

Best Practice Statement:

Minimising Trauma and Pain in Wound Management

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Development Process

The overriding aim of this Best Practice Statement is to provide relevant and useful guidance to those active in the clinical area. In the absence of robust clinical evidence to support practice we must seek to fill the void with such information. It is not acceptable to simply decry the lack of evidence and then do nothing. This statement has been developed in three distinct stages involving two layers of separate review, this has been essential to ensure that the document has evolved in line with the view of Specialists from across the UK. The outcome of this process has been the development of a document which provides guidance to those seeking to ensure their practice is both relevant and up to date.

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The Best Practice Statement on Pain and Trauma in Wound Management

The purpose of Best Practice Statements is to offer guidance through consensus expert opinion where there is a lack of rigorous evidence. Evidence can be lacking due to the absence of high quality clinical trials, (such as randomised control studies) the presence of flawed or weak study design, the uniqueness of a particular clinical scenario or ethical considerations. Whatever the cause, the lack of evidence can lead to confusion among clinicians and variations in care. This in turn can lead to inequality in care provision and may severely compromise the individual's care.

Pain can affect everyone. The psychological impact of pain cannot be measured nor underestimated and is likely to affect healing. Poor techniques in wound care can further traumatise wounds leading to additional pain and slowed healing or other complications. However strategies can be adopted through which pain can be avoided or minimised. This document has been drawn up through the review of existing studies and the consensus of experts in the fields of pain and wound care. It provides guidance by which healthcare professionals can develop and improve their own care of all individuals with wounds, and as such sets a new standard by which to measure care provision.

This statement, whilst based on available evidence and care practices is not designed on an ethereal plain. Instead it guides clinicians in a practical and helpful way through preparation before dressing change, and during dressing changes. Specific guidance is offered for particularly challenging and painful arenas of wound care.

The Tissue Viability Nurses Association is pleased to endorse this statement and recommends it as a useful and comprehensive document. It sets a new standard in this area of wound care practice and will be instrumental in raising and improving levels of care in wound management across many different areas of practice.

Alison Finnie
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An Overview Of Trauma And Pain Issues In The UK

Helen Holinworth

Within this Best Practice Statement on Minimising Trauma and Pain in Wound Management there exists a wealth of guidance to those faced with managing wounds. It is the aim of the authors to provide advice which practitioners can relate to their practice and therefore ensure the level of care provided is optimal at all times. Best practice statements are developed by carefully weaving together expert opinion, specialist knowledge and research evidence to provide nurses and professional colleagues with a focused approach to enhancing care. Clear practical expressions of care standards foster consistent and cohesive practice, and enable practitioners to influence patients' experiences of wound trauma and pain.

Interest in reducing patients' experiences of wound pain and tissue trauma during wound care and at dressing changes has increased dramatically over the last few years, and has provided the springboard for international initiatives (European Wound Management Association 2002, Ostomy and Wound Care 2003). Most tissue viability conferences now include presentations addressing aspects of wound or ulcer pain. However, despite the raised profile, this has not yet reflected in significant changes at a practical level. Discrepancies between practitioners knowing the reasons why patients experience wound pain and tissue trauma, and actually implementing research based patient centred care in their day-to-day practice, illustrate the paradox that so often exists between theory and practice. Failing to provide evidence-based practice is unacceptable, both professionally and ethically, and underscores the importance of these Best Practice Statements. It is essential that strategies to minimise wound pain and tissue trauma are embraced at a national and local level by management and all health care professionals. Trivializing the importance of this aspect of care due to directions from other professionals, short-term perspectives on costs, personal coping strategies, or ever increasing work pressures, is no longer acceptable. Restrictive practices and entrenched attitudes cannot be allowed to detract from the quality of care to which our patients are entitled. However, it is also important to recognise that reducing the pain patients experience in the context of wound care is not simply the province of specialist practitioners; it is the responsibility of every clinician.

Nurses are still thwarted in their efforts to provide optimum wound care (Hollinworth 1999), and out dated inappropriate practice is repeatedly exposed (Hollinworth 2002, 2004). While this raises professional issues, the problem is exacerbated by practitioners' confusion about the differing properties of dressings (Hollinworth and Collier 2000), colleagues who change planned care without documenting a sound rationale, and restrictive practices that are difficult to challenge. Research repeatedly demonstrates that traditional products (gauze and paraffin tulle) (Terrill and Varughese 2000, Bethell 2003), and dressings incorporating adhesives (Dykes et al 2001, Hollinworth and Collier 2000), impact on the wound pain and tissue trauma experienced by patients, and yet these practices persist. As nurses we have a professional obligation to address these issues (Nursing and Midwifery Council 2002). However, there are a host of other causes of wound related pain, some fairly obvious like infection and arterial disease, others perhaps more obscure, such as exposure to air.

A key component of the development team's vision is that practitioners can use these best practice statements as a lever to drive change forward. Psychological aspects of wound care is another area of concern. In stressful, time pressured environments, protective barriers are erected that distance the practitioner from the patient's experience of having a painful wound. We need to recognise the suffering of people with wounds, and value the type of relationship developed with our patients. It is clear therefore that sensitive management of wound pain, and preventing tissue damage during wound care procedures, are areas of patient centred care that must be urgently addressed at a practical level. The starting point is assessment.

Assessment of the person with wound related pain

Wound management must be underpinned by a careful, detailed assessment of an individual's past and current experience of pain. However, practitioners must firstly ensure they are adequately equipped with the skills and professional commitment to interpret this information into meaningful care. Nurses may intuitively know that a wound is usually painful and that the patient's body needs to be handled gently, but fail to actively listen to that person, focusing only on getting the dressing done or procedure completed. It may not be possible to tease out the physical, psychological and social components of having a wound and experiencing pain, but these issues must always be considered during the assessment process. For each patient, these findings need to be documented and used to substantiate the individualised care that is planned, whenever possible, in partnership with the patient. While assessment is critical, it is vital that assessment of wound related pain is ongoing, and care continually evaluated. Assessing pain once, perhaps before undertaking wound care, is of little value. There are real opportunities here to involve patients; sadly these opportunities are currently underused. If people perceived their contribution to care as valued, rather than being viewed by professionals as complaining or interfering, then many more patients would be willing participants in their care. Nurses currently underestimate the impact patient participation can have on health related outcomes.

There are a range of validated pain assessment tools that can be used in the context of wound and ulcer pain, but apart from selecting a simple tool and not relying on observation alone, there is currently no consensus on which tool is the most appropriate. This enables practitioners to select the tool most suitable to an individual patient's circumstances. It is really important to use the selected tool consistently, and facilitate continuity of care by documenting the findings. The faces rating scale is useful for children, people with learning difficulties, and those for whom English is not their first language. Visual analogue scales are popular, but meaningful words or phrases may be more useful with older people, including those with impaired cognition. If suitable, pain diaries have the added value of providing a broader picture of the person's experience of wound pain; what activities exacerbates pain and the impact of medication, therapy, or dressing changes over perhaps a week. However, current tools do not readily enable patients or practitioners to differentiate between pain caused by a concurrent disease process, acute inflammatory pain, chronic inflammation with hyperalgesia, periwound skin denuded by exudates, or the grief of altered body image. We cannot know these things unless nurses observe their patients reactions, and care enough to listen. Fostering a reciprocal trusting relationship with our patients and their families is therefore critical to assessing and then managing wound related pain.

Practical strategies to manage wound related pain

Having exposed the causes, type and severity of pain that patients with wounds are experiencing, practitioners have a professional responsibility to implement effective pain reducing strategies. It is unacceptable to disregard this obligation. Again, the best practice statements provide a clear focus for our actions. The aim must be to control or prevent wound related pain using carefully selected pharmacological interventions, while always having in mind individual patient circumstances. Sometimes specialist expertise is required. Adding an anticonvulsant to effectively manage neuropathic pain, nasal diamorphine for procedural pain in children, and transdermal or topical opiates to manage fungating wound pain, all provide examples. While every effort must be made to minimise pain during wound care procedures, pre-emptive analgesia to reduce the continual barrage of pain impulses that heighten the pain experience, should always be offered. Sharp debridement is an initiative requiring particular attention; it is wrong to just assume there will be no pain.

Non-pharmacological strategies including distraction, relaxation techniques, patient involvement (effective even with children), giving information, and allowing a person to call 'time out' during a procedure, complement rather than replace other strategies to reduce wound related pain. Emotional support is important (Hollinworth and Hawkins 2002); so too is a sensitive caring approach. We should not underestimate the significance of careful positioning, privacy, a warm environment, avoiding prodding or manipulating the wound, gentle touch, and where necessary acting as the patient's advocate. The impact on the patient's experience can be immense.

Other practical strategies include selecting wound management products that:

- do not adhere to the wound bed.
- do not traumatise fragile tissues around wound margins during removal.
- protect the periwound skin from the corrosive effects of chronic wound exudates.
- avoid allergic reactions (particularly important in leg ulcer patients).
- manage exudates appropriately.
- facilitate effective wear time.

Product selection must be supported by a sound rationale that is documented, and includes hydrofibres, soft silicone products, sheet hydrogels, and alginates. Treatment of underlying aetiology is critical, but leg ulcer patients cannot be expected to tolerate compression unless pain, often the worst aspect of having an ulcer, is controlled. This again emphasises the importance of partnership in care; stoical people may not understand the link between taking analgesia and ulcer healing. Antimicrobial products, judicious use of systemic antibiotics, protective barrier films, gentle irrigation with warm isotonic cleansing solutions, comfortable pressure relieving equipment, reflect some of the practical strategies nurses can use to address wound pain issues, and prevent tissue trauma. However, all these strategies are dependent on the motivation of the practitioner to enhance the care of patients with wounds.

Conclusion

Commitment to enhancing wound care, and in particular reducing the potential for wound pain and tissue trauma is the responsibility of every professional. The evidence has been available for some time, but has not been readily translated into changes in the care patients receive. Concerns relating to the pain that people with wounds experience is therefore a challenge and an opportunity. Best practice statements provide nurses with a unique practical opportunity to make change happen in everyday practice. Key aspects of care have been distilled by knowledgeable experts so that practitioners are equipped with simple effective 'ready to use' strategies that will minimise wound related pain and trauma. However none of this is any value unless these statements are valued and used by us all. Our professional responsibility is clear.

Statement 1 - Prior To Dressing Change

Statement	Reason for Statement	How to demonstrate statement is being achieved
<p>A history of the individuals global pain should be undertaken.</p> <p>All individuals identified with pain should be assessed to determine the likely cause of pain.</p> <p>All individuals should have their pain assessed using a range of validated pain assessment strategies.</p> <p>Individuals identified as having pain should be offered the appropriate treatment.</p>	<p>Pain should be recognised and assessed in the context of the individuals overall physical and psychosocial health.</p> <p>Underlying medical condition or disease process may cause pain. For example. Rheumatoid, peripheral vascular disease etc. If an underlying medical condition or disease process is identified, intervention should be made.</p> <p>Assessing pain enables correct and suitable treatment and intervention to be initiated and maintained.</p> <p>Individuals should be offered the opportunity to be commenced on a treatment regime to manage their pain.</p>	<p>There is evidence within the individuals health records that staff act on components identified through assessment.</p> <p>There is evidence within the individuals health records that:</p> <ul style="list-style-type: none"> • investigations have been carried out to assess underlying medical / disease condition. • staff act on individual aspects of the causes of pain. • the advice of a specialist(s) is sought if necessary. <p>There is evidence within the individuals health records that:</p> <ul style="list-style-type: none"> • pain assessment has been carried out • patients are reassessed according to changes in their pain, physical condition or wound status. • staff act on individual components of the pain assessment. • the method of pain assessment used should take into account, and be sensitive to factors such as age, language, culture, sensory impairment (e.g. vision) and cognitive awareness. <p>There is evidence within the individuals health records that:</p> <ul style="list-style-type: none"> • appropriate pain management strategies are offered and evaluated. • advice of a specialist(s) is sought if necessary.

Statement 1 - Prior to Dressing Change

Statement	Reason for Statement	How to demonstrate statement is being achieved
<p>Wound pain should be assessed using a range of validated pain strategies.</p> <p>There is a professional responsibility that wherever possible wound pain should be managed effectively according to the cause.</p> <p>Trauma to the wound bed must be avoided wherever possible and minimised where appropriate.</p>	<p>Early recognition and accurate assessment of pain enables correct and suitable treatment and intervention to be initiated and maintained.</p> <p>It is a professional responsibility to minimise the individuals experience of wound pain.</p> <p>Traumatic removal of inappropriate or adhered dressing treatments can lead to delayed healing and cause unnecessary suffering to the individual.</p>	<p>There is evidence within health records of all individuals with wound pain that:</p> <ul style="list-style-type: none"> • pain assessment has been carried out. • they received treatment with supporting rationale and appropriate interventions. • the individuals condition and wound pain is reassessed regularly for changes and/or effectiveness of pain management strategies. <p>There is evidence within health records of all individuals with wound pain that:</p> <ul style="list-style-type: none"> • elimination or controlling the source of pain by appropriate interventions (wound treatment, dressing selection and pain relief) has been carried out. • interventions have been taken in response to pain and their effectiveness. • wound pain is regularly reassessed according to the individuals overall condition and the condition of the wound. <p>There is evidence within health records of the individual with a wound that:</p> <ul style="list-style-type: none"> • a careful assessment (as per Prior to Dressing Change statement) has been completed. • dressing selection reflects the need to avoid wound bed trauma.

Statement 2 - At Dressing Change

Statement	Reason for Statement	How to demonstrate statement is being achieved
<p>Trauma to the wound bed must be avoided wherever possible and minimised where appropriate.</p> <p>Trauma to the peri-wound area must be avoided wherever possible and minimised where appropriate.</p> <p>Pain at dressing changes must be absent or minimised.</p> <p>Analgesic interventions should be considered for use to reduce pain during wound debridement.</p>	<p>Causing trauma to the wound bed can lead to delayed healing and cause unnecessary suffering to the individual with a wound.</p> <p>Trauma to the peri-wound area can result in skin break down, pain and an increased risk of infection.</p> <p>While it may be impossible in some circumstances to completely avoid pain at dressing changes in every case efforts should be made to minimise pain.</p> <p>Individuals undergoing wound debridement can benefit from the use of pain management strategies, resulting in reduced pain.</p>	<p>There is evidence within health records of the individual with a wound that:</p> <ul style="list-style-type: none"> • a full assessment (as per Prior to Dressing Change statement) has been completed. • dressing selection reflects the need to avoid wound bed trauma. • indicates where dressing adherence has occurred and the strategies employed to prevent recurrence. <p>There is evidence within health records of the individual with a wound that:</p> <ul style="list-style-type: none"> • a full assessment (as per Prior to Dressing Change statement) has been completed. • dressing selection reflects the need to avoid trauma to the peri-wound area. <p>There is evidence within health records of the individual with a wound that:</p> <ul style="list-style-type: none"> • regular assessments of the peri-wound area has been carried out. • appropriate dressing selection and wound management techniques have been implemented. <p>There is evidence within the health records of the individual undergoing wound debridement that an assessment of the need for and use of appropriate analgesia has been carried out.</p> <ul style="list-style-type: none"> • Where appropriate topical local anaesthetic will be used prior to wound debridement.

Statement 3 - Between Dressing Changes

Statement	Reason for Statement	How to demonstrate statement is being achieved
<p>Each individuals perception of global pain and wound pain should be assessed between dressing changes.</p> <p>Given the wide range of strategies [pharmacological and non pharmacological] for managing wound pain the choice needs careful consideration in partnership with the individual.</p> <p>The individual should be offered the opportunity to be central to all decisions made in relation to their global and wound pain.</p>	<p>Each individual will have a perception of pain unique to them.</p> <p>The need for and the choice of analgesia will vary according to the needs of the patient and the condition of the wound. Selection of pain management strategies should be made according to those needs.</p> <p>Optimum clinical outcomes can best be achieved where the individual is central to the decision making process.</p>	<p>There is evidence within health records of the individual with a wound that:</p> <ul style="list-style-type: none"> • global pain and wound pain associated with the wound has been assessed between dressing changes. • actions, where appropriate, have been offered as a result of the assessment. • There is evidence within the health records of the individual with a wound that consideration has been given to the choice of pain management strategies and that this reflects the needs and circumstances of the individual. • There is evidence within the health records of the individual with a wound that the opportunity to participate in the decision making process has been offered.

Statement – Wound Specific

Statement	Reason for Statement	How to demonstrate statement is being achieved
<p>Superficial wounds The pain associated with superficial wounds such as donor sites and abrasions, where clean of infection, can be reduced by the application of a moist wound healing dressing.</p> <p>Radiotherapy Wounds Radiotherapy treatment can cause heat, burning and localised erythema to the area receiving treatment which require local management.</p> <p>Due to the effects of radiotherapy the tissue can become very friable and at increased risk to trauma.</p>	<p>Appropriate dressing selection can in itself be a useful pain management strategy.</p> <p>Radiotherapy treatment and associated skin changes may cause pain to the individual.</p> <p>Trauma to the area receiving radiotherapy can occur and should be avoided where possible and minimised where appropriate.</p>	<ul style="list-style-type: none"> There is evidence in the health records of the individual with a wound that the dressing selection reflects the potential for pain reduction. <p>There is evidence in the health records of the individual that:</p> <ul style="list-style-type: none"> a thorough assessment of pain using a recognised tool has been carried out. that staff act upon individual components of the pain assessment. medication or other methods of pain relief are recorded with outcome measures. Where an area has received radiotherapy the use of tapes and adhesives should be avoided. Evidence shows that where skin is dry and intact bland moisturisers should be applied. Dressings, which are likely to adhere or cause trauma to the wound bed, should be avoided. Treatment and management of radiotherapy wounds should be based on local / national practice guidelines.

Statement – Wound Specific

Statement	Reason for Statement	How to demonstrate statement is being achieved
<p>Fungating Wounds Due to the active disease process wound pain can occur.</p> <p>Trauma to wound bed or peri-wound area may be caused by traumatic dressing changes.</p>	<p>Individuals with fungating wounds can have increased pain due to the ongoing disease process.</p> <p>Trauma to the wound and peri-wound area can result in pain, skin breakdown and increased risk of infection.</p>	<p>There is evidence in the health records of the individual that:</p> <ul style="list-style-type: none"> • a full assessment of the individual's wound, pain, and emotional status has been carried out • staff act on individual components of the pain and wound assessment. • wound dressing have been selected following full wound assessment and be based on each individual's symptoms. • pain management strategies have been recorded with outcome measures. <ul style="list-style-type: none"> • There is evidence in the health records of the individual that a full assessment (as per Prior to Dressing Change statement) has been completed. • Dressing selection reflects careful consideration of potential problems of adherence and trauma. • Dressing changes should be kept to a minimum to avoid wound bed trauma, taking into consideration individuals preferences. • Dressing products which are likely to adhere to the wound bed should be avoided. • Dressings which function by causing trauma to the wound bed should not be used. • Where fragile skin is present to the peri-wound area skin barriers should be considered to reduce the potential trauma of adhesion or individual sensitivity.

Statement - Wound Specific

Statement	Reason for Statement	How to demonstrate statement is being achieved
<p>Pressure Ulcers Superficial pressure ulcers require management to prevent further wound trauma from friction.</p>	<p>Superficial pressure ulcers particularly on the heel and sacrum are likely to be subjected to repeated force from friction.</p>	<ul style="list-style-type: none"> • Where considered appropriate, individuals with superficial pressure ulcers will be treated with dressing products which reduce the impact of friction on the wound bed and peri-wound area.
<p>Leg Ulcers Individuals with a painful leg ulcer will have a comprehensive assessment in line with local guidelines to establish the cause of the ulcer and the pain.</p>	<p>Pain in leg ulcers can be caused by a variety of underlying medical conditions which require diagnosis and specialist referral.</p>	<ul style="list-style-type: none"> • The health records of individuals with a painful leg ulcer will record a full leg ulcer assessment [In line with local /national guidelines] and appropriate specialist referral where required.
<p>The peri-wound area of a leg ulcer should be protected from exudate so as to prevent skin trauma.</p>	<p>Exudate which is not managed effectively can result in trauma to skin causing breakdown and increased pain.</p>	<ul style="list-style-type: none"> • Individuals with a leg ulcer producing exudate will have effective dressing selection [In line with local /national guidelines] which reduces the risk of peri-wound trauma.
<p>Surgical Wounds Cavity wounds must not be packed or loosely filled with dressing products likely to adhere to the wound bed.</p>	<p>Cavity wounds packed or loosely filled with dressing materials likely to adhere to the wound bed will cause unnecessary wound bed trauma and pain.</p>	<ul style="list-style-type: none"> • Dressing materials which are likely to adhere to the wound bed resulting in trauma and pain must not be used to pack or loosely fill surgical cavity wounds.

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Additional Reading

- Independent Multi Disciplinary Advisory Group (2004). Issues in Paediatric Wound Care Minimising Trauma and Pain. Tendra Academy Report, Mölnlycke Health Care.

Personal Action Plan

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The Wound Academy was previously known as the Tendra Academy