# Assessment of wound pain: overview and a new initiative

Trudie Young

## Abstract

**All wounds have the potential to cause pain, and the nature of the pain varies with the type of wound. Many factors may exacerbate wound pain, including infection, trauma at dressing changes and poor technique when applying compression therapy. Failure to assess wound pain or inadequate pain assessment can cause the patient further anguish and extended suffering. Nurses caring for patients with painful wounds need to identify the source of the pain and exacerbating factors, and determine whether it has nociceptive and/or neuropathic elements in order to optimize pain management for the individual patient. This article examines the assessment of wound pain and introduces an initiative that has been developed to improve the assessment process. The 'Heal not Hurt' initiative is an excellent example of the profession and industry working together to implement best practice guidance in patient-centered pain-free wound care in clinical care.**

**Key words:** Wound Pain ■ Pain Management ■ Tissue viability ■ Wound care

All wounds have the potential to cause pain. Wuff and Baron (2003) suggest that chronic persistent pain lasting longer than 7 weeks can become a disease state in itself. Common wounds that are described as painful include arterial ulcers, pressure ulcers, venous leg ulcers, minor injuries, diabetic foot ulcers and surgical wounds (Chan et al, 1990; Hofman, 1997; Szor and Bourguignon, 1999; O'Flynn, 2000; King, 2003; Rich and McLachlan, 2003).

The nature of the pain varies with the type of wound; for example, arterial ulcer pain may be exacerbated by activity, whereas diabetic neuropathy pain is not generally associated with increased activity but is present at rest (Sibbald et al, 2003). In venous leg ulceration the areas of atrophie blanche or varicose eczema may be the focus of the pain experience, whereas the pain of diabetic foot may manifest as Charcot arthropathy (Sibbald et al, 2006).

All wounds have the potential to become infected and as a result the patient may experience any pain associated with this infection and its accompanying inflammatory response. The time at which wound pain is thought to be exacerbated is during wound cleansing and dressing change (Kammerlander and Eberlein, 2002). In addition, wound pain can be compounded by treatments such as compression therapy, dressing issues, such as slippage and adherence, and the frequency with which these painful stimuli occur.

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## Assessment of wound pain

Failure to assess wound pain can cause the patient considerable distress, particularly at the time of dressing change and during the periods before treatment in anticipation of wound pain (Soon and Acton, 2006). The pain experience may result in an individual losing faith in his/her spirituality (Shukla et al, 2005).

In the past it was acceptable for wound pain to be assessed as present or absent, but we know now that this is woefully inadequate. Nurses today recognize that pain assessment involves identifying the source of the pain and exacerbating factors, and determining whether the pain has nociceptive (arising from actual tissue damage) and/or neuropathic (arising from damaged nervous tissue) elements. However, it can be difficult to recognize neuropathic pain (Johnson, 2004). Johnson describes how compression of certain nerve roots can result in sciatica with pain travelling down the back of the leg and causing numbness of the big toe, whereas compression of other nerve roots can result in pain in areas as diverse as the thorax and the genitals. Nociceptive and neuropathic pain descriptors (terms used by individuals to describe their pain) can help to distinguish between the two types of pain: nociceptive pain is often described as tender, nagging or cramping, whereas neuropathic pain may be described as smarting, stabbing or burning (Young and Roden, 2006).

Pain assessment can be improved by the use of validated pain assessment tools. These exist for both neuropathic and nociceptive pain (Johnson, 2004). The tools will help to establish the intensity of the pain. We should assume that all patients can use a pain tool. Also, it is imperative that healthcare professionals understands the scoring system and how to interpret it (Briggs and Nelson, 2004).

However, pain assessment tools cannot capture the totality of the pain experience, i.e. the affective dimension, how the patient feels about the pain, and the cognitive dimension, which encompasses patients' beliefs about their pain (Briggs and Bou, 2002). Differing cultural expressions of pain are often open to misinterpretation. Another complicating factor is the presence of pain generated by coexisting disease such as arthritis. Also, wound pain may differ at different times of the day, and a 24-hour guide to potential pain triggers can help to assess the presence of pain that may not be witnessed by the nursing staff (Young and Roden, 2006).

All these components of wound pain highlight its multidimensional presentation (World Union of Wound Healing Societies, 2004). The impact of inadequate pain assessment for the individual is further anguish and extended suffering, as well as the potential to hinder future developments. A Cochrane systematic review of the role of topical agents and dressings for pain in venous leg ulcers found that many of the studies were methodologically weak in the assessment of pain outcomes (Briggs and Nelson, 2004).

## Nurses' beliefs and attitudes

There are many nursing myths surrounding wound pain, e.g. certain wounds are more

painful than others, the deeper a wound the more pain it causes, and the elderly have a greater tolerance to pain. Nurses have identified themselves as barriers to pain management due to lack of time and knowledge (Ferrell, 1991), and have been known to use denial to compensate for these deficits and not acknowledge the existence of patients' wound pain (Krasner, 1996).

It is to be hoped that the current emphasis on evidenced-based practice will render these myths and practices obsolete, although a survey undertaken in 2002 did find that nurses would rather observe a patient's body language for non-verbal pain cues than use a validated pain assessment tool (Moffatt et al, 2002). However, progress was evident in a recent literature review of pressure ulceration, which identified the use of validated pain assessment tools in the pressure ulcer population (de Laat et al, 2005).

The consequence of incorrect pain assessment is often inappropriate pain management with nurses acting as the gatekeepers of analgesia. A large French survey found that many patients with acute and chronic wounds were not prescribed any analgesia (Meaume et al, 2004). On a more positive note, the intervention of a tissue viability nurse and an alteration in the wound dressing regimen alleviated a patient's wound pain and their need for systemic analgesia (Tudor, 2003).

## Future developments

If we acknowledge the complexity of the pain assessment process and the limitations that this places on healthcare professionals, how can we move forward? Reddy et al (2003) suggest that patient involvement may be one option. They describe two tenets to help achieve a patient-centered approach to wound care:

- Always take time to assess the patient's pain and engage the patient in treatment decisions and processes
- Ensure the right of the patient to have access to pain medication and treatments that minimize pain and trauma.

This approach is echoed in the document *Best Practice Statement: Minimizing Trauma and Pain in Wound Management* (Independent Advisory Group, 2004a):

> **'Assessing pain ... 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 ... then many more patients would be willing participants in their care.'**

A patient-centered approach was adopted by Gibson et al (2004), who provided patient education on wound pain, use of a pain assessment tool and how to negotiate using coping strategies during episodes of procedure-related wound pain. The pilot study appeared successful and provided examples of patient empowerment and satisfaction with subsequent wound care interventions.

The internet is another resource that can assist both nurses and patients in managing pain: websites such as Pain Concern (a self-help site; www.painconcern.org.uk/) and the multiprofessional British Pain Society (www.britishpainsociety.org/) offer a plethora of useful information. The political position is also now represented with the establishment of the Chronic Pain Policy Coalition (www.paincoalition.org.uk/) in 2006. This organization provides a forum for patients, professionals and parliamentarians who operate at policy level to develop an improved strategy for the prevention, treatment and management of chronic pain and its associated conditions:

> **'The coalition believes that all people living with chronic pain**

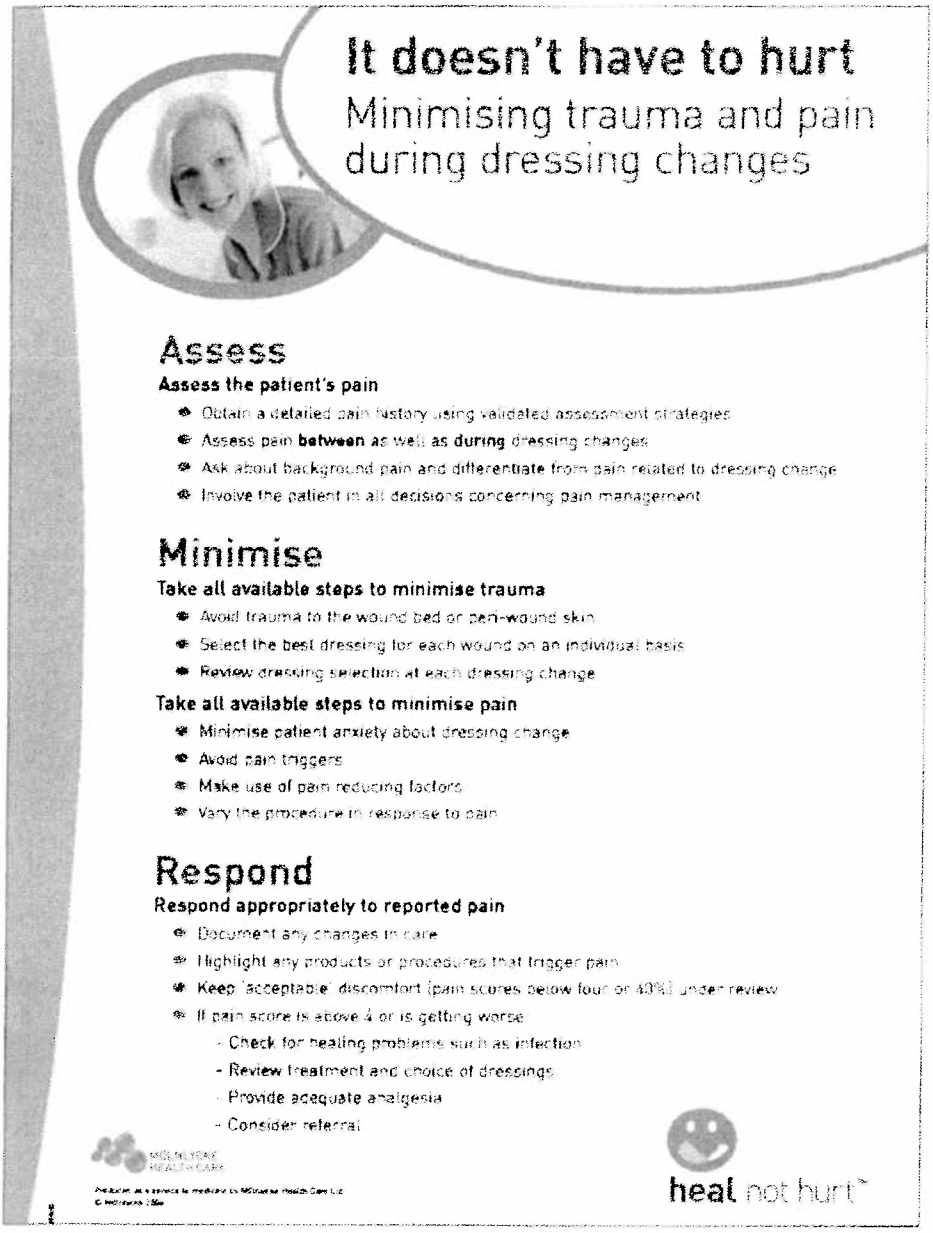
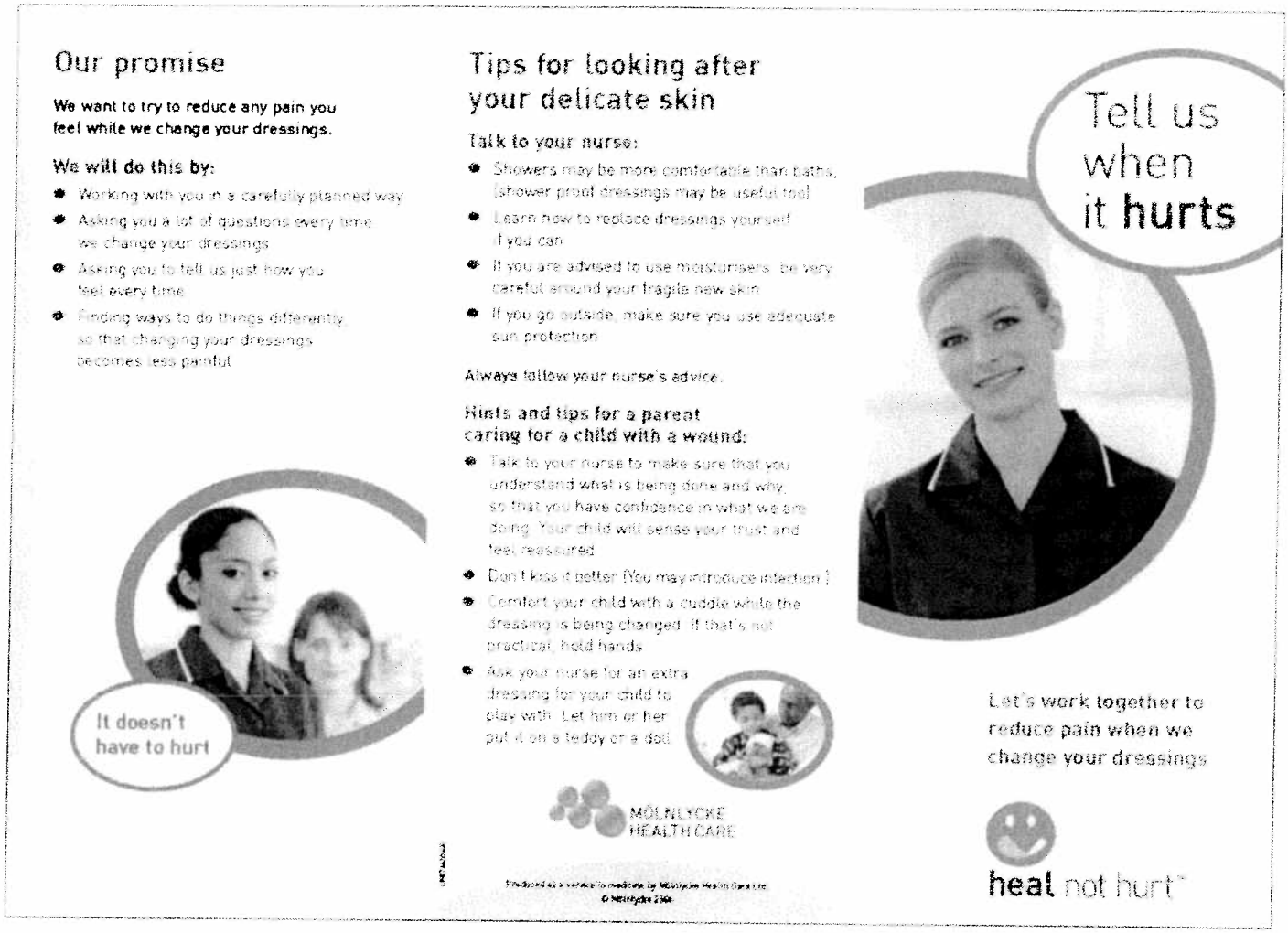



*Figure 1. Heal not Hurt leaflet.*

*Figure 2. Tell Us When It Hurts* **leaflet.**




**in the UK must expect and ask for: active involvement in the management of their pain and timely assessment of their pain.'**

## The 'Heal not Hurt' initiative

The idea of patient empowerment and involvement appears to be a positive advancement, but how can this be translated into clinical practice? The 'Heal not Hurt' initiative (*Figure 1*) is an excellent example of the profession and industry working together to provide a vehicle for implementing best practice guidance in patient-centered pain-free wound care (White et al, 2007). The initiative aims to bring to the clinical area the current principles of best practice in assessing and managing wound pain. These are based on evidence from:

- The position paper from The European Wound Management Association (EWMA, 2002)
- The consensus document from The World Union of Wound Healing Societies (The World Union of Wound Healing Societies, 2004)
- The suite of documents from the Tendra Academy (Independent Advisory Group, 2004a, 2004b, 2005; Tendra Academy Expert Forum 2006).

Molnlycke Health Care is the industrial partner in the initiative and provides the following resources free of charge to all clinicians and patients who participate in the initiative:

- Copies of all the above documents, along with an evidence summary document
- A pocket guide summary
- Badges for staff to wear
- Posters for display in the clinical area.

In addition, Molnlycke provides the following resources for patients:

- *Tell Us When It Hurts* leaflet (*Figure 2*)
- Monitoring pain at dressing changes aid – assessment tool and ongoing record.

The initiative has been welcomed by tissue viability and pain nurse specialists across the UK. Initially it was thought that it might result in duplication of assessment; however, pain teams have welcomed the initiative's support in raising awareness of pain assessment. The background information ensures that clinicians have access to evidence to support their practice in wound pain assessment and management. The posters and badges raise interest and awareness of the issue of wound pain and the potential to resolve it rather than allowing patients to suffer in silence. The assessment tool and ongoing record allows the patient and the nurse to assess and document wound pain before, during and after dressing changes, thereby pinpointing problem areas and enabling the nurse to concentrate on specific pain management strategies. For the initiative to be a success it is important to assess how it integrates into existing practice. To date the initiative has been received successfully in many areas (White et al, 2007).

## Conclusion

Many patients view pain is an acceptable and inevitable consequence of having a wound. The plethora of articles, books, documents, position papers etc on the subject has demonstrated emerging awareness of the problem by wound care clinicians. Tissue viability nurse specialists are altering their view and acceptance of wound pain by implementing pain assessment and management strategies (Young and Roden, 2006). Success of these changes should only be judged by the individual with the wound, for whom alleviation of pain is often their main priority. The Heal not Hurt initiative provides an excellent example of how industry and clinicians can work together to reduce the pain and trauma associated with wound care.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### KEY POINTS

- All wounds have the potential to cause pain; the nature of the pain varies with the type of wound.
- Accurate pain assessment using validated pain assessment tools is key to implementing an effective management strategy.
- Health professionals should always take time to assess the patient's pain and engage the patient in treatment decisions and procedures.
- Health professionals should respect the patient's right to have access to pain medication and treatments that minimize pain and trauma.
- 'Heal not Hurt' is a new initiative aimed at reducing trauma and pain in wound care; it involves the profession and industry working together to implement best practice guidance in patient-centered pain-free wound care in the clinical area.