Comfort–Function Goals
A way to establish accountability for pain relief.

Despite a growing body of research on pain relief, the dissemination of educational resources on how to relieve pain, and frequent pain management programs for clinicians, there’s been little improvement in the provision of pain relief. More than 30 years ago, Marks and Sachar published their historic study showing that 73% of medical inpatients experienced moderate-to-severe pain.¹ The study revealed that the physicians who cared for these patients lacked knowledge of appropriate analgesic use and made incorrect decisions regarding the treatment of pain. Recent research shows that providers today have many of the same weaknesses and that pain continues to be undertreated.

In 2002 researchers conducted a national telephone survey of 250 adults who had recently had surgery.² Half of them had had surgery less than one year before, and more than half had had inpatient surgery; the median age of participants was 46 years and 65% were female. According to the researchers, “Approximately 80% of patients experienced acute pain after surgery. Of these patients, 86% had moderate, severe, or extreme pain, with more patients experiencing pain after discharge than before discharge.”

A recent prospective cohort study found a high incidence of significant pain among 5,584 hospitalized patients.³ Researchers collected data on the patients over a three-year period (1997 to 2000); 59% of those studied had pain (19% had moderate pain and 28% severe pain). Although patients with a wide variety of diagnoses experienced pain, moderate-to-severe pain was most common in patients with sickle cell disease. Research shows that this population may be at particularly high risk for undertreated pain. Jacob and colleagues collected data over a nine-month period (August 2000 through April 2001) on patients five to 19 years old who had been admitted for painful vasoocclusive sickle cell episodes.⁴ Patient-controlled IV morphine was prescribed; however, all prescriptions were below recommended dosing guidelines. The children self-administered less analgesic than was prescribed, and their pain ratings changed little from the time of admission. Failure of the clinicians to prescribe appropriate dosages, adequately teach the use of patient-controlled analgesia, and intervene when pain relief was unsatisfactory probably contributed to these findings.

A review of the medical records of patients 65 years of age and older who had been hospitalized during 1999 for hip fracture revealed significant undertreatment of pain and numerous examples of inappropriate pain management.⁵ Despite strong warnings in all accepted clinical practice guidelines against the use of meperidine (Demerol) and the intramuscular route of administration in older patients, more than half of the patients received at least one dose of meperidine and were given intramuscular analgesics. Propoxyphene, also inappropriate for use in older adults (see Pain Control, June 2000), was given to more than 25% of the patients. Acetaminophen (Tylenol and others), the least effective analgesic, was the most commonly administered, and the doses given were well below recommended amounts. Although nurses were aware that around-the-clock administration of analgesics is recommended in older adults...

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adults, this approach was used in only 22% of patients during the first 24 hours, when pain was likely to be at its worst. The nurses administered a mean of 0.62 mg/hour of parenteral morphine equivalents, which was approximately 21% of the mean minimum that had been prescribed (2.9 mg/hour) during the 72-hour study period, and only 27% of the patients received IV patient-controlled analgesia.

Other disturbing findings were that eight patients didn’t receive any opioids during the 72-hour study period, and patients with dementia received significantly less opioid and nonopioid analgesia than those who didn’t have dementia. Nurses who cared for these patients identified difficulty contacting physicians and talking to them about analgesics as the major barriers to managing pain.

Research does reveal improvement in some areas of pain management, such as assessment, but not in pain relief. A 10-year (1992 to 2001) review of quality improvement data from 20 studies on inpatient pain management in eight U.S. hospitals revealed a number of interesting trends. Several quality improvement indicators were evaluated: the documentation of pain intensity assessment (using a numeric or descriptive scale), the frequency of pain assessment, the appropriateness of treatment, the regularity of analgesic administration, the prevention and control of pain to facilitate function and improve the quality of patients’ lives, and patient teaching about pain management. Researchers found that the documentation of pain ratings increased over time, but the intensity of pain and the interference of pain with function and the quality of patients’ lives remained high. Thus, pain assessment didn’t necessarily guarantee pain relief.

ENSURING ACCOUNTABILITY FOR PAIN RELIEF
In the past 15 years, government agencies, professional organizations, and other advocates have made many efforts to alert health care providers to the problem of undertreated pain and educate them in adequate pain relief. (See Pain Management Resources, left.) Unfortunately, guidelines and other incentives have been slow to change the behavior and attitudes of providers. Thus, undertreatment of pain doesn’t appear to be strongly related to a lack of educational resources. While there is evidence that clinicians are assessing pain more frequently, are required to focus on it in their facilities, and have access to educational material on pain, the literature shows that this hasn’t resulted in a widespread reduction in persistent unrelieved pain. At the heart of this issue appears to be a failure to hold members of the health care team accountable for providing the best possible pain relief to their patients.

One solution to the lack of accountability is the establishment of comfort–function goals and their application to the care of people with pain. The effects of good pain control on function should be a major focus when formulating and revising pain care plans for patients. This approach requires clinicians to routinely discuss the achievement of functional goals with their patients, ideally during the initial interview. Functional goals can be expressed in terms of the activities that are crucial to patients’ recovery or the quality of their lives. When caring for surgical patients, for example, clinicians can explain that appropriate functional goals might be to breathe deeply with minimal discomfort and ambulate after surgery; patients with chronic pain may identify walking the dog or working as functional goals.

After discussing functional goals, guide the patient to select a pain rating that will allow him to accomplish them easily. For example, the surgical patient may select as the comfort–function goal a pain rating of 3 (on a 0-to-10 scale) during postoperative ambulation to the next nursing station.

When discussing comfort–function goals, a nurse should remember that patients don’t necessarily know either the importance of pain relief or how much pain relief to expect. That helps explain why patient care...
satisfaction with pain relief doesn’t necessarily mean that pain was adequately treated. Research has shown that patients may report extremely high satisfaction with their pain treatment despite having high pain intensity ratings.\textsuperscript{2, 3, 10} Nurses must be prepared to help patients establish realistic comfort–function goals. Patients who choose a pain rating of 0 probably have unrealistic expectations about the level of discomfort commonly experienced after surgery. Nurses can explain to these patients that their pain can probably be reduced to a level that will enable them to participate well in recovery activities but that they’re unlikely to be pain-free. Remind patients that they must tell their nurses or physicians if they have pain that interferes with their accomplishing the identified functional goals. There are also patients who will select a high pain rating when establishing the comfort–function goal. It’s important to discuss the harmful effects of unrelieved pain with these patients and remind them that studies show that pain rated at higher than 3 on a 0-to-10 scale interferes with function.\textsuperscript{9} Be sure to tell all patients that they must stay on top of their pain and take their analgesics before it becomes severe. It’s also wise to remember that patients and their families may have concerns about addiction and explain that there is an extremely low risk of addiction when opioids are taken for pain relief.\textsuperscript{11}

Accountability for pain relief can be established by holding clinicians responsible for using the comfort–function goal to direct pain management decisions. Pain ratings higher than the comfort–function goal require intervention, such as an increase in analgesic dosage or the addition of another analgesic to the treatment plan. If the comfort–function goal cannot be met with existing analgesic orders, the clinical pharmacist, nurse practitioner, or physician must be contacted. Establishing a comfort–function goal and holding clinicians responsible for achieving and maintaining that goal may also prevent personal biases from affecting treatment of pain. Research shows that nurses are likely to allow their personal opinions on the intensity of a patient’s pain, and not the patient’s rating of it, to determine their choice of analgesic dose.\textsuperscript{12}

It’s a good idea to discuss achievement of comfort–function goals routinely during shift report and rounds. In the outpatient setting, the comfort–function goal can be discussed with the patient and caregiver at each clinic visit. The comfort–function goal can be used as a reference point when discussing problems and successes in achieving satisfactory pain relief. Expect all nurses and other team members caring for patients with pain to establish this goal and be accountable for achieving it and maintaining it.

Institutional quality improvement should focus on regular review of medical records with attention to the documentation of comfort–function goals. Such documentation, on the same page as ongoing pain ratings, serves as a continual reminder to clinicians and facilitates data collection and analysis. Staff inservices and meetings are ideal times to discuss the use of the comfort–function goals, identify and solve pain problems unique to each care unit, and develop ways to improve pain management at the institutional level.

Managers and administrators must evaluate and discuss during annual review their staff’s performance in terms of managing pain. “The buck stops here” applies to nurses in all settings. As the primary pain manager, the nurse caring for the patient with pain is accountable for pain relief.

\textbf{REFERENCES}