of the ‘vital signs’)

n. add your local indicators here
Factor 4
Care planning, implementation, evaluation, review and prevention

Please note that this benchmark must be used in conjunction with the How to use Essence of Care 2010 document

Indicators of best practice for factor 4
The following indicators support best practice for the prevention and management of pain:

a. general indicators (see page 4) are considered in relation to this factor

b. planning, implementing, evaluating and revising care is a collaborative process that involves people and their carers or advocates (as appropriate), as well as all relevant members of staff
c. pain management plans are evidence-based and reflect all the components of people’s care including recognising the individual’s experience of pain and expectations of pain relief, the agreed level of pain relief and function to be achieved, and/or the coping strategies required

d. a documented rationale for the pain management plan is in place

e. interventions, such as medication to prevent, reduce or remove pain, are provided promptly and the results evaluated. This includes the need to employ distraction methods for people and/or prescribe in anticipation of pain

f. access to a range of pain management interventions and services, such as psychological care and care at the end of life, is facilitated as appropriate

g. people and carers can initiate a review of pain management strategies as they require

h. people hold their own pain management records where appropriate

i. safety issues in relation to pain management, including the use of medication, risk of self-harm, increased risk of suicide, are addressed

j. staff are competent and plan, implement, evaluate and revise care and demonstrate a professional attitude to people who require their pain to be managed

k. add your local indicators here

---

9 For example, using guidance developed by the National Institute for Clinical Excellence such as NICE (2010) *Neuropathic Pain. The Pharmacological Management of Neuropathic Pain in Adults in Non-Specialist Settings* accessed 13 July 2010 at http://www.nice.org.uk/nicemedia/live/12948/47949/47949.pdf

Factor 5
Knowledge and Skills

Please note that this benchmark must be used in conjunction with the How to use Essence of Care 2010 document

POOR PRACTICE
People, carers and/or staff have inadequate knowledge and skills to manage pain effectively

BEST PRACTICE
People, carers and staff have the knowledge and skills to understand how best to manage pain

Indicators of best practice for factor 5
The following indicators support best practice for the prevention and management of pain:

a. general indicators (see page 4) are considered in relation to this factor

b. timely, individualised, correct and evidence-based information about people’s pain and pain management and coping strategies, is provided, where appropriate, to enable people and/or carers to participate equally in decisions about the most appropriate package for managing pain

c. information concerning management strategies for pain, including complementary therapies, pain relieving injections and medicines etc, is available, together with a summary of the evidence base and an indication in which clinical conditions the treatments are effective.

d. information concerning assistance available when people cannot care for themselves (or carers cannot provide care), or in an emergency, is provided to people and carers
e. education and training needs of *people* and carers are assessed and learning outcomes are identified and met

f. *people* and carers are provided with ongoing, individualised evidence-based education and training to meet their pain management needs and preferences

g. the views and expectations of *people* and carers are used to inform the education and training programmes of *people*, carers and staff. This includes the use of *people*’s testimonies such as in the Expert Patient Programme (DH 2008)

h. staff education includes the prevention of pain as well as the complexity and impact of pain on the social, physical, spiritual, emotional, psychological and economic well-being of *people* and carers

i. staff attitudes to *people* in pain and pain management are assessed and education put in place to ensure understanding of *people*’s perspectives

j. commissioners have the knowledge and skills to commission a clinically and cost effective service for *people* with pain and their carers

k. *add your local indicators here*
Indicators of best practice for factor 6

The following indicators support best practice for the prevention and management of pain:

a. *general indicators (see page 4) are considered in relation to this factor*

b. All means are explored to enable *people* to manage their pain if they wish to do so, including consideration and support of *people’s* and *carers’* capacity and capability

c. *people* are offered the opportunity to manage their pain, and/or its impact on their lives, to an acceptable level

d. *people* and carers have the opportunity to attend education programmes or sessions to enable them to manage pain

e. Self-management plans are developed in partnership with *people*, carers and staff

f. Ongoing assessment and review of self-management plans is evident
g. the organisation identifies and removes barriers to *people* managing their pain

h. *people* and carers are provided with up-to-date information about external resources, such as peer support groups and networks, Royal Colleges, the British Pain Society and web based services

i. up-to-date evidence-based information is provided on a range of resources and how to access them. This includes information about, for example, medication and technological, mechanical and electronic methods of pain management, or complementary therapies (as appropriate)

j. *people* and carers are enabled to use methods of pain control (where appropriate)

k. staff support is provided when requested for *people* and carers to manage pain

l. monitoring and assessment takes place for *people* who are administering medicines to themselves

m. the risk of harm to *people* and carers who are managing pain is assessed and revised to meet individuals’ needs, including the need for good management of medicines

n. *add your local indicators here*

---

Factor 7
Partnership working

Please note that this benchmark must be used in conjunction with the How to use Essence of Care 2010 document.

POOR PRACTICE
Health and social organisations do not provide an integrated service and do not liaise with other relevant agencies.

BEST PRACTICE
People, carers and appropriate agencies work collaboratively to enable people to meet their pain management needs.

Indicators of best practice for factor 7

The following indicators support best practice for the prevention and management of pain:

a. *general indicators (see page 4) are considered in relation to this factor*

b. co-ordinated, continuous, consistent, multidisciplinary, multidimensional and accessible services exist between health and social care organisations within different environments that work in partnership with, for example, employers, voluntary organisations and schools, Royal Colleges, the British Pain Society, as appropriate and as agreed. A key worker co-ordinates continuing management and care.

c. joint planning to facilitate people’s desired outcomes is evident

d. opportunities exist for people and carers to participate in joint planning across agency boundaries, for example, as in the case of rehabilitation or end of life care.
e. there is prompt and accurate information sharing between all involved in the management of care whilst meeting people’s needs and ensuring confidentiality is demonstrated

f. an assessment and joint care review are undertaken by all relevant staff prior to people moving to another service and/or environment

g. joint documentation is utilised in the management of pain across agency boundaries (where appropriate)

h. add your local indicators here
Factor 8
Service evaluation and audit

Please note that this benchmark must be used in conjunction with the How to use Essence of Care 2010 document

POOR PRACTICE
No service evaluation is carried out

BEST PRACTICE
Services are regularly reviewed and evaluated by people, carers, providers, and commissioners for effect, breadth and equity

Indicators of best practice for factor 8

The following indicators support best practice for the prevention and management of pain:

a. general indicators (see page 4) are considered in relation to this factor

b. services that support people with pain and their carers are systematically reviewed and published at least annually and as required. Service review should include availability, access, quality, timeliness, and continuity of services; appropriateness of services for local health care needs; recorded pain scores; cost effectiveness and clinical effectiveness; staff attitudes; and an analysis of information obtained from complaints, letters, people’s interviews, the national Patient Satisfaction Survey and Patient Advice and Liaison Services

c. risk is assessed and reassessed within an appropriate time frame
d. risks, incidents, complaints and concerns are recorded, monitored, analysed and the information used to improve care

e. a written evaluation of pain services is provided annually by staff and commissioners

f. *add your local indicators here*
Notes
Notes