

World Wide Wounds

Pain at wound dressing-related procedures: a template for assessment

Author(s)	Contents
<p>Helen Hollinworth MSc, BA, RN, RNT Senior Teaching Practitioner Faculty of Health Suffolk College, Ipswich, UK. Email: helenhollinworth@suffolk.ac.uk</p>	<ul style="list-style-type: none"> • Introduction • Rationale for a wound pain assessment tool • Types of pain • Activities that exacerbate pain • Activities that reduce pain • Making assessment patient-centred • Determining the intensity of pain • Conclusion • References
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Keywords: wound pain; pain management; person-centered assessment; dressing-related procedures.

Key Points

1. Each person's experience of wound pain is complex and is influenced by a wide range of factors.
2. A rational approach to individual person-centred assessment and the management of pain is crucial to relieve or minimise pain at the earliest opportunity.
3. An unacceptable level of pain during or after dressing changes may necessitate a change in management.

Abstract

This paper presents a simple, practical framework to assess a patient's experience of pain at wound dressing-related procedures that has been inspired by the World Union of Wound Healing Societies' consensus document [1]. It aims to enable individualised assessment of wound-related pain so that effective management can be implemented at the earliest opportunity. An assessment tool and rationale, together with a patient-led questionnaire, can be downloaded and used as a template for assessment.

Introduction

Key opinion leaders from around the world have emphasised the significance of minimising pain at wound dressing-related procedures [1], but all members of the interdisciplinary team must act on these recommendations if patients' experiences of care are to change.

Although it may not be feasible to eliminate wound-related pain, it is usually possible to modify the pain the patient experiences. Each person's experience of wound pain is complex and is influenced by a wide range of factors specific to the individual [2],[3]. Wound pain can be persistent, greatly affecting individuals' quality of life and having a significant impact on the lives of those around them. For others the pain experienced is specifically related to, and often exacerbated by, wound dressing-related procedures and

may be more transient [4].

It is also important to recognise that emotional components, including anxiety and previous experience, can compound a person's perception of pain and may negatively affect the patient/practitioner relationship.

Rationale for a wound pain assessment tool

A thorough person-centred assessment is crucial to providing sensitive and effective management of wound pain. The characteristics of the pain, including type, onset, duration, and exacerbating and relieving factors, will help to identify the cause of the pain and strategies likely to relieve it [5]. This is particularly relevant to the pain experienced during, and sometimes after, dressing changes.

The key aspects of the [assessment tool](#) presented in this paper are supported by a [rationale](#) rationale based on the World Union of Wound Healing Societies' consensus document [1]. The aim is to structure the assessment process, enabling early assessment of an individual's dressing-related pain so that effective management strategies can be implemented as soon as possible. It is envisaged that this tool could be adapted to suit local needs and incorporated into existing patient documentation, providing a simple, practical framework that is quick and easy for less experienced practitioners to use. In addition, a [patient-led questionnaire](#), which is based on the [assessment tool](#), is presented. This allows individual patients to document their wound pain experience.

Types of pain

Pain can be divided into two types: nociceptive pain and neuropathic pain. Most people will have experienced nociceptive pain, which can be defined as the normal physiological response to a painful stimulus [1], at some time in their lives. Trauma associated with nociceptive pain can also cause inflammation and damage to the peripheral nerve endings which results in hypersensitivity, so that even minor stimulation can cause intense pain. Fortunately, nociceptive pain is usually relieved by analgesia and subsides over time.

Neuropathic pain is initiated or caused by a primary lesion or dysfunction in the nervous system [6]. This might be the result of nociceptive pain, ischaemia, diabetes or trauma damaging the peripheral nervous system and altering the pain response.

Patients often describe neuropathic pain using words such as 'burning', 'stabbing' or 'shooting' and liken it to an electric shock. In the past neuropathic pain has often been poorly assessed and inadequately managed. This type of pain requires different management strategies, including antidepressants and anti-epileptic medication to control the specific symptoms associated with nerve damage [6].

It is reasonable to assume that all wounds are painful but many patients experience unremitting pain, even while at rest [1]. Persistent underlying pain may relate to wound aetiology, such as ischaemia or hypoxia, venous insufficiency, vasculitis or pressure from neoplasms. Other causes include prolonged inflammatory response, eczema, hypersensitivities and local infection. The pain initiated by a wound dressing-related procedure is often additional to this [1].

It can be difficult for patients to determine or articulate the exact location of persistent pain. The use of a body map can aid this process and may help healthcare professionals to understand the patient's experience of living with pain.

Activities that exacerbate pain

The assessment process should identify triggers that exacerbate an individual's pain. It

has not always been recognised that pain may be focused at the site of the wound (primary hyperalgaesia) and, particularly in chronic wounds, often extends to tissues peripheral to the wound (secondary hyperalgaesia) [5]. Any increased sensitivity in the area surrounding the wound must be identified so that care can be taken during dressing-related procedures to minimise pain that may be triggered by wound cleansing and/or dressing removal.

Body movement or a change of position can exacerbate wound-related pain as pressure and touch are known to trigger pain. Pain is also often worse at night, disrupting sleep patterns and increasing anxiety, which compounds the individual's pain experience.

A number of dressing-related activities can also precipitate or exacerbate pain, such as dressings that have slipped or constricting bandages.

Dressing removal has consistently been identified as the time when patients' experience the most pain [4], [7],[8]. This is often caused by trauma to the wound and surrounding tissues when dressings are applied or removed. In addition, wound cleansing using swabs, cold cleansing solutions or topical antiseptics can initiate significant pain that may take hours to subside. Other dressing-related activities that exacerbate pain include leaving the wound exposed to the air or allowing it to dry out, the type of primary dressing that is applied and rough handling by practitioners. Once identified, most of these causes of pain at dressing change can be avoided or minimised in the future.

If patients experience pain at dressing change they are likely to develop anticipatory pain, which can affect quality of life as much as the actual pain sensation itself.

Activities that reduce pain

Patients are often able to identify circumstances particular to them that relieve the intensity of their pain and some may describe how analgesia, leg elevation or a warm environment reduce wound pain. Similarly, several strategies can be used to reduce pain during dressing-related procedures. These include:

- the use of warm cleansing solutions
- careful removal of dressings and their residue or encouraging patients to remove their own dressings
- the use of 'time out'
- the use of atraumatic dressings
- correct application of dressings and bandages
- changing the frequency of dressing changes.

Correctly matching the parameters of a dressing to the state of the wound and surrounding tissue is also an important consideration. The characteristics of the dressing in relation to the maintenance of a moist wound healing environment, prevention of damage to the wound and surrounding skin, absorbency (fluid-handling/retention capacity) and allergy are all important factors [1].

A calm, confident and supportive approach by health professionals can also do much to allay patients' anxieties and therefore reduce their pain.

Making assessment patient-centred

Understanding the emotional and social effects of living with a painful wound and having to undergo regular dressing-related procedures is of utmost importance. For assessment to be truly patient-centred, practitioners must take time to engage with and listen to

patients.

Age, ethnicity and previous negative experiences can all influence the perception of pain, as can the attitudes of healthcare professionals. Numerous studies have identified that health professionals consistently rate patients' pain lower than patients do [7]. It is therefore important to encourage patients to articulate their feelings about their wound and the pain they are experiencing.

This can be a challenge as many patients may accept pain as an inevitable consequence of their wound which cannot be relieved. A pain diary that encourages them to record in their own words the intensity of their pain, their mood, their response to treatment and strategies that reduce their pain can be very useful. A practitioner who listens carefully for just a few minutes can enable patients to explore their own feelings and coping strategies, and help them to feel valued as a person [9].

Determining the intensity of pain

Pain intensity, as perceived by the patient, should be recorded each time a dressing-related procedure is carried out. Evaluating pain can be challenging for individuals as it is a deeply personal experience, and can be particularly difficult in children and people who are frail or cognitively impaired. It is therefore important to select and consistently use an appropriate, recognised pain scale, and to carefully monitor verbal and non-verbal cues that may indicate pain [1].

Pain assessment tools include visual scales using a line ranging from 'no pain' to 'worst imaginable pain' or cartoon faces to depict happy or miserable faces. Verbal rating scales are simple to use in clinical practice as they focus on easily understood words, such as 'mild' or 'severe'.

Pain should be evaluated before an intervention, otherwise pain assessment during or after the dressing-related procedure has considerably less value. Patient involvement in pain assessment is vital, but clinicians should also assess for factors that may increase pain such as adherent dressings, excoriation of the surrounding skin, wound infection and allergies. If identified, immediate steps should be taken to address these issues.

Conclusion

Wound pain can be divided into persistent pain, which is present between dressing changes, and procedural pain, which is heightened during dressing changes. All wounds are uncomfortable but some people experience both persistent and procedural pain, which significantly affects their quality of life. Not all procedural pain related to wound management can be eliminated and patients can realistically be expected to feel some sensation during dressing changes. However, the aim of pain assessment is to reduce discomfort and identify factors that exacerbate the patient's pain experience, which can only be achieved using a structured approach to pain assessment.

The use of this [assessment tool](#), which may be adapted locally, provides a practical means of identifying procedural pain. Adopting the [patient-led questionnaire](#) makes explicit the partnership approach to wound pain.

If assessment indicates that the patient's pain is inadequately managed then care should be adapted accordingly. Brief strategies to address dressing-related wound pain are included in the [rationale](#) which can be used to support the key aspects of assessment. The [assessment tool](#) also provides a section to record any changes made to reduce pain at wound dressing-related procedures.

Practitioners need to actively engage with patients, and learn from their experiences [10]. Although healthcare professionals are accountable for their practice, ethical and professional tensions can arise if unnecessary pain is inflicted on patients as a result of

dressing-related procedures [11],[12]. If the person with a wound, rather than the professional, is central to the assessment process these issues can be resolved more easily.

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