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Interview

Your Local Anaesthetic/Recovery Unit: What Makes it Special?

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1. Describe the type of service you provide.

We routinely review all patients with either Patient Controlled Analgesia (PCA), Epidural Analgesia or Local Anaesthetic infusions. We produce policies for all of these techniques and are always available for troubleshooting, advice and education. We ensure that the correct equipment is in working order and always available. We also liaise with the recovery staff and anaesthetists to inform them pre-operatively of any complicated pain patients, for example, those with a history of chronic pain requiring strong opioids. These patients can pose a challenge in the recovery room due to increased tolerance to these drugs.

2. How is your team set up?

We are based in the anaesthetic department and work closely with the anaesthetists. Our working day starts with going through the theatre lists to identify patients that may require our involvement. We review all major surgery within 24 hours post-operatively and suggest amendments to their pain control whilst monitoring safety and side effects of the techniques utilised. Ward staff will call us to review post-operative patients with uncontrolled pain and we adapt our round to prioritise accordingly. We also see non-surgical patients with uncontrolled acute pain, for example pancreatitis patients and those with rib fractures.

3. Introduce us to your team.

The team consists of 3 consultant anaesthetists, each with 1 session per week, and 2.5 WTE Clinical Nurse Specialists (the 0.5 post is a training post). We operate a 08.00–17.00 service Monday to Friday and outside these hours the on-call anaesthetist will provide advice. St George's has developed into a hospital that undertakes complicated, painful surgery across all specialties. During 2008, we were involved in the management of 2907 patients. Therefore, we are a very busy service and continue to see all patients daily until a satisfactory outcome has been achieved.

4. What are the daily clinical challenges you cope with in your unit?

Many of our patients have co-morbidities which dictate what analgesia they can/cannot receive. Our role is to focus on thorough assessment and understand the pharmacology and pharmacodynamics of analgesia, whilst providing effective pain relief. Our service strives to administer safe analgesia that is rationalised to minimise side effects.

As pain has such an emotional element, some patients can be resistant to our suggestions of changing their analgesia, if we feel the method/drug utilised is potentially unsafe. Often other healthcare professionals have initiated these treatments and, when they get into difficulty, call us to assess them. We are an advisory service and occasionally other members of the multidisciplinary team disagree with our advice. We will always present an unbiased rationalised case that is evidence-based to support our suggestions. These are not always accepted

5. What part of your working day do you find the most rewarding?

Suggesting/making changes in treatment for a patient that has pain, and on reviewing them, finding it has significantly reduced; especially if the patient was unconvinced of your rationale and their pain improves. It reinforces that we are providing effective pain control. We equally manage the side effects of some analgesic techniques and it is rewarding to see them subside.

6. What provision do you have for ongoing education?

We provide mandatory training for all staff caring for patients with Patient Controlled Analgesia,

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Epidural analgesia or Local anaesthetic infusions. We also respond to requests for presenting on specialist courses for all disciplines such as physiotherapists, pharmacists and doctors. Although the bulk of our work is within the surgical directorate, we also teach medical staff the principles of effective pain management.

To maintain my own personal development I attend specialist conferences at least once a year, such as The Pain Society and The National Acute Pain Symposium. In addition to this I attend study days that are not specifically pain related but still a significant part of my role, such as 'Reducing Medication Errors'. This year, I aim to have a piece of work on acute pain management in print in a Nursing publication.

7. What was the last audit/research your unit took part in, and what were the outcomes?

The Acute Pain Service collects data on pain relief, side effects and satisfaction for all the patients seen by them. In a brief reference to Acute Pain Services in 1997, the Audit Commission (UK) proposed a standard whereby less than 20% of patients should experience severe pain following surgery after 1997, and that this should ideally reduce to less than 5% by 2002. By producing an annual report we have been able to monitor our outcomes against these parameters. From this data, in particular, we have made changes to our epidural service, which has resulted in a significant improvement in outcome. By continually monitoring we are able to re-evaluate our outcomes, enabling our service to consistently meet these criteria.

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