



THE
AUSTRALIAN
PAIN SOCIETY

**SUBMISSION TO THE AUSTRALIAN GOVERNMENT
DEPARTMENT OF HEALTH**

**REVIEW OF NURSING EDUCATION
EDUCATING THE NURSE OF THE FUTURE (THE REVIEW) –
INDEPENDENT REVIEW OF NURSING EDUCATION**

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**REVIEW OF NURSING EDUCATION
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Introduction

The Australian Pain Society (APS) is a not-for-profit multidisciplinary organization whose mission is to minimize pain and related suffering through advocacy and leadership in clinical practice, education and research.

Our vision is that all people will have optimal access to pain prevention and management throughout their life.

The Australian Pain Society (APS) welcomes the opportunity to provide feedback to the Department of Health regarding the Review of Nursing Education: Educating the Nurse of The Future.

The document has been prepared on behalf of the Society by Trudy Maunsell, President Elect of the Australian Pain Society, following her attendance at the Brisbane consultation workshop on June 24, 2019. This submission includes input from our multidisciplinary membership, as well as other professional organizations who connect with APS via our Relationships Committee.

The following topics, as per the Terms of Reference, will be addressed:

- the preparation of Assistants in Nursing, Enrolled Nurses, Registered Nurses and Nurse Practitioners to meet the needs of the future health system,
- the effectiveness of current educational preparation to meet future health, aged care and disability needs of the Australian community including clinical training,
- national and international trends, research, policies and procedures related to pain management education
- regional needs and circumstances

with emphasis on the management of pain across the lifespan (paediatric to aged care and end of life care) and the clinical care spectrum (from community care to tertiary hospital setting)

Background

Pain, according to the International Association for the Study of Pain (IASP) (Merskey and Bogduk 1994; IASP 2014), is an “unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage” – it is a highly individualized, subjective experience with each person learning the application of the term through experiences related to injury in early life. Pain is a multifactorial experience influenced by culture, previous pain events, beliefs, mood and the ability to cope (Schug et al 2011: xxiii). Pain must be treated with a patient centered approach and from an interdisciplinary, biopsychosocial perspective.

Acute pain is defined as “pain of recent onset and probable limited duration. It usually has an identifiable temporal and causal relationship to injury or disease” and often considered to be a normal consequence of such injury or disease” (Ready 1992 as cited by Schug et al 2015:1). However, there are significant adverse effects of unresolved pain both physiologically and psychologically and if the transition from acute to persistent pain is to be prevented or minimized, we must take a proactive approach to acute pain and its resolution.

Persistent (chronic) pain is pain which persists beyond the normal expected time of healing after injury, surgery or disease and affects more than 3.24 million Australians, with the prevalence predicted to increase to 5.23 million by 2050 (Deloitte 2019:vi). Persistent pain is largely invisible and those with persistent pain report feeling stigmatized by coworkers, friends, family and health carers (DOH 2019:5). Persistent pain significantly impacts upon quality of life and the ability to function for those of working age as well as for up to 80% of older Australians and individuals residing in residential aged care facilities (RACF’s) (Goucke et al 2019). Cognitive difficulties are also common in this group with around 50% of Australian’s living in RACF’s having a diagnosis of dementia and 90% experiencing some degree of cognitive impairment (Brown et al 2016). Communicative disabilities such as dysphasia, hearing and/or vision loss, and language barriers are also common, impeding the effective communication of painful experiences to care professionals. Combined, these conditions mean that pain is frequently unrecognized, undiagnosed and untreated in many of the people who live in RACF’s.

Ensuring the delivery of high quality pain management care across all RACF’s is a health service imperative. This is especially true for individuals who are nearing the end of their lives with effective pain relief being rated as “very” to “extremely important” by 94% of people with advanced and chronic end-stage medical disease and their families (Heyland et al 2006). In fact, there is widespread agreement that adequate pain control and time with family/friends are top priorities at the end of life, according to Downey et al (2009: 175-188).

Pain experiences are common in infants, children and adolescents with many neonates and children exposed to frequent, painful diagnostic and therapeutic procedures, often with

little or no analgesic intervention (IASP 2019). Exposure to severe pain without adequate pain management has significant long-term consequences including increased morbidity and mortality and exposure to pain in premature infants is associated with higher pain self-ratings during venipuncture, poorer cognition and motor function in school aged children. Research has shown that exposure to pain in early life has long-standing consequences in terms of increases in the risk of developing problems into adulthood (chronic pain, anxiety and depressive disorders (IASP 2019). It has been suggested that in the Australian setting that between 25-35% of children and adolescents experience chronic pain (Faculty of Pain Medicine 2017).

A variety of factors increase the risk of both acute and persistent pain in people with intellectual disability including greater risk of accidental injury, reduced involvement in health decision-making, more physical comorbidities, reduced use of pain management services and age-related changes associated with greater life expectancy than in previous years. It has been estimated that pain occurs in at least 13% of people with intellectual disability (IASP 2019). It has been reported that patients with intellectual disability are prescribed and given significantly less analgesia compared to cognitively intact peers (Boerlage et al 2013).

Pain is also not recognized, assessed and managed in torture survivors and these patients require the same interventions as patients with other pain related problems. Left unaddressed, persistent pain in this population may undermine attempts to treat other problems. It is important that their pain is not mistakenly assumed to be a symptom of post-traumatic stress and neglecting pain treatment (IASP 2019).

The safe and effective management of pain requires appropriate education of medical, nursing and allied health staff and attention to organisational aspects regarding the safe delivery of pain relief. This education must include patient assessment, the safe use of appropriate medicines, basic nursing cares (“comfort cares”), non-pharmacological interventions, self-management techniques and advanced pain management interventions for severe acute pain, persistent pain and intractable palliative pain / end of life cares. It is well recognized that the need for and complexity of this education will vary according to the setting in which the pain management is to be delivered e.g. primary care, community based or the hospital setting and the experience of staff delivering that care (Schug et al 2015:53).

The APS supports this review of nursing education given the many developments which have taken place in pain advocacy, research, technological advances and clinical practice since the last review in 2002. Strategic planning around pain-related workforce training and education, along with regulatory reform of accreditation and funding systems, needs to be reflected in new models of education if we are to significantly reduce the number of people who experience poorly managed pain.

By adopting a collaborative multidisciplinary approach that considers the biological, psychological and social components of the pain experience, it is possible to reduce pain and improve the overall quality of an individual's life and function.

Key issues

- **The preparation of Assistants in Nursing, Enrolled Nurses, Registered Nurses and Nurse Practitioners to meet the needs of the future health system,**
- **The effectiveness of current educational preparation to meet future health, aged care and disability needs of the Australian community including clinical training,**

The current educational preparation of nurses on pain management in undergraduate programs is inadequate and there are limited opportunities for post graduate education and articulation between different levels of nursing for this specialty. Current levels of education in pain and its management have failed to meet the health needs of the Australian population with children, the aged, people from rural and remote areas, culturally and linguistically diverse (CALD) clients, Aboriginal and Torres Strait Islander peoples, refugees and marginalized groups such as the lesbian, gay, bisexual, transgender, queer or questioning, intersex and asexual or allied (LGBTQIA) community and those with mental health issues being particularly vulnerable.

Unless rectified, we will continue to fail to meet future health needs. National leadership and action on pain is critical to ensure Australian live healthier lives through the effective prevention and coordinated management of chronic conditions, the leading cause of illness, disability and death in Australia, according to the National Strategic Action Plan for Pain Management (2019: 1).

“Every nurse should be able to assess and manage pain”, according to the International Association for the Study of Pain (IASP) Curriculum Outline on Pain for Nursing (2017:1) and included as Appendix 1. Staff providing nursing care, regardless of level (assistants in nursing, personal care assistants, enrolled nurses, registered nurses, clinical nurse consultants and nurse practitioners) and regardless of the setting (paediatric to aged care and end of life care) and the clinical care spectrum (from community care to tertiary hospital setting) must know how to assess and manage pain.

There is considerable variation in content in undergraduate nursing programs with pain and its management not considered a core subject, rather a symptom to be considered especially for cancer pain and palliation. The NSW Pain Management Taskforce (2012:45) recommended the inclusion of pain management in undergraduate and postgraduate curricula and that training programs for clinicians wishing to develop skills and knowledge in pain management be developed. A multidisciplinary post graduate program is available from

the University of Sydney and provides the opportunity to gain up to Masters level qualifications, but the cost is prohibitive for many nursing staff.

Standardisation among universities in their teaching curricula about pain management has been proposed by the National Strategic Action Plan for Pain Management 2018-2021 (see Appendix 2) (2019:16) and this should also include curricula developed for Technical and Further Education (TAFE) programs for enrolled nurses. Assistants in nursing and personal care assistants must also be educated in pain assessment and management and play a key role in the pain management care of those living in RACF's, community care facilities and disability support services.

Challenging beliefs about pain and its treatment is critical to building resilience in consumers and to producing more effective health outcomes (DOH 2019: 6). A major goal of the National Strategic Action Plan for Pain Management (2019:8) is that health practitioners are well informed and skilled on best practice evidence-based pain management care and are supported to deliver this care. They go on to state that their objectives are that all health practitioners and carers are trained in pain management to improve conceptualization of pain and underpin care plans and practices and that systems and guidelines are established to ensure pain is adequately managed across health and care systems. A key priority of the plan is the inclusion of pain management in accreditation standards for health providers.

An expansion of training opportunities for health practitioners in pain management is another strategy to improve not only pain management but to provide opportunities for advanced practice and articulation to higher roles. These include:

- the provision of short courses in pain assessment and management
- the completion of readily available online training material such as the Faculty of Pain Medicine Better Pain Management program (see Appendix 3).
- the development of workplace-based programs in clinical pain management (these clinical placements should include primary and community care as well as metropolitan and tertiary centres)
- the provision of MBS item numbers for nursing (similar to the diabetes educator model already funded by the MBS)
- the development of programs similar to the Program of Experience in the Palliative Approach (PEPA) program (which funds clinical placements or workshops including backfill and travel expenses)
- the introduction of a recognized pathway for pain specialization and training (such as recently introduced by the Australian Physiotherapist Association)
- conjoint clinical / academic appointments for more experienced clinicians to improve pain management education and research
- the development of specialty nursing standards for pain management in Australia akin to that used in New Zealand (Holloway and MacGeorge 2017; New Zealand Pain

Society – Nurses Interest Group 2013) see Appendix 4 and similar to the National practice standards for nurses in general practice developed by the Australian Nursing and Midwifery Federation (2014)

- the development of “blended” undergraduate and post graduate programs, incorporating cross discipline education on pain management
 - succession planning for clinical nurses to the role of clinical nurse consultants and nurse practitioners in pain management
 - mentoring programs / activities for nurses in rural and remote areas with regional and metropolitan centres to improve access to information and education in rural and remote areas
- **National and international trends, research, policies and procedures related to pain management education**
 - **Regional needs and circumstances**

Current national and international trends, research, policies and procedures related to pain management education are focused on the identification of gaps and inconsistencies in acute and chronic pain management whilst addressing the “opioid crisis”.

The following recommendations have been made by the US Pain Management Best Practice Inter-Agency Task Force (2019) with many of these recommendations supported by Australian pain management bodies including the Australian Pain Society, the Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine and PainAustralia.

Some of these recommendations include:

- Emphasizing the importance of individualized patient-centered care in the diagnosis and treatment of acute and chronic pain
- The development of effective pain management treatment plans with measurable outcomes focusing on functional improvement
- A multimodal approach which includes the use of medications, nerve blocks, physical therapy and other modalities for acute pain conditions
- A multidisciplinary approach for chronic pain across various disciplines who identify gaps/ inconsistencies and make recommendations for best practice (including medications of various classes where the benefit outweighs risk, restorative therapies, interventional approaches, behavioral approaches and complementary and integrative health
- Multidisciplinary management of complex aspects of acute and chronic pain based on the biopsychosocial model of care
- Consideration of special populations including children / youth, older adults, women, pregnant women, individuals with chronic relapsing pain, racial and ethnic

- populations, active members of the defense forces and Veterans and patients with cancer pain
- Risk assessment and risk stratification with particular emphasis on safe opioid stewardship
 - Addressing the stigma which is often cited by patients experiencing chronic pain
 - Providing more effective education and training about acute and chronic pain at all levels of clinical training, including undergraduate educational curricula, graduate professional training and continuing professional education, with the use of proven innovations such as the Extension for Community Healthcare Outcomes (Project ECHO) model.
 - Education to members of the public, policy makers and legislators
 - Addressing barriers to access to care including addressing the gaps in our workforce for all disciplines involved in pain management care, improved insurance coverage and payment for different pain management treatments including care coordination, complex opioid management and telemedicine and support for education, time and financial resource for primary care providers managing patients with painful conditions
 - Research and development is critical to the understanding of pain and its mechanisms, especially those underlying the transition from acute to chronic pain

Australians in rural and remote areas tend to experience higher rates of medication prescription and higher rates of pain management, likely due to higher prevalence rates and decreased access to appropriate pain management interventions. General practitioners (GP's) in remote Medicare locals were less likely to refer Australians living with chronic pain to another health professional – the highest rates were recorded for metropolitan areas, followed by regional areas and rural areas (Deloitte 2019: 30). Management practices are also likely influenced by the availability of allied health professionals in any given area.

There is a dearth of research into pain assessment and management for Aboriginal and Torres Strait Islander (ATSI) peoples and the development of guidelines and strategies to improve the identification and management for this vulnerable population is a key strategic priority of the Australian Pain Society.

Conclusion

The APS supports this review of nursing education given the many developments which have taken place in pain advocacy, research, technological advances and clinical practice since the last review in 2002. Strategic planning around pain-related workforce training and education, along with regulatory reform of accreditation and funding systems, needs to be reflected in new models of education if we are to significantly reduce the number of people who experience poorly managed pain.

Appendices

- Appendix 1: IASP Curriculum Outline on Pain for Nursing
- Appendix 2: The National Strategic Action Plan for Pain Management (2019)
- Appendix 3: Better Pain Management: Pain education for professionals
- Appendix 4: New Zealand Pain Society – Nurses Interest Group (2013) *New Zealand Pain Management Nursing Knowledge and Skills Framework for Registered Nurses*

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IASP Curriculum Outline on Pain for Nursing

Task Force Members: Huda Abu-Saad Huijjer, Christine Miaskowski (Chair), Robyn Quinn, Alison Twycross

Every nurse should be able to assess and manage pain. This curriculum is intended to be used to provide the optimal level of education on pain and its management for entry level nurses throughout the world.

Outline Summary

Introduction

Principles

Objectives

Curriculum Content Outline

- I. Multidimensional Nature of Pain
- II. Pain Assessment and Measurement
- III. Management of Pain
- IV. Clinical Conditions

References

Introduction

Pain is a multidimensional and complex phenomenon that requires comprehensive and ongoing assessment and effective management. The multidimensional nature of pain requires an interprofessional approach to assessment and management. All professionals need to serve as advocates for the person in pain and ensure that pain treatment is based on ethical principles and evidence-based standards and guidelines. Nurses play a critical role in effective pain management because they have frequent contact with patients in a variety of settings (e.g., home, hospital, outpatient clinic, community). This frequent contact places the nurse in a unique position to:

1. Identify patients who have pain.
2. Perform a comprehensive pain assessment including its impact on the patient and the patient's family members.
3. Initiate actions to manage the pain and evaluate the effectiveness of those actions.

Nurses' central role and responsibility in the assessment and management of pain means that they are required to be knowledgeable about pain mechanisms, the epidemiology of pain, barriers to effective pain control, frequently encountered pain conditions, variables which influence the patients' perception of and response to pain, valid and reliable methods of clinical pain assessment, and a range of available methods for the alleviation of pain.

Principles

The following principles guide the pain curriculum for entry level nurses:

Appendix 1: IASP Curriculum Outline on Pain for Nursing

1. Pain is viewed as a biopsychosocial phenomenon that includes sensory, emotional, cognitive, developmental, behavioral, spiritual and cultural components.
2. Pain may be acute, persistent, or a combination of acute on chronic. The etiology of the pain will guide the development of the pain management plan.
3. Pain must be assessed in a comprehensive and consistent manner using valid and reliable assessment tools.
4. Patients have a right to the best possible pain management. Pain assessment and management are integral aspects of nursing care and should involve patients and their family members.
5. Pain assessment and management should be recorded in a clear and readily accessible manner.
6. Patient and family education about pain and its management are essential components of nursing care.
7. Nurses are essential members of the pain management team.

Objectives

Upon completion of this pain curriculum, the entry-level nurse will be able to:

1. Apply current knowledge of anatomy, physiology, pharmacology, psychology and sociology to the assessment and management of people with pain.
2. Distinguish between different types of acute, recurrent, and persistent (chronic) pain in terms of mechanisms, assessment, and management and understand the consequences of unrelieved pain.
3. Engage in regular evidence-based pain assessment and care planning that takes into account the sensory, cognitive, affective, behavioral, social, cultural, spiritual, and political components of the pain condition.
4. Identify professional, system, patients, family and community barriers to effective pain assessment and management.
5. Recognize individuals who are at risk for undertreatment of their pain (e.g., individuals who are unable to self-report pain, neonates, cognitively impaired).
6. Use valid and reliable pain assessment tools that are appropriate to the needs of the individual patient and the demands of the care situation.
7. Administer prescribed analgesics and evaluate their effects on patients' pain and function.
8. Prevent and manage common adverse effects associated with pain treatment.
9. Describe the differences between physical dependence, psychological dependence (addiction), tolerance, and pseudoaddiction.
10. Identify and deliver a range of basic physical and psychological comfort measures (e.g., positioning, information, distraction) to decrease patients' pain.
11. Provide patients and family members with information about a variety of pain management interventions.
12. Demonstrate effective collaboration as a nurse-member of the interprofessional team that may include patients and family caregivers, to identify clearly defined, realistic and agreed upon goals for pain management.
13. Ensure accurate record-keeping and communication with patients, family caregivers, and members of the interprofessional team.

Appendix 1: IASP Curriculum Outline on Pain for Nursing

14. Practice in accordance with an ethical code that recognizes human rights, diversity, and the requirement to "do no harm."
15. Reflect critically on effective ways to work with and improve care for people with pain.
16. Regularly update personal knowledge on pain and its management.

Curriculum Content Outline

I. Multidimensional Nature of Pain

A. Magnitude of problem – epidemiology

B. Impact of unrelieved pain

1. Impact of acute pain on recovery and on the development of persistent (chronic) pain
2. Impact of persistent cancer and noncancer pain on:
 - i. The individual (e.g., physical, psychosocial, spiritual, vocational, socioeconomic)
 - ii. The family (e.g., roles, relationships, psychological concerns, socioeconomic factors)
 - iii. Society (e.g., cost, lost productivity)

C. Definitions of pain

1. Types of pain based on duration
 - i. Acute pain
 - ii. Persistent (chronic) pain
 - iii. Breakthrough pain
2. Types of pain based on mechanism
 - i. Nociceptive pain (somatic, visceral)
 - ii. Neuropathic pain

D. Multiple dimensions of Pain

1. Physiological dimension – neural mechanisms of pain
 - i. Transduction
 - ii. Transmission
 - iii. Modulation
 - iv. Perception
2. Sensory dimension
 - i. Location
 - ii. Intensity
 - iii. Quality
 - iv. Temporal pattern
 - v. Relieving and exacerbating factors
3. Affective dimension

Appendix 1: IASP Curriculum Outline on Pain for Nursing

- i. Influence of negative and positive emotions
 - ii. Affective consequences of pain, including suffering
 - iii. Impact of pain on mood, sleep, socialization
4. Cognitive dimension
 - i. Personal beliefs, attitudes, and meanings attached to the pain experience and/or the disease condition associated with pain
 - ii. Spiritual beliefs, community, culture, family, and social networks related to cognitive responses to pain
5. Behavioral dimension
 - i. Response to stressors (e.g., situational, developmental)
 - ii. Pain expression behaviors
 - iii. Pain control behaviors
 - iv. Usual behaviors prevented by pain
6. Social, cultural, ethical and political dimensions
 - i. Social and cultural variations in conceptualizing pain, its meaning, and management
 - ii. Access to resources, including availability and costs of treatment

II. Pain Assessment and Measurement

A. Evaluate the feasibility, validity, reliability, sensitivity, and clinical utility of different pain assessment methods for specific groups (e.g., age groups, cognitively impaired, diagnostic groups) and clinical settings

B. Conduct an initial comprehensive pain assessment using valid and reliable comprehensive multidimensional pain assessment tools

C. Perform ongoing pain assessments using valid and reliable unidimensional measures

1. Intensity/severity
2. Pain relief
3. Impact of pain on function
4. Improvement in pain intensity

D. Identify patients at risk for inadequate pain assessments and effective pain management and use valid and reliable tools to assess pain in these high risk patients

1. Infants and children
2. Older adults
3. Cognitively impaired or developmentally disabled individuals
4. Individuals with a history of addictive disease or current use of illicit substances
5. Individuals who speak a language other than that spoken by the healthcare professionals
6. Patients who are unable to communicate effectively due to disease or treatment

Appendix 1: IASP Curriculum Outline on Pain for Nursing

E. Communicate verbally and record initial and ongoing pain assessments in the patient's health care record so that these assessments are accessible to all members of the pain management team

III. Management of Pain

A. Establish the goals of pain management with the patient and their family caregivers

B. Identify patient, family caregiver, system, and clinician barriers to effective pain management

C. Utilize appropriate pharmacologic interventions for pain management

1. Nonopioid analgesics
 - a. Mechanisms of action
 - b. Indications
 - c. Onset and peak duration of action
 - d. Adverse effects
 - e. Interactions with other drugs
2. Opioid analgesics
 - a. Types of opioid analgesics
 - i. Short-acting
 - ii. Long-acting
 - b. Mechanisms of action
 - c. Indications
 - d. Onset and peak duration of action
 - e. Equianalgesic dosing
 - f. Adverse effects
 - g. Interactions with other drugs
 - h. Definitions of tolerance, physical dependence, and psychological addiction
3. Adjuvants
 - a. Mechanisms of action
 - b. Indications
 - c. Onset of action, titration, and duration of an adequate analgesic trial
 - d. Adverse effects
 - e. Specific drugs
 - i. Anticonvulsants
 - ii. Antidepressants
 - iii. Local anesthetics
 - iv. Corticosteroids
 - v. Other agents
 - f. Interactions with other drugs
4. Methods of drug delivery
 - a. Oral/enteric
 - b. Parenteral (intravenous or subcutaneous, infusion devices, patient-controlled analgesia)
 - c. Transdermal

Appendix 1: IASP Curriculum Outline on Pain for Nursing

- d. Transmucosal
- e. Topical
- f. Spinal (epidural or intrathecal)
- g. Regional
5. Age-specific issues
6. Disease-specific therapies (e.g., anticancer therapies)

D. Utilize appropriate nonpharmacologic interventions for pain management

1. Therapeutic use of oneself (e.g., active listening, acknowledging and valuing the individual's and/or family's perspective, being empathic)
2. Physical strategies (e.g., exercise, turning and positioning, wound support, massage, heat, cold, hydrotherapy)
3. Psychological and behavioral strategies (e.g., cognitive-behavioral strategies, stress management, patient and family education and counseling)
4. Neurostimulation (transcutaneous nerve stimulation, acupuncture, epidural stimulation, brain and spinal cord stimulation)
5. Neuroablative strategies (neurolytic nerve blocks, neurosurgical techniques)
6. Palliative radiotherapy (cancer pain)

E. Multimodal and interprofessional pain management

1. Role of each profession
2. Unique contribution of nursing
3. Patient and family members as integral members of the pain management team
4. Palliative care, including hospice, home care, and long-term care
5. Patient and family education
6. Integration and coordination of care; discharge planning
7. Health promotion to prevent persistent pain (e.g., back pain)

F. Monitoring of pain relief and improvements in function and prevention and management of adverse effects

1. Follow-up evaluation of therapeutic effects
2. Follow-up evaluation of patients' and family members' responses to the pain management plan

IV. Clinical Conditions

A. Acute pain associated with trauma, surgery, or acute medical conditions

B. Common chronic pain conditions

1. Low back pain
2. Arthritis
3. Headache
4. Cancer pain
5. Pain associated with HIV disease

Appendix 1: IASP Curriculum Outline on Pain for Nursing

6. Neuropathic pain conditions

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IASP Interprofessional Pain Curriculum Outline

Note: This Interprofessional (IP) Pain Curriculum Outline is based on the four components of the Core Curriculum. This outline is to be used with health science students who are in their first professional program (pre-licensure/undergraduate/entry-practice level) to facilitate shared opportunities for students from more than one profession to learn together (e.g. dentistry, medicine, nursing, occupational therapy, pharmacy, physical therapy, psychology, and/or social work). The outline provides a basic overview of suggested topics for interprofessional learning that can be developed further and in more detail uniprofessionally. It does not replace the uniprofessional curricula that provide additional depth in content required by each individual profession and discipline. **The outline can be implemented in a variety of ways considering the professions involved, patient populations being studied, and regional needs.**

The outline provides curriculum topics under each component that are common in pain management. An important purpose of this outline is to facilitate interprofessional learning; therefore, the detail applied under each component will depend on the student learning tasks. For example, these may include interprofessional team planning for pain assessment and management of cases based on real patients. It is expected that implementation methods will vary. However, a suggested model is to balance selected core lectures with concepts essential to all (e.g., overview of mechanisms, pharmacology) with small-group work to develop interprofessional patient-focused assignments. **While all students need to reflect on the various components of the outline, the depth of application of the suggested detail will depend on the professions involved and the specific patient focus of the students' assignments.**

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Outline Summary

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Principles

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I. Multidimensional Nature of Pain

II. Pain Assessment and Measurement

III. Management of Pain

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Introduction

Appendix 1: IASP Curriculum Outline on Pain for Nursing

Interprofessional education (IPE) has been defined as two or more professions learning with, from and about each other to improve collaboration and the quality of care (1,2). IPE is sometimes confused with the intraprofessional model that involves different departments within the same profession (e.g. medical departments of surgery, anesthesia, neurology). Effective pain management can be complex, requiring collaborative approaches that exceed the expertise of any one profession. Research evidence for IPE supports positive health outcomes for patients and health systems from collaborative teams (2). However, for health care professionals to collaborate in meeting patients' needs, they first must understand each other's roles and expertise. This understanding is the foundation for valuing and respecting others' contributions to the management of complex problems, such as those for people with persistent pain. Interprofessional education fosters this understanding through interactive group work unlike multiprofessional education usually delivered in a large group didactic lecture format (3).

An interprofessional pain curriculum provides a common basis for different professions to learn the same language as well as a basic understanding of pain mechanisms and major biopsychosocial concepts important to all. Interprofessional education provides a basis for collaborative competencies that include a) recognizing and respecting the roles, responsibilities, and competence of others in relation to one's own, and b) knowing when, where, and how to involve these other professionals (4). Interprofessional group opportunities allow students to learn of each other's expertise, both shared and unique, that is essential to interprofessional and/or multiprofessional pain management. Working as a team to plan, manage, and monitor care (interprofessional) and/or communicating/coordinating care from individual health care professionals (multiprofessional) can result in more effective patient outcomes.

A subgroup of the IASP Education Initiatives Working Group was directed to develop an interprofessional pain curriculum outline based on the four components of the IASP CORE Curriculum. The iterative development process (2010-2012) included extensive discussion until consensus was reached on foundational pain content that was complete, clear and relevant to all professions (Phase 1-2). The interprofessional draft was then cross-referenced with the revised uniprofessional drafts to ensure inclusion of their common priorities (Phase 3). Feedback was elicited from the total Working Group (Phase 4) before circulating it to the IASP Education SIG membership for input (Phase 5). Responses (N=61) from a good variety of professionals and countries were utilized by the total Working Group and the final submission to Council Executive was approved on August 14, 2012 (Phase 6). It is expected that the Outline will be further tested and evaluated as used by the membership.

Principles

1. All health care professionals have an obligation to be empathic, assess, and work with patients and families to manage pain.
2. Interprofessional learning opportunities provide students with an understanding and appreciation of the expertise of professions other than their own.

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3. Comprehensive pain assessment and management is multidimensional (i.e. sensory, emotional, cognitive, developmental, behavioral, spiritual, cultural) and requires health professional collaboration.
4. Effective pain management outcomes occur when health care professionals work together with patients, families, communities and health care providers (e.g. regulatory, insurance).
5. Interprofessional pain education is most successful when it reflects real world practices and is integrated early in the educational experience.

Objectives

Upon completion of this pain curriculum, the entry-level health care professional student will be able to:

1. Discuss the multidimensional nature of pain and its components, implications for patient-families, and relationship to clinical interventions.
2. Discuss clinical assessment and measurement approaches and misbeliefs common to health care professionals.
3. Describe multiprofessional and interprofessional strategies for the planning, intervention and monitoring of pain management outcomes.
4. Develop and discuss as part of an interprofessional student group the rationale for patient-focused pain assessment and management plans based on authentic patient cases (actual or scenarios).
5. Discuss inadequately managed pain assessment and management from an ethical, safety, social and political perspective.

Curriculum Content Outline

I. Multidimensional Nature of Pain

A. Epidemiology

1. Pain as a public health problem with social, ethical, legal and economic consequences
2. Epidemiology with overview of statistics related to acute, recurrent and/or persistent (chronic) and cancer pain
3. Barriers to effective pain assessment and management: individual, family, health professional, society, political institutions

B. Development of pain theories

1. Historical development of pain theories and basis for current understanding of pain
2. Definition of pain and pain terms
3. Classification systems of pain
4. Differences between nociception, pain, suffering and harm
5. Pain and behavior

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C. Mechanisms

1. Anatomy and physiology to include neural mechanisms [peripheral pain mechanisms, dorsal horn processing, ascending and descending modulation and central mechanisms]
2. Multiple dimensions of pain to include physiological, sensory, affective, cognitive, behavioral, social/cultural/political
3. Pathological consequences of unrelieved pain, and implications of being a multidimensional experience (biological, psychological and social)
4. Factors influencing neurophysiology (e.g. genetics, age, sex, ethnicity)

D. Ethics

1. Ethical standards of care (provision of measures to minimize pain and suffering) for health care professionals
2. Ethical standards and guidelines related to use of analgesics (e.g. inadequate analgesic prescribing; over-medication; confusion regarding physical dependence, tolerance and addiction, abuse screening, use of placebos)
3. Inadequate pain management for specific groups including infants, children, elders, those with communication difficulties and/or learning disabilities
4. Legal issues related to disability, compensation
5. Political and societal issues related to access to pain management and attitudes to marginalized populations
6. Experimental pain issues related to appropriate and meaningful measures and methods

II. Pain Assessment and Measurement

A. Interprofessional and Multiprofessional Collaboration

1. Assessment of patient priorities as a team where possible (interprofessional) and/or communication of planning between individual health care professionals (multiprofessional) to ensure:
 - Comprehensive assessment especially when pain problems are complex e.g. pain sensory characteristics, treatment history, impact of pain on functional status, perception of self/relationships, and past pain experiences
 - Clear documentation of pain assessment and measurement data
 - Ongoing communication for comprehensive and consistent approaches
 - Monitoring of efficacy and effectiveness of management plan
 - Consideration of appropriate assessment and measurement approaches for people with special needs (e.g. infants, children, older adults, developmentally challenged, cognitively impaired)
 - Development of interprofessional consultant networks (informal/formal) when needed for adequate assessment with complex patients

B. Assessment

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1. History
 - Pain location, onset and duration, severity, quality, alleviating and aggravating factors
 - Impact on mood, usual activities/function/quality of life/sleep
 - Previous pain and treatment history
 - Ongoing response to treatment, adverse effects
 - Comorbidities impacting pain (e.g. chronic disease, surgery, trauma, mood, cognitions, abuse history, medications)
 - Personal characteristics (e.g. age, sex, race, religion, culture, language)
 - Expectations of pain management and current understanding of the condition
2. Physical examination
 - Neurological and musculoskeletal assessment
 - Posture and range-of-motion evaluation
 - Focused according to the presenting condition
3. Review of clinical records
4. Investigations
 - Laboratory tests
 - Imaging studies, e.g:
 - X-rays (flexion/extension views if needed)
 - Ultra Sound (U/S)
 - MRI, CT, Bone scan

C. Measurement

1. Approaches
 - Qualitative
 - Quantitative
2. Testing issues
 - Feasibility
 - Validity
 - Reliability
 - Sensitivity
 - Clinical utility
3. Tools (uni- and multi-dimensional)
 - Numerical Rating Scales (NRS)
 - Visual Analogue Scales (VAS)
 - Verbal/categorical scales
 - Faces scales
 - Pain drawings
 - Comprehensive pain questionnaires
 - Functional measures (e.g. pain-related disability, specific activities, health status)
 - Measures of psychological status (e.g. depression, anxiety, beliefs)
 - Measures for special populations (e.g. non-verbal, infants, cognitively impaired)

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III. Management of Pain

A. Goals of Pain Management

1. Reduction of pain intensity
2. Enhancement of physical functioning
3. Improvement of psychological functioning
4. Reduction of healthcare utilization
5. Promotion of return to work/school and/or role within the family/society
6. Improvement of health-related quality of life

B. Pain Management Planning Decisions

1. Develop, monitor and modify the management plan as an interprofessional and/or multiprofessional team
2. Involve patient and family caregivers in establishing clear, realistic goals
3. Use combinations of methods where appropriate including physical, psychological, pharmacological and interventional
4. Provide patient information/education including: communication methods, management options, management of potential adverse effects
5. Develop transparent treatment plan with realistic goals

C. Treatment Considerations

1. Type(s) of pain
2. Multidimensional nature of pain (e.g. biological, psychological, social)
 - Use of combinations of pharmacological and non-pharmacological methods
3. Patient issues
 - Access to clinics, treatment center, advantages of early intervention
 - Patient involvement / understanding of management plan/motivation to change
 - Cultural / societal limitations
4. Caregiver issues
 - Understanding of pain (false beliefs)
 - Fears and anxieties (e.g. drug addiction, side effects)
 - Understanding of patient goals/needs
5. Health professional issues
 - Understanding of pain (false beliefs)
 - Fears and anxieties (e.g. drug addiction, adverse effects)
 - Understanding of current evidence supporting management strategies
6. Political issues
 - Pain management as a human right
 - Access to clinics, treatment centers
 - Access to pain relieving medications
 - Access to interventional treatment
7. Substance abuse issues
 - Define aberrant drug-related behavior and substance dependency (abuse)

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- Assessment/screening of risk of abuse

D. Pharmacological Methods

1. Include for each analgesic selected the following:
 - Mechanisms of action
 - Indications for use
 - Pharmacokinetics including mechanisms of toxicity where appropriate
 - Adverse effects and their management
 - Equianalgesic dosing
 - Interactions with other drugs
 - Formulations (short and long acting)
 - Administration routes
 - Age-specific therapies (including, neonate, infant and elderly)
 - Disease, surgery, cancer and/or trauma pain-specific strategies
2. Clarify tolerance, physical dependence and psychological dependence
3. Utilize combinations of analgesics and adjuvants where appropriate:
 - Over the counter medications (acetaminophen/paracetamol)
 - Non-steroidal anti-inflammatory drugs (NSAIDS)
 - Opioids
 - Antidepressants
 - Anticonvulsants
 - Local anesthetics
 - Topical agents
 - Other
4. Knowledge of legislative requirements and current guidelines regarding controlled drugs

E. Non-pharmacological Methods

1. Utilize combinations of physical and psychological strategies, where appropriate:
 - Clinician therapeutic use of self (e.g. active-listening, being empathic)
 - Physical strategies to support home and occupational function and activity (e.g. heat, cold, positioning, exercise, massage, wound support, exercise, mobilization, manipulation, reach devices, other comprehensive rehabilitation approaches)
 - Psychological and behavioral strategies (e.g. cognitive-behavioral strategies, coping strategies, biofeedback, patient-family education and counseling)
 - Neuromodulation (e.g. transcutaneous electrical nerve stimulation [TENS], acupuncture, brain and spinal cord stimulation)
 - Neuroablative strategies (e.g. neurolytic nerve blocks, neurosurgical techniques)
 - Procedural/Interventional (e.g. injections)
 - Surgery
 - Complementary alternative medicine (CAM)
 - Palliative radiotherapy (e.g. cancer pain)

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- Information and communication technologies (e.g. virtual reality, computer-assisted interventions, smartphones)

F. Evaluation of Outcomes

1. Monitor management outcomes related to pain severity and function levels, adverse effect management, and impact on mood, family and quality of life issues
2. Utilize an interprofessional and multiprofessional team approach to insure integration and coordination of care
3. Consider barriers related to treatment availability and costs at the patient-family, institution, society and government levels

IV. Clinical Conditions

The following list includes suggestions under each to help with decisions about the selection of patient cases for interprofessional small group learning. The choice of clinical condition and detail will depend on the students and specific patient populations to be studied.

A. Taxonomy of Pain Systems

1. Distinction between acute, recurrent, incident, and or persistent (chronic) pain (may have combination of more than one type)
2. Distinction between nociceptive (somatic, visceral) and non-nociceptive (neuropathic) pain (may have both nociceptive and neuropathic pain)
3. Distinction between commonly used pain terms in clinical practice (e.g. allodynia, analgesia, dysesthesia, hyperalgesia, paresthesia, pain threshold, pain tolerance)
4. Involvement of biological, psychological and social factors influencing the perception of pain

B. Pain in Special Populations

1. Pain in infants, children and adolescents
2. Pain in older adults
3. Pain in individuals with limited ability to communicate
4. Pain in pregnancy, labor, breast feeding
5. Pain with psychiatric disorders
6. Pain in individuals with substance abuse

C. Acute Time-Limited Pain

1. surgery
2. trauma
3. infection
4. inflammation
5. burn

D. Cancer Pain

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1. primary pain
2. local invasion
3. metastatic spread
4. treatment-related
5. end-of-life

E. Visceral Pain

1. referred patterns
2. cardiac and non-cardiac chest pain
3. abdominal, peritoneal, retroperitoneal pain
4. pelvic pain (male and female)
5. sickle cell crisis

F. Headache and Facial Pain

1. headache
2. orofacial pain
3. trigeminal neuralgia

G. Neuropathic Pain

1. Primary Lesion Central
 - multiple sclerosis
 - post-stroke
 - spinal cord injury
 - traumatic brain injury
 - syringomyelia
2. Primary Lesion Peripheral
 - degenerative disc disease with radiculopathy in neck and low back
 - peripheral neuropathies (diabetes, cancer, alcohol, HIV)
 - post herpetic neuralgia
 - acute disc herniation with radiculopathy
 - complex regional pain syndrome II (CRPS II) (causalgia)
 - phantom limb
3. Mixed or unclear origin
 - complex regional pain syndrome I (CRPS I) (reflex sympathetic dystrophy)
 - irritable bowel syndrome
 - fibromyalgia
 - other

H. Musculoskeletal

1. rheumatoid arthritis, osteoarthritis
2. neck pain, whiplash and referred pain
3. low back pain and referred pain
4. injuries from athletics

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5. myofascial pain syndrome

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Australian Government

Department of Health

NATIONAL STRATEGIC ACTION PLAN FOR PAIN MANAGEMENT

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ABOUT THE PLAN

For many people, pain is a temporary discomfort associated with injury, illness or post-surgery. However, when pain becomes chronic (persistent or recurrent for 3 months or longer), it has a deep impact on quality of life as people living with pain become excluded from community, work or education.

With at least one in five Australians living experiencing chronic pain today, it is an escalating health issue and carries a significant economic burden in lost productivity and health costs. Addressing pain is in the interests of all Australians.

Yet many people living with pain cannot get access to best practice pain management, often due to cost, location or low awareness of treatment options, and medication is playing an increasing role. To date, pain has not been a national health policy priority, despite its significant impact on people's lives.

The Australian Government announced support for the development of the first ever National Strategic Action Plan for Pain Management (the Action Plan) in May 2018. The Action Plan sets out the key priority actions to improve access to, and knowledge of best practice pain management, in the next three years.

Painaustralia, the national peak body working to improve the quality of life for people living with pain, has consulted widely with consumers and consumer groups, clinicians, allied health practitioners, key health groups, researchers, experts and the whole community to understand what people think the key priorities are for the Action Plan.

These consultations have confirmed the need for action and nationally coordinated policy setting. Greater awareness of pain and pain management, more timely access to consumer-centred interdisciplinary services and research to underpin greater knowledge of pain as well as new treatments have emerged as key priorities, as has harnessing leaps in research, clinical evidence and technology.

The Action Plan builds on the strong foundation and advocacy of Australia's pain sector which developed

the National Pain Strategy in 2010 to provide a blueprint for best practice pain management.

The Action Plan also leverages and builds on key activities taking place at a state and territory level and through primary health networks (PHNs) that have increased community awareness of pain management, integrated services, provided education and training for health practitioners and invested in pain services. The Action Plan also seeks to foster innovation in service design and delivery.

National leadership and action on pain is critical to ensure Australians live healthier lives through effective prevention and coordinated management of chronic conditions: the leading cause of illness, disability and death in Australia. The Action Plan aligns to the goals of the National Strategic Framework for Chronic Conditions published by Australian Health Ministers Advisory Council (AHMAC) in 2017 and will underpin Australia's obligations as a member state of the World Health Organisation and its efforts through the Global Action Plan for Prevention and Control of Non-Communicable Diseases 2013-2020.

The Action Plan comes at a critical time: pain management finds itself at the intersection of key global public health challenges of the 21st century including the safe and effective use of medications and the urgent need to stem the rise of chronic conditions.

The Action Plan will provide a key step towards a national and holistic policy framework that will support consumers, health practitioners and the wider community to improve the quality of life for people living with pain, their families and carers and minimise its impact.



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We also acknowledge the many organisations and individuals that have contributed to the development of this Action Plan, including:

- > ACT Pain Support
- > Arthritis Australia
- > Australian Pain Association
- > Australian Pain Management Association
- > Australian Pain Society
- > Australian Rheumatology Association
- > Australian Pharmaceutical Society
- > Australian Physiotherapists Association
- > Brain Foundation
- > Carers Australia
- > Chronic Pain Australia
- > Consumers Health Forum
- > Department of Health, Australian Government
- > Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists
- > MS Australia
- > National Rural Health Alliance
- > Pain Revolution
- > Palliative Care Australia
- > Parkinson's Australia
- > Primary Health Networks
- > Royal Australian College of General Practice
- > Royal Australasian College of Physicians
- > Royal Australasian College of Psychiatrists
- > Scriptwise
- > State and Territory Departments of Health

We also wish to thank all the consumers and consumer groups that participated in the CHF-led consumer roundtable held in September 2018 and participated in our online survey July-August 2018.

HOW IS PAIN DEFINED?

Pain is complex and has many contributors

While acute pain is often a normal part of life, it is also important to deepen the understanding of chronic pain, given its significant impact.

The National Pain Strategy documents the evidence-base for the **'bio-psycho-social' model of pain assessment and management**. This model recognises three overlapping components: physical, psychological and environmental, and notes that to assess a person suffering from pain, it is important to assess the contribution of factors in these three areas to the pain experience of each patient.

Five categories of pain (National Pain Strategy):

- > Acute pain, defined as a normal and time-limited response to trauma or other 'noxious' experience, including pain related to medical procedures and acute medical conditions. Acute pain can also arise from physiological causes such as childbirth. If poorly managed, it can lead to more serious health issues, including chronic pain.
- > Pain that is progressing towards chronic pain, but this progression may be prevented ('subacute' pain). For example, acute wound pain may progress to chronic wound-associated pain.
- > Recurrent pain, e.g. migraine
- > Chronic (or persistent) non-cancer pain that persists for longer than 3 months
- > Cancer-related pain

Different types of pain:

Nociceptive pain is caused by damage to body tissue and usually described as a sharp, aching, or throbbing pain and can be caused by a range of conditions or factors including injury, surgery, arthritis, osteoporosis or musculoskeletal conditions.

Neuropathic pain is a type of pain that occurs following damage to the nervous system itself. The sensations associated with this type of pain are described as burning or shooting pains. The skin can be numb, tingling or extremely sensitive.

Nociplastic pain is essentially pain related to increased nervous system sensitisation rather than tissue or nerve injury despite no clear evidence of actual or threatened tissue damage.

Many health conditions can contribute to the development and maintenance of chronic pain:

- Back and leg pain (lower back pain is the leading cause of disability worldwide);
- Complex Regional Pain Syndrome (CPRS);
- Chronic widespread pain ('Fibromyalgia')
- Pelvic pain, including endometriosis;
- Migraine and headache;
- Sciatica;
- Orofacial pain;
- Neuropathic (nerve) pain; and
- Musculoskeletal conditions - conditions of the bones, joints, muscles and connective tissues, including arthritis, osteoarthritis, osteoporosis and gout.

Injury is also a leading contributor to chronic pain, and pain can follow surgery. The ePPOC program that benchmarks Australian and New Zealand pain services found in almost **40% of pain cases an injury at work, home or school or another place was the triggering event**, in 10.3% it was a motor vehicle crash and surgery accounted for 10.5% of pain cases. 17% of pain cases had no known cause (from the patient perspective), 10% was due to illness and 12% had other causes.

WHY ACTION IS NEEDED - AUSTRALIA'S PAIN BURDEN

Millions of Australians live with pain

One in five Australian adults are estimated to live with chronic pain (daily pain for more than three months, experienced in the last three months)¹. This is consistent with global burden of disease data, which show that lower back pain was the leading cause of disability globally in 2017.² Four million Australians currently live with arthritis, and this is projected to rise to 5.4 million by 2030.³

Some pain conditions are more prevalent in rural communities, with people outside the major cities reported to be 23% more likely to have back pain, rising to 30% for residents aged 55 to 64.⁴

Chronic pain is even more common among Australians aged over 65, with one in three living with chronic pain.⁵ Up to 80 percent of residents of aged care facilities are living with persistent pain, which is often under-treated or poorly managed.⁶

Between 25 to 35% of children and adolescents experience chronic pain.⁷

The pain burden is growing

Chronic pain affects more than 3.24 million Australians. PainAustralia's report, *The Cost of Pain in Australia* by Deloitte Access Economics, provides the most comprehensive analysis of the financial impact of chronic pain in Australia to date and it found more than 68% of people living with chronic pain are of working age. Without action, the prevalence of chronic pain will increase to 5.23 million Australians (16.9%) by 2050.⁸

By 2032, it is projected that the number of cases of arthritis and other musculoskeletal conditions will increase by 43% to 8.7 million and affect over 30.2% of the population. Osteoarthritis is projected to affect three million people (up from 1.9 million), back problems to affect 3.8 million people (up from 2.9 million) and osteoporosis to affect 1.2 million people (up from 0.8 million).⁹

Pain is closely associated with other health conditions, mental health and disability

Comorbidity (the occurrence of two or more diseases in a person at one time) is very common among people living with pain conditions like arthritis and back pain.

For those who experience chronic pain, the pain can be debilitating and have an adverse effect on work, sleep, and relationships. Individuals with chronic pain may also commonly experience comorbidities such as depression, sleep disturbance and fatigue.

These comorbidities often contribute to worse health, societal and financial outcomes – for example, major depression in patients with chronic pain is associated with reduced functioning, poorer treatment response, and increased health care costs.

Chronic pain and mental health problems, particularly depression, commonly occur together. Major depression in patients with chronic pain is associated with reduced functioning, poorer treatment response and increased health care costs. High rates of generalised anxiety disorder, post traumatic stress disorder and substance misuse are also reported in people with chronic pain. Moreover, suicide is reported to be two to three times higher in those suffering chronic pain compared to the general population, and it is associated with depression.¹⁰ This may be due to opioid related deaths, but there is a lack of research in this area.

In 2018 the top three chronic disease combinations were: depression or anxiety (44.6%), osteoarthritis and degenerative arthritis (29.3%) and high blood pressure (25.1%).¹¹

Chronic pain and mental health problems, particularly depression, commonly occur together.¹² In Australia and New Zealand, 40.5% of pain patients captured in ePPOC data in 2016 reported also suffering depression and/or anxiety.¹³

Pain carries a significant economic cost

The Cost of Pain report has pulled data out of the health, aging and disability sectors, to reveal the staggering cost of chronic pain to taxpayers. In 2018, this figure was \$139.3 billion. This was on top of the fact that last year alone, Australians paid \$2.7 billion in out of pocket expenses to manage their pain, with costs to the health system in excess of \$12 billion.¹⁴

There were estimated to be 9.9 million missed workdays due to chronic pain each year in Australia in 2006.¹⁵

Chronic pain is estimated to be Australia's third most costly health condition in terms of health expenditure, noting musculoskeletal conditions are the second most costly, and injuries the fourth (both carry a strong association with chronic pain).¹⁶

Chronic pain is a leading cause of economic and social exclusion

Pain deeply impacts on people's ability to participate in work, education or the community. Globally, the median period that a person lives with chronic pain is seven years.¹⁷

Back pain and arthritis are two of the most common health conditions that cause premature retirement for people between the ages of 45 and 64, accounting for about 40% of cases.^{18, 19}

Most patients included in 2016 ePPOC data stated that their pain affected the number of hours they were able to work or study (92%) and the type of work they were able to do (95%). 19% of episodes involved a compensation claim and 34% were unemployed due to their pain condition.²⁰

The daily challenges of chronic pain include decreased enjoyment of normal activities, loss of function and relationship difficulties.²¹

As chronic pain is largely invisible, those living with pain report feeling stigmatised by co-workers, friends, family, and the medical profession.²²

People can't access pain services

Up to 80% of people living with chronic pain are missing out on treatment that could improve their health, quality of life and workforce participation²³ including access to pain specialists and one-stop pain clinics that offer interdisciplinary care, but also services at the primary care level.

Most public and private pain clinics that offer interdisciplinary care in one physical location are predominately located in the major capital cities.²⁴ Specialist Pain Medicine Physicians (SPMPs) are concentrated in the major cities of NSW, South Australia, Victoria, Western Australia and Queensland. There is no pain specialist in the NT.

There are only seven paediatric pain clinics in Australia, with none in Tasmania, the ACT or the NT.

The physiotherapy workforce, integral to interdisciplinary pain management, is also not evenly distributed and there is a shortage in rural and remote areas.²⁵

There is low awareness of pain and its treatment options

Awareness of pain and pain management is also low among health practitioners and consumers. For example, clinicians' beliefs and practice behaviours relating to lower back pain were found to be discordant with contemporary evidence on the most effective treatments.²⁶

Challenging beliefs about pain and its treatment is critical to build resilience in consumers and producing more effective health outcomes. Explaining the neuroscience of pain has been shown to improve pain and movement, and reduce fear avoidance.²⁷

Over the last 20 years between 1996 and 2016, research aimed at understanding pain has attracted \$133 million. In comparison, between 2012 and 2017, cardiovascular disease has received \$687 million of research funding.²⁸

There is a reliance on pain medications

A 30% increase in opioid prescribing occurred between 2009 and 2014.²⁹

The Australian Commission on Safety and Quality in Health Care revealed opioid medications were being prescribed in some regional areas at 10 times the rate of other areas and they recommend action on pain and opioid management in rural areas.³⁰

Rising numbers of Australians are dying from accidentally overdosing on a prescription drug. The rate of opioid induced deaths almost doubled in 10 years, from 3.8 to 6.6 deaths per 100,000 Australians between 2007 and 2016 and more than three-quarters of all drug deaths involved pharmaceutical opioids. There is growing interest in ensuring the safe and effective use of medications.

Specific and significant recent changes were made to address these issues, including the up-scheduling of codeine and the decision to progress real time prescription monitoring. However, there is more that can be done to address over-reliance on pain medications and its negative consequences.

WHAT CONSUMERS TOLD US



'There have been some small improvements (since 2010)- however there are still lengthy delays in accessing pain services'

'People with chronic pain just wish to live a life free of pain, or lessened pain. Education needs to be improved in this area, instead of the constant stigma across all of the community'

'I want to become a productive member of my community again. I hate living under the poverty line. And I hate having no self-esteem because I don't feel I contribute'

'We need public awareness campaigns...not all pain is not treatable and curable... people need to be empowered and trusted to manage their own pain'

'Our voices need to be heard, we are not being listened to by decision-makers, but we need more support to tell our stories – resources will help us'

'Carers, especially young carers of people living with pain need to be better supported and heard so they can continue to care'

WHAT WE WANT TO ACHIEVE – VISION FOR 2021

OVERARCHING GOAL: Improved quality of life for people living with pain and the pain burden for individuals and the community is minimised

KEY GOALS

OBJECTIVES

GOAL 1:

People living with pain are recognised as a national and public health priority

- > Pain is understood as key public policy priority by decision-makers.
- > Pain is included in other key national health and economic strategies, policies, plans and frameworks, particularly chronic conditions frameworks, being brought forward by governments or health and medical groups.
- > Future pain policy is underpinned by frameworks that ensure actions are evaluated and that pain is included in future priority setting.

GOAL 2:

Consumers, their carers and the wider community are more empowered knowledgeable and supported to understand and manage pain

- > Consumers will have confidence and knowledge to seek out best practice advice and treatment and to be active participants in their remedial journey, which will build resilience in managing chronic pain.
- > Consumers will be supported by the community and by the economic and regulatory environment, and stigma will be reduced.
- > Community understanding of chronic pain, the safe and effective use of pain medications and best practice management including active non-pharmacological management is enhanced.
- > Accessible and user-friendly information and support programs are available to all consumers, carers and families, regardless of background and location.

GOAL 3:

Health practitioners are well-informed and skilled on best practice evidence-based care and are supported to deliver this care

- > All health practitioners and carers are trained in pain management to improve conceptualisation of pain and underpin care plans and practices.
- > Systems and guidelines are established that ensure pain is adequately managed across health and care systems.

GOAL 4:

People living with pain have timely access to consumer-centred best practice pain management including self-management, early intervention strategies and interdisciplinary care and support

- > Patient-centred interdisciplinary assessment and pain care and support services that takes into the account the health and wellbeing of the whole person is offered in all locations and made available through delivery and funding models at the primary care level wherever possible
- > Opportunities for communication between health practitioners and patients about pain assessment and care plans are possible
- > Technology is harnessed to expand access to multiple services including primary care services and pain specialists.
- > Through targeted interventions, specific population groups are not excluded from best practice services or information about pain management.
- > The reliance on prescribing pain medications for chronic pain is minimised.

GOAL 5:

Outcomes in pain management are improved and evaluated on an ongoing basis to ensure consumer-centred pain services are provided that are best practice and keep pace with innovation

- > All pain services can participate in independent evaluation.
- > Pain services are patient-centred and offer best practice care that keeps pace with innovation and the latest clinical evidence base.
- > Quality use of medicines is evaluated and benchmarked across the health system.
- > Pharmacological and non-pharmacological pain management interventions are better understood.
- > The role of primary and tertiary level health services in pain management are each understood.

GOAL 6:

Knowledge of pain flourishes and is communicated to health practitioners and consumers through a national research strategy

- > Pain research at a national level through a network of pain research specialists.
- > Identification of gaps in knowledge and practice in achieving the Action Plan goals
- > Translation and dissemination of research into practice and policy
- > Research findings are communicated to the community.

GOAL 7:

Chronic pain is minimised through prevention and early intervention strategies

- > Best practice acute and sub-acute diagnostic and treatment strategies are understood and provided across health settings.
- > Pain policy is linked to chronic disease frameworks.
- > Greater support is provided to people returning to work following an injury, surgery or diagnosis of a pain condition.

GOAL 8:

People living with pain are supported to participate in work and community

- > Greater support is provided to people returning to work following an injury, surgery or diagnosis of a pain condition.
-

PARTNERSHIPS AND ENABLERS

The delivery of this Action Plan will require commitment and priority setting at all levels of government and by key partners including not-for profit organisations, researchers, the private sector, individuals and communities.

Real improvements in awareness of pain management will require whole-of-community engagement, while the improvement in access to interdisciplinary services will require strong partnerships between governments, health practitioners, primary health networks and consumers.

In 2010, Australia was the first country in the world to develop a national framework for pain, as 200 delegates gathered to develop a National Pain Strategy which provides a blueprint for the treatment and management of acute, chronic and cancer pain. Pain medicine is an independent medical speciality; the importance of interdisciplinary care is recognised; and our education and research programs are internationally recognised. We must harness the opportunity of our collective local knowledge and expertise, and implement effective initiatives that are evidence based, reflect current national guidelines, and align with key national health initiatives such as MyHealth Record.



Figure 1: KEY PARTNERSHIPS AND PARTICIPANTS TO DELIVER ACTION PLAN

INTERDISCIPLINARY PAIN MANAGEMENT

There is a growing consensus and research base that supports the importance of coordinated interdisciplinary management strategies to address pain. This approach is endorsed in the 2010 National Pain Strategy and by the International Association for the Study of Pain. This requires coordinated interdisciplinary assessment and management involving, at a minimum, physical, psychological, and social/ environmental risk factors in each patient.³¹

This is known as the biopsychosocial (or more recently sociopsychobiomedical) prism from which to view a complex health issue like pain from different angles. Treatment is not 'one-size-fits-all' but needs to be person-specific.

A multidisciplinary team is likely to include a physician, clinical psychologist or psychiatrist, physiotherapist or other allied health professional such as occupational therapist, pharmacist and may include a dietician and social worker or counsellor.³² Nurses are also an important part of the multidisciplinary team. A critical step in the development of an effective pain management plan is face-to-face discussion by consumers and team members on the relative importance of factors identified by them in the patient, and ongoing communication between team members and patients on the progress of the pain management strategy.

Interdisciplinary pain management can be provided in specialist pain clinics. However, the National Pain Strategy recommends that in most cases, people living with pain can be best supported in primary care, with only a small proportion requiring tertiary care.³³

Evidence to support the importance of interdisciplinary approaches is growing. Patient outcomes of 60 pain services in Australia and New Zealand that apply interdisciplinary approaches are showing significant reductions in medication use and 75% of patients improved mental health or reduced interference in the quality of life caused by their pain.³⁴

Prescribing Wellness: Comprehensive pain management outside specialist services (Holliday, Hayes, Jones, Harris and Nicholas, 2018)

Physical – Establishing safe, consistent patterns of movement can calm nervous system arousal and reduce central sensitisation. This can be facilitated by negotiating measurable, achievable treatment goals that reflect meaningful and enjoyable activities, not just pain relief.

Psychological – It is important to explore any cognitive, behavioural and affective factors contributing to pain, to recognise and modify unhelpful conditions.

Social engagement – People typically feel safe when socially well connected and under threat when isolated. Meaningful positive engagement at work or home is crucial for pain recovery.

Nutrition – Obesity is frequently associated with chronic pain. Simple nutritional interventions for pain are recommended.

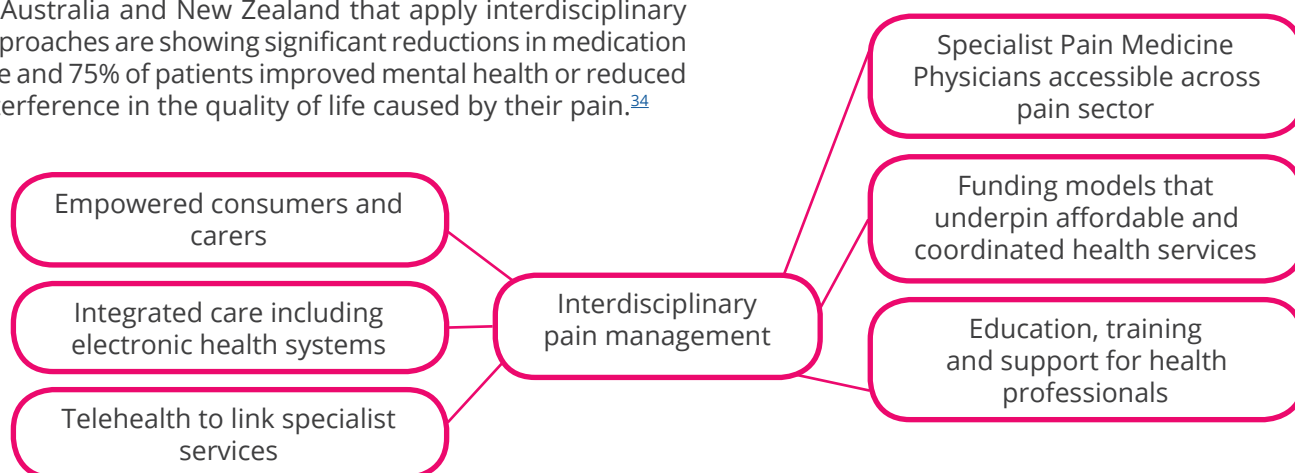


Figure 2: ENABLERS FOR INTERDISCIPLINARY PAIN MANAGEMENT

KEY GOALS AND ACTIONS 2018-2021 – THE KEY PRIORITIES

THE
FOLLOWING
ACTIONS
EMERGED
AS THE KEY
PRIORITIES
DURING THE
CONSULTATION
PROCESS

Establish a National Pain Leadership Group

COAG Health Ministers to endorse the Action Plan

Community awareness campaign

Interactive national website and app to provide a 'one stop shop' for information and resources

Include pain management in accreditation standards for health providers

Establish a National Institute of Pain Research

Provide an overarching education strategy for health practitioners

Map and review pain services by location and needs analysis

Recognise pain as a complex condition in its own right for the purposes of MBS rebates

Determine a single validated assessment and monitoring tool for chronic pain

These high priority actions have been guided by principles of assessment including ensuring they:

- Have the greatest positive impact for consumers
- Will be the most effective investment of efforts and resources
- Ensure consumers and carers are given a strong voice
- Are evidence based and meet principles of best practice pain management
- Can be widely supported and endorsed
- Deliver on the goals of the National Pain Strategy or meet a newly identified goal
- Meet unmet need
- Have the support of key enablers

KEY GOALS AND ACTIONS

2018-2021

BETTER COORDINATION AND LEADERSHIP

GOAL 1 People living with pain are recognised as a national and public health priority

ACTION ITEMS (how this will be achieved):

1.1 The formation and development of a **National Pain Leadership Group (NPLG)** to inform, support and lead and govern advice provided to the Minister for Health and COAG Health Ministers on the delivery and ongoing evaluation of the Action Plan and the national adoption and delivery of the 2010 National Pain Strategy as the key overarching document. It will:

- identify partnerships, frameworks and resources to deliver the National Action Plan and realise the goals of the 2010 National Pain Strategy over the longer term;
- inform future responses to contemporary challenges facing the pain sector and consumers living with pain; and
- be underpinned and directly informed by a Consumer Reference Group that recognises consumers as key partners and involves representatives from across Australia and reflects a consumer-led strategy.

1.2 COAG Health Ministers to endorse the Action Plan to lead and govern the delivery of the goals of the 2010 National Pain Strategy.

1.3 Supporting PainAustralia as the national peak pain advocacy body to advocate to decision-makers and raise awareness across the community to improve quality of life for people living with pain, their carers and families and to minimise the social and economic burden of pain on individuals and the community, as well as convene the NPLG to deliver constructive, unified advice.

CONTEXT

Pain remains one of the most misunderstood and neglected health issues, despite at least one in five Australians living with chronic pain. Pain has significant social and economic impacts and costs.

To date, pain has not been a key consideration in national health policy strategies and frameworks. For example, the Aboriginal and Torres Strait Islander Health Plan 2013-2023 or the Fifth National Mental Health Plan are silent on pain, yet it is a key priority to address chronic conditions as outlined in the National Strategic Framework or Chronic Conditions that has been agreed by Australian Health Ministers in 2017.

A focus on pain by the Australian Government will underpin efforts to reduce the burden of non-communicable disease through the World Health Organisation Global Action Plan to Prevent and Control Non-Communicable Diseases 2013-2020. Pain treatment is regarded a human right by the World Medical Association.³⁵

Pain is a critical consideration to ensure Australians live healthier lives through effective prevention and coordinated management of chronic conditions: the leading cause of illness, disability and death in Australia. Strategic and ongoing national action is required to recognise the complexity and ubiquity of pain in our community and reduce its impact.

GOAL 2

Consumers, their carers and the wider community are more empowered, knowledgeable and supported to understand and manage pain

ACTION ITEMS (how this will be achieved):

2.1 Fund and implement a **community awareness campaign** on pain and pain management treatment and support options with materials and messages developed in partnership with consumers, health professionals and community groups.

It will include:

- Vertically integrated communication strategies that ensure accessible and diverse communication through various media platforms including TV, radio, social media, print media and clinic-based media to share messages and reach out to a wide community audience.
- Specific strategies to communicate to Aboriginal and Torres Strait Islander Australians, Culturally and Linguistically Diverse (CALD) Australians and people accessing community and residential aged care services.
- Specific messaging and resources to be developed on 'living with pain' – a complex message but powerful opportunity to build resilience for people managing pain as a chronic condition.
- Storybooks, consumer vignettes and videos will be used to enhance understanding of the consumer lived experience.
- Care pathway summaries and guidance documents improve understanding by consumers and health practitioners of 'pain across the lifespan'.
- Materials to guide and raise awareness of the role of carers, including young carers of people with chronic pain, that taps into existing carer resources, but are pain-specific.
- Targeted communication strategies to highlight the latest evidence and guidelines for specific conditions e.g. lower back pain.
- Targeted communication strategy on the quality use of medicines with a pain focus to provide clear

direction and guidance on emerging treatments, such as medicinal cannabis for chronic pain that disseminates recent TGA guidance and better meets consumer expectations. Such guidance must be evidence-based, and further research is needed to improve the evidence base for some emerging treatments, including the use of medicinal cannabis for chronic non-cancer pain.

2.2 Development and dissemination of a **consumer handbook and smartphone application** for people living with chronic pain or those who have received a recent diagnosis of a pain condition. It will provide a definitive and best practice guide for people with chronic pain to improve health literacy, questions to ask health providers, where to get help and self-management strategies. It will support them to navigate health pathways on their remedial journey to be active participants in their healthcare. It will be available as a smartphone app in plain English, multiple languages and in electronic and print form. It will be provided at point of care and through other channels.

2.3 **Interactive and comprehensive national website and app for easy access to the website** for consumers, carers and health practitioners – a 'one stop shop' providing a gateway for best practice evidence-based pain education and information in Australia.

It will harness and support a wide array of emerging online tools and resources including:

- Information about pain and best practice treatment options.
- Up to date information about where to seek help.
- Self-check tools to help consumers screen for risk factors.
- Real life stories from consumers about how they manage their pain and remain engaged in life and work.
- Information for health professionals, courses and training opportunities and a community of practice.
- An online forum to connect consumers, carers and other people affected by pain, administered by trained moderators.
- A directory of courses on pain management for health practitioners.

2.4 Develop or collate existing **national standardised patient information and guidance into a document for distribution on discharge from hospital on safe and effective use of pain medications**, and on non-pharmacological management of pain, required to be delivered by hospital standards.

2.5 Provide **consumers with access to effective resources that enable them to communicate and navigate their pain experience between health providers, workplaces, carers or family** to reduce stigma, the need to repeat their story and better self-manage pain. Examples include 'PainTrain' and pain diaries. These tools also support health providers to better coordinate care.

2.6 Development of an **education program and resources for schools**, including building on the findings of the Hunter New England Population Health Children Initiative which is currently conducting consultations to define the best approach for integrating pain education in the school setting.

2.7 Explore the feasibility of expanded activities for the **'Brain Bus' children's education program**. 'The Brain Bus' provides an opportunity for school age children to learn about pain and the science behind it, through an interactive program that draws on the principles of neuroscience with the use of illusions and virtual reality. The program ignites interest in science while laying the foundations to help children understand their own pain experiences, promoting prevention and early intervention of chronic pain in our future generations.

2.8 National **information and support telephone line** that is resourced by accredited and trained staff and volunteers. This could draw on existing models operated nationally such as the Butterfly Foundation, Lifeline and National Health Direct phone services.

2.9 Small grants for **community pain support groups** that are not-for-profit, charity groups providing essential support services for people with chronic pain, their family and carers, linking them to activities, events, discussion forums and support networks. A small grants program would enable these organisations to increase their capacity on the ground. This could be coordinated by Painaustralia.

2.10 Develop a **peer to peer support network, facilitated by trained and accredited providers. Peer supporters are identified and trained to support other people living with pain**, particularly those who have recently had a chronic pain condition diagnosis. A trial of this initiative could be developed in a local community with an existing peer to peer network for wider adoption.

2.11 Partnerships between pain groups to coordinate a funded **national Pain Champion Advocacy Network** that includes **a network of speakers that can inspire action across communities and develop resources to support consumer advocacy such as a self-advocacy kit**.

CONTEXT

There is low awareness of pain and its treatment options in the community.

People living with pain commonly report stigma and misunderstanding of their condition in the community, workplace and by health practitioners.

Increasing community understanding of best practice pain treatments will more effectively align professional and consumer conversations on pain management. Changing common beliefs about pain and its treatment is also critical to achieve better outcomes from pain management.

Consumers need greater confidence to seek out best practice treatment and be active participants in their remedial journey as well as building resilience in managing chronic pain.

Currently there are a range of overlapping resources and websites in place which consumers can access to support them in their pain management. The development of a national website and resource suite should be cognisant of these existing resources, and seek to curate existing material and provide a single portal to enable sharing of and access to evidence-based information and resources, rather than duplicating existing information and resources.

It will be important that consumer-focused initiatives are inclusive of the needs of specific groups including Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, people from rural and remote areas, older Australians, people with dementia, children and young people, and other relevant groups.

KEY GOALS AND ACTIONS

2018-2021

BETTER CARE

GOAL 3 Health practitioners are well-informed on best practice evidence-based assessment and care and supported to deliver this care

ACTION ITEMS (how this will be achieved):

- 3.1** Develop an **overarching education strategy** to promote evidence-based pain management education across health practitioner disciplines, through undergraduate, postgraduate and continuing education. This should include, among other things, standardisation among universities in their teaching curricula with regard to pain management; and a focus on value based healthcare. The development of this strategy should also take into account the National Registration and Accreditation System review recommendations; and self-regulated allied health professionals should be among the health practitioner disciplines engaged in the education strategy.
- 3.2** Develop a broad national approach to assessment and monitoring, involving an integrated suite of **validated assessment and monitoring tools for chronic pain** use by GPs, practice nurses etc. across Australia, that combines existing best practice assessment techniques and the sociopsychobiomedical approach. This includes consideration of assessment and monitoring tools for priority population groups, e.g. CALD, Indigenous Australians, children and young people.
- 3.3** Develop **national clinical guidelines on pain and support for health providers to provide best practice pain management as outlined in the National Pain Strategy**. Available in accessible format through a handbook, smartphone application and other communication strategies, for provision to all health services and health practitioners in Australia. This will include models of care and pain assessment.
- 3.4** **Review of existing decision plan support systems available**, including medical software that is readily available, dose calculators, treatment protocols and plans, tapering or stopping opioid treatments, advice for health practitioners and online tools.
- 3.5** **Expand training opportunities for health practitioners in pain management** – licencing for an expanded number of health practitioners to complete training such as the Faculty of Pain Medicine Better Pain Management Program, or greater access for more practitioners to have access to selected modules of relevance. Provide short courses to expand general knowledge in primary care.
- 3.6** **Develop a six-month workplace-based certificate in clinical pain medicine for GPs** or other interested health professionals to complete.
- 3.7** Creation of a **public database of health practitioners who have completed pain management training courses** (on interactive website).
- 3.8** **MBS item for pain education** by medical, nursing or allied health practitioners, like the diabetes educator model which is already funded under the MBS.
- 3.9** **MBS item for GPs with specialist qualification in pain medicine** as a fellow of the FPM.

3.10 Specific materials and engagement activities to provide prescribers with guidance on the quality use of medications. This can be developed between professional bodies, peak groups and the Chief Medical Officer. This includes ensuring existing guidance is being provided, identification of the barriers to uptake of guidance and provision of engagement activities such as webinars and workshops in place.

3.11 Develop a 'train the trainer' model for Residential Aged Care providers and distribution and dissemination of the existing guidance and management strategy documents.

3.12 Adopt the guideline for treatment of persistent pain in children, as per the WHO Global Action Plan for the Prevention and Control of Non-Communicable Diseases 2013-2020.

CONTEXT

Pain remains one of the most misunderstood and neglected health issues, despite at least one in five Australians living with chronic pain. Pain has significant social and economic impacts and costs.

To date, pain has not been a key consideration in national health policy strategies and frameworks. For example, the Aboriginal and Torres Strait Islander Health Plan 2013-2023 or the Fifth National Mental Health Plan are silent on pain, yet it clearly as a key priority to address chronic conditions as outlined in the National Strategic Framework or Chronic Conditions that has been agreed by Australian Health Ministers in 2017.

A focus on pain by the Australian Government will underpin efforts to reduce the burden of non-communicable disease through the World Health Organisation Global Action Plan to Prevent and Control Non-Communicable Diseases 2013-2020. Pain treatment is regarded a human right by the World Medical Association.

Pain is a critical consideration to ensure Australians live healthier lives through effective prevention and coordinated management of chronic conditions: the leading cause of illness, disability and death in Australia. Strategic and ongoing national action is required to recognise the complexity and ubiquity of pain in our community and reduce its impact.



GOAL 4

People living with pain have timely access to consumer-centred best practice pain management including self-management, early intervention strategies and interdisciplinary care and support

ACTION ITEMS (how this will be achieved):

4.1 Map and review pain services by location in collaboration with States and Territories, Primary Health Networks and consumers to identify areas of most need and those with limited services. This will capture areas with waiting times of 18 months and over, and lack of capacity in specific regions to meet demand. This mapping will include a specific focus on paediatric pain services.

This will inform:

- Future investments by State and Territory Governments in interdisciplinary community-based pain services in areas of most need.
- Investments by all governments in telehealth, health practitioner training and other initiatives.
- Investments in services for specific groups including such as children and young people.

4.2 Recognise pain as a complex condition in its own right for the purposes of Medicare-supported pain management plan – with access to 10 individual services and 10 group services per calendar year based on clinical discretion (a similar level of support as the Better Access Mental Health Care program) including case conference attendant by a multidisciplinary team, seven telehealth services as part of the overall plan and specific supports like mental health services and allied health services.

4.3 Provide an MBS item for chronic pain group programs that are similar to those provided for mental health.

4.4 Review existing models of 'mini pain programs' that can be extended in regional and/or rural communities to provide coordinated care packages and increase capacity of health practitioners. Existing models include the Pain Revolution Local Pain Educator (LPE) model and other models in South Australia and Western Australia that embed capacity in regional and rural communities in pain management and education. This involves health practitioners enrolling in pain courses and then becoming pain educators and mentors once training is complete ('train the trainer'), as well as improving

coordination of services between general practice and allied health and referral pathways. Some PHNs are also undertaking activities to address the needs of people with persistent pain in their communities through expert education programs and individual case management, indicating potential for PHNs more broadly to play a key role in this area.

4.5 Expand and offer a telehealth pain services program to regional Australia as part of the telehealth program. Also **expanded Medicare item 2820 to support telehealth variations** like pain education and involvement of multidisciplinary teams.

4.6 Extend access to Medicare Item 132 to all specialist pain medicine specialists (SPMPs) – currently only available to FRACP or FAFRM qualified specialists.

4.7 Allow Specialist Pain Management Physicians to generate and extend interdisciplinary care plans through Medicare and eliminate the risk of non-referral for a Chronic Disease Management Plan that could significantly improve consumer outcomes.

4.8 The national rollout of information portals that support clinicians to assess and manage patient care through primary, secondary and community care. Examples include 'HealthPathways' which are available to varying degrees across PHNs. This will underpin efforts to develop 'care maps' and models of care that support interdisciplinary pain management in all PHNs so all members of a health care team whether they are in primary or secondary settings can work effectively together in the care and management of an individual, and referral to tertiary settings where needed.

4.9 Develop best practice 'models of care' to provide pathways for pain management in all communities, even those without pain services, and in settings where new models for pain management are required including palliative care, residential aged care, and referrals to addiction specialists. These will be developed by a Working Group of experts that reports to the National Pain Leadership Group and will include examples where State or Territory governments or PHNs have:

- Developed 'care maps' to support interdisciplinary pain management for all members of a health care team and tools such as 'HealthPathways'.
- Embedded self-management and empowerment strategies for consumers in their model of care.

4.10 Establishment of **clinical pain liaison roles**

that utilises the skills of GPs, nurses or allied health practitioners to identify chronic pain early in primary care, support education of local practitioners and smooth transitions and communications across services. For example, NSW is currently rolling out a program of this nature – the roles are flexibly employed depending on community need e.g. indigenous health, age care. The roles are jointly governed by Local Health Districts and PHNs.

CONTEXT

Many Australians with pain cannot access best practice pain management due to:

- cost
- location
- limited consumer knowledge and confidence
- lack of appropriately skilled health professionals
- failure to prioritise pain and pain management in health information and services for specific population groups
- failure of health funding and systems to support access to coordinated multiple services.

Most pain specialists and pain services are in metropolitan areas and to date, access to telehealth has been limited. The geographical variation in opioid prescribing highlights the reliance on these treatments in regional areas in lieu of alternative treatment options that are not available. Fifty per cent of Australians do not have private health insurance and cannot access private services and other treatments, and access to public services is limited.

There are significant barriers to accessing coordinated pain management at the primary care level, and it is unacceptable that people with chronic pain are required to have another chronic condition to access a Medicare GP Management Plan.

Without action, the translation of interdisciplinary chronic pain assessment and care into time-poor primary care settings will remain out of reach. Yet embedding this in primary care is vital to improve health outcomes for people living with pain.

In ensuring access to best practice pain management services, it will be important to consider the needs of specific groups including Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, people from rural and remote areas, older Australians, people with dementia, children and young people, and other relevant groups.

It will also be critical that access to best practice pain management across a range of settings is considered, including hospitals (noting opioid stewardship by hospitals is an issue that requires specific focus), residential aged care facilities, and prisons.

KEY GOALS AND ACTIONS

2018-2021

BETTER IMPLEMENTATION

GOAL 5

Outcomes in pain management are improved and evaluated on an ongoing basis to ensure consumer-centred pain services are provided that are best practice and keep pace with innovation

ACTION ITEMS (how this will be achieved):

- 5.1** Include pain assessment, reassessment and management principles in accreditation standards for hospitals, residential aged care facilities and community regulated by the Australian Commission on Safety and Quality in Health Care (ACSQHC).
- 5.2** **Secure the future funding of the Electronic Persistent Pain Outcomes Collaboration (ePPOC).** This includes developing a model for outcomes measurement developed at the primary care level and ensuring all public pain services can be funded to participate.
- 5.3** **Embed consumer perspectives in service design and quality improvement at the service level,** such as the Stanford 'CHOIR' Pain model.
- 5.4** **Evaluation of the effectiveness of existing patient resources for pain management** with a view to making them widely available in the Australian context e.g. pain diaries, self-management strategies.
- 5.5** **Strengthen requirements for pain management within aged care funding and accreditation systems**

CONTEXT

Pain medicine is an evolving medical speciality, and since the 2010 National Pain Strategy, some progress has been made in some areas of pain management and service delivery.

The Australasian benchmarking system Electronic Persistent Pain Outcomes Collaboration (ePPOC) is providing a vital insight into pain services, but not all services participate due to funding contracts. Consumer engagement in the design and delivery of services also requires further development.

Initiatives to evaluate and improve outcomes in pain management should be inclusive of specific groups including Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, people from rural and remote areas, older Australians, people with dementia, children and young people, and other relevant groups.

Addressing the needs of people with cognitive impairment, including dementia, is particularly important. More than sixty per cent of the people living with dementia who are referred to the Australian Government-funded Severe Behaviour Response Teams have unidentified undiagnosed pain. People with cognitive impairment are often unable to say they are in pain or identify the site of pain. Their pain may be expressed through changes in behaviour, such as confusion, distress, restlessness, irritability or aggression. Appropriate pain management may reduce the inappropriate use of antipsychotic medication. Hospital and aged care staff in particular should have the clinical skills in pain assessment and management for people with cognitive impairment. The knowledge and experience of families and carers in managing a person's pain should also be sought.

KEY GOALS AND ACTIONS

2018-2021

BETTER RESEARCH

GOAL 6 Best practice pain knowledge is growing and is communicated to health practitioners and consumers through a national pain research strategy.

ACTION ITEMS (how this will be achieved):

6.1 Establish a new National Institute of Pain Research. This body would link key partners and work across institutional and geographical boundaries to develop a pain research strategy (similar to the National Institute of Dementia Research model) to:

- establish and support a network of pain researchers by operating across organisational and geographic boundaries, bringing together capabilities and driving trans-disciplinary approaches to 'learn by doing' and 'learn from others';
- amplify our collective impact by harvesting our capabilities across research, health professional and government sectors and harnessing the value of our scientific, clinical and entrepreneurial resources. This would enable a shared commitment that 'leapfrogs' business-as-usual thinking to translate new investments into better patient experiences and outcomes;
- establish a forward plan of pain research priorities in collaboration with the pain sector, consumers and governments; and
- bring about the collaboration and open innovation needed to take Australia beyond the traditional and conventional pain management mindset as new approaches support experimentation and learning, and a continuous flow of knowledge and ideas that develops, attracts and retains talent and partners.

6.2 Pain and pain medicine to be a strategic priority for disbursement through the Medical Research Future Fund and NHMRC.

6.3 Support for ongoing research and clinical guidance on the use of emerging pharmacological and non-pharmacological interventions, including emerging treatments such as medicinal cannabis. This must keep pace with rising consumer expectations and be accompanied by effective communication strategies. It is noted that clinical guidance of pharmacological and non-pharmacological interventions come under the umbrella of Therapeutic Goods Administration/ Pharmaceutical Benefits Advisory Committee and Medical Services Advisory Committee.

6.4 Update and analyse the collection of information on pain in the ABS National Health Survey 2017-18 to develop a strong and new understanding of the prevalence of pain and its social and economic impact.

CONTEXT

Investments in pain research over the last 20 years have not been coordinated or prioritised, despite the significant impact of pain.

Investment has not kept pace with the burden of pain, attracting 1/6 of funding of other conditions and spread across a wide and varied scope of 50 field areas.

Strategic focus and investment are needed to understand the impact of research on improving health outcomes. For Australians to have access to the most up to date pain treatments, research is critical.

Australia has some of the leading pain researchers and the opportunity to be a world leader in this area.

Pain research should include a focus on improving the evidence base for pain management for specific groups including Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, people from rural and remote areas, older Australians, people with dementia, children and young people, and other relevant groups.

KEY GOALS AND ACTIONS

2018-2021

BETTER PREVENTION

GOAL 7 Chronic pain is minimised through prevention and early intervention strategies

ACTION ITEMS (how this will be achieved):

7.1 Strategies for improved management of acute pain and early recognition of patients at risk of developing chronic pain offer important preventative options in decreasing the prevalence of chronic pain. E.g. Dissemination and instruction in hospitals, primary care and other health settings, noting FPM has developed the leading resource on evidenced-based acute pain management, Acute Pain Management: Scientific Evidence. This could include rapid response pain clinics in hospitals.

7.2 Develop a **national standardised pain and rehabilitation strategy/program for peri-operative, post-injury or illness care and recovery and other strategies** including safe and effective use of medications.

7.1 Link measures to **reduce obesity such as improving levels of physical activity** with chronic pain prevention strategies and information and recognising **the role of nutrition in chronic pain management**.

7.2 Trial preventative **Quality Use of Medicine (QUM) strategies to alleviate the transition from sub-acute to chronic pain**. The role of NPS MedicinesWise should be considered in the implementation of this and other relevant action items within this Action Plan.

CONTEXT

All chronic pain starts with acute pain. Preventing the escalation of chronic pain is in the whole community's interest and is critical to prevent the misuse of medications, but a renewed focus is needed to:

- offer best practice post injury, operation or illness pain assessment, support and management; and
- ensure appropriate diagnostic and treatment strategies to prevent the transition from acute to chronic pain.

Prevention and early intervention strategies should include initiatives relevant to specific groups including Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, people from rural and remote areas, older Australians, people with dementia, children and young people, and other relevant groups.

KEY GOALS AND ACTIONS

2018-2021

BETTER SUPPORT

GOAL 8 People living with pain are supported to participate in work, education and the community

ACTION ITEMS (how this will be achieved):

- 8.1** Support initiatives to **develop a national approach to better support people to return to work following injury or diagnosis of a chronic pain condition** through an early intervention and interdisciplinary pain management pathway, that includes counselling and support delivered in the workplace on return to work. This requires partnerships between insurers, employers, workers compensation providers and primary and tertiary health services.
- 8.2** **Challenging beliefs following certification of work unfitness for health practitioners and the community:** that it can be reviewed over time, that work is generally positive for health outcomes, the impact of certification of sickness on health and wellbeing outcomes and how evidence-based pain management can assist people to re-enter the workforce.
- 8.3** Support for group pain programs as in Goal 4 and greater support for pain community support groups as in Goal 2.

CONTEXT

Pain carries a significant economic cost and is the leading cause of early retirement. People living with pain become socially isolated and endure higher levels of poverty.

More access to support and coordination of treatment and support has been shown to enable a return to function and/or work such as those identified in the Work Injury Screening and Early Intervention (WISE) study, or group pain education and exercise programs such as ADAPT, INTERVENE and STEPS programs offered in NSW and WA.

Initiatives to support people living with pain to participate in work, education and the community should be inclusive of specific groups including Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, people from rural and remote areas, older Australians, people with dementia, children and young people, and other relevant groups.

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New Zealand Pain Management Nursing Knowledge and Skills Framework for Registered Nurses

2013

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Foreword

Pain affects all of us at some time in our lives. There are a number of definitions of pain but for the purpose of this document pain is described as “a physical and emotional experience associated with actual or potential tissue damage or described in terms of such damage” (Merskey, 1979). As the largest group of health care professionals working across many practice settings nurses are key providers of health care and regularly come into contact with people experiencing pain. It is imperative therefore that nurses’ pain management knowledge and skills are of a standard to ensure the best possible outcomes for people with pain and their family/whānau. To do this, nurses need to reflect on their practice and identify which definition of pain informs it.

The New Zealand Pain Management Nursing Knowledge and Skills Framework (NZPMNKSF) has been developed for Registered Nurses (RNs) providing care to people with pain whether acute or chronic (persistent). This is done not with the intention of excluding the valuable role played by Enrolled Nurses in contributing to the assessment and management of pain but to highlight that it is the RN who provides direction and delegation of the Enrolled Nurse’s (ENs) practice, and who maintains overall responsibility for the plan of care provided by the EN. Indeed it is hoped that these guidelines will enable RNs to support ENs more effectively as they care for people experiencing pain.

Recognising an opportunity to identify and articulate the fundamental knowledge and skills that nurses require to care for people with pain within a professional development framework, a small group of pain nurse specialists from the Nurses’ Interest Group (NIG) under the auspices of the New Zealand Pain Society late 2009 commenced work on the Pain Management Nursing Knowledge and Skills Framework for Registered Nurses in New Zealand. The working group

acknowledges the use of the National Diabetes Knowledge and Skills Framework (2009) as an initial guide. The release of the New Zealand Adult Respiratory Knowledge and Skills Framework (2010) further informed the development of the NZPMNKSF.

A draft framework was circulated for critical comment amongst pain management nurses nationally, and following changes made to the document, a further round of consultation with this core group occurred. A process of national consultation has also taken place with professional nursing groups such as NZNO, including the National Council of Māori Nurses, Te Rūnanga O Aotearoa NZNO, College of Nurses Aotearoa (NZ), Nurse Executives in the Tertiary Sector (NETS), Nurse Educators New Zealand (NENZ), New Zealand Institute of Rural Health (NZIRH), and Private Hospitals Association. Public agencies such as the Cancer Society, Aged Concern, Arthritis NZ, and Endometriosis NZ were also invited to submit comment. Informal discussion was also held with mental health and addictions health practitioners in the consultation/development process.

In response to constructive feedback following national consultation, the NZPMNKSF has undergone further refinement with the intention of making it a more concise and accessible document. As well, I extend thanks to Erica Gleeson (CNS, Pain Management, MidCentral Health) who has made a significant contribution to the assessment process of this document, and to Judy Leader (NP, Pain Management, MidCentral Health) and Kate McCallum (CNS, The Auckland Regional Pain Service, ADHB) for their constructive contributions.

Sue King
Nurse Practitioner – Pain Management, Waikato Hospital

Rationale and approach

Pain is a significant health problem in New Zealand^{1,2}, yet it continues to be largely under recognised. Despite the availability of effective strategies, modalities and treatments known to control pain and pain related side effects, inadequate assessment and the under treatment of pain remains a problem for significant numbers of people³. International literature highlights that acute pain associated with trauma, surgery and other conditions continues to be poorly managed with less than 50% of patients receiving effective pain relief⁴. This results in adverse outcomes including the risk of progression from acute to chronic (persistent) pain⁵. Similarly, it has been estimated that at least 40% of people with cancer pain are not receiving effective pain interventions^{6,7}.

Chronic pain affects 1 in 5 people at some point in their life^{1,2}. We are living longer which results in an increasing number of New Zealanders developing cancer⁸ and/or other chronic conditions that can cause pain⁹. Chronic conditions such as diabetes and cardiovascular disease disproportionately affect Māori and Pacific Island people¹. Statistically, Māori and Pacific Island peoples are socioeconomically disadvantaged, a recognized factor influencing health. Differential access to health care, communication difficulties and costs associated with treatments are well recognised barriers to healthcare¹. Complications of poorly managed diabetes and heart disease include the development of chronic pain through ulcers, stroke, and diabetic neuropathy.

The size of the gap between recommended best practice and current practice in pain management in New Zealand is not known. Clinical outcome data on pain management in New Zealand is also scarce². Undoubtedly, pain management could be significantly improved and Registered Nurses have the potential to play a vital role in promoting pain management and education. A major prerequisite of effective care delivery is nurses who are prepared at a fundamental level of current knowledge, competence and confidence in understanding and managing pain. A pathway has been created with the development of this Knowledge and Skills Framework which will promote consistent evidence-based practice and will contribute to improved health outcomes for the person/people with pain.

New Zealand Pain Management Nursing Knowledge and Skills Framework for Registered Nurses – an Introduction

New Zealand Registered Nurses (RNs) are required to prove their competence to practice under the Health Practitioners' Competence Assurance (HPCA) Act (2003)¹⁰, as well as demonstrate competence as a prerequisite for renewal of their practising certificate. The Act's principal purpose is to protect the public's health and safety by ensuring all health practitioners are competent and fit to deliver the care for which they are charged.

There are a number of frameworks by which this can be done, though none is specific to pain management nursing or accurately reflects the diversity of settings in which nurses' practice. The New Zealand Pain Management Nursing Knowledge and Skills Framework sets out the required knowledge and skills across the variety of areas of nursing practice where Registered Nurses will come into contact with people who have pain in the New Zealand context. It is cross-referenced to the Nursing Council of New Zealand's (2007) competencies for registration¹¹.

Registered Nurses utilise nursing knowledge and complex nursing judgment to assess health needs and provide care, and to advise and support people to manage their health. They practise independently and in collaboration with other health professionals, perform general nursing functions, delegate to and direct Enrolled Nurses, Healthcare Assistants and others. They provide comprehensive assessments to develop, implement, and evaluate an integrated plan of health care, and provide interventions that require substantial scientific and professional knowledge, skills and clinical decision making. This occurs in a range of settings; in partnership with individuals, families, whānau and communities. Registered Nurses may practise in a variety of clinical contexts depending on their educational preparation and practice experience. Registered Nurses may also use this expertise to manage, teach, evaluate nursing practice and research.

Levels of Practice

This framework articulates three levels of practice however they do not directly correlate with levels on PDRPs

1. COMPETENT

All Registered Nurses regardless of their practice setting are likely to have contact with the person with pain and will require a level of practical capability in pain management nursing.

2. PROFICIENT

These Registered Nurses require specialty pain management nursing knowledge and skills to enable them to provide care to people with pain who have increasingly complex health needs.

3. EXPERT

These Registered Nurses require advanced knowledge and skills in pain management nursing as their practice requires them to respond to people with pain who have complex health needs requiring episodic or longer-term partnership in their pain management.

NCNZ Domains of Practice

Domain 1 – Professional Responsibility

This domain contains competencies that relate to professional, legal and ethical responsibilities and cultural safety. These include being able to demonstrate knowledge and judgement as well as being accountable for their own actions and decisions, while promoting an environment that maximises patient safety, independence, quality of life and health.

Domain 2 – Management of Nursing Care

This domain contains competencies that relate to patient assessment and management of care which is responsive to patients' needs, and which is supported by nursing knowledge and evidence-based research.

Domain 3 – Interpersonal Relationships

This domain contains competencies that relate to interpersonal and therapeutic communication with patients and other nursing staff, as well as interprofessional communication and documentation.

Domain 4 – Interprofessional Health Care and Quality Improvement

This domain contains competencies requiring the nurse to demonstrate that, as a member of the health care team, the nurse evaluates the effectiveness of care and promotes a nursing perspective within the interprofessional activities of the team.

How can the New Zealand Pain Management Nursing Knowledge and Skills Framework Assist Nurses, Employers and People with Pain?

Registered Nurse Prescribing

Registered Nurse prescribing is a potential future development, and the Nursing Council is currently undertaking extensive consultation in preparation for this to occur for identified nursing groups. Nurse Specialists are one of the groups. Extending prescribing rights to specialist nurses has been assisted by a recent successful project allowing Nurse Specialists in Diabetes who have completed specific education to prescribe. Evaluation of the project found that the nurses prescribing was of good quality, clinically appropriate and safe. It is expected that pain management nurses who wish to be designated RN prescribers would be practising at the expert level and this knowledge and skills would be augmented by specific prescribing education, experience and endorsement as determined by NCNZ.

The New Zealand Pain Management Nursing Knowledge and Skills Framework for Registered Nurses:

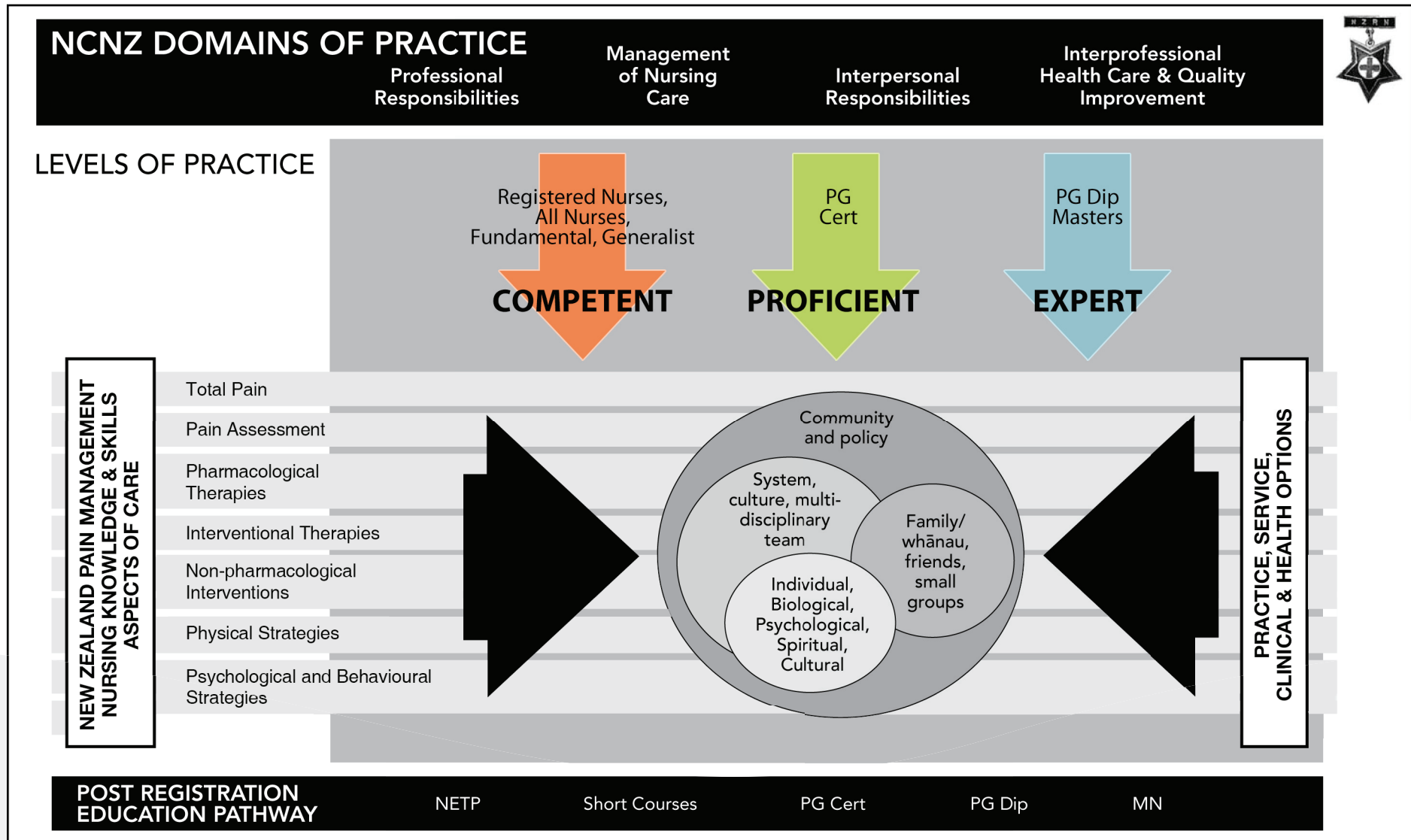
- Assists in the development of a range of transferable clinical skills which can be used in care delivery throughout a nurse's career;
- Seeks to minimise risk by providing a framework of knowledge and skills to guide pain management nursing care;
- Provides guidance to employers about what to expect at different levels of registered nursing practice in the management of pain;
- Can inform curriculum development for undergraduate and postgraduate registered nursing programmes;
- Provides a reference point for the planning of educational programmes / content and clinical preparation of each area of registered nursing practice;
- Helps the preparation of registered nurses who wish to progress to advanced practice roles in pain management;
- Provides a mechanism by which registered nurses can measure health outcomes and the effectiveness of their practice;
- Provides a mechanism for portfolio development for local Professional Development and Recognition Programmes and Nursing Council of New Zealand's requirements for ongoing registration.

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Diagram illustrating NCNZ domains, levels of practice, aspects of care and education pathway





NEW ZEALAND PAIN MANAGEMENT KNOWLEDGE & SKILLS FRAMEWORK FOR REGISTERED NURSES



A pictorial illustration of NCNZ domains, levels of practice, aspects of care and educational pathway.

Professional Development Principles

The following section sets out the assessment process acknowledging that the purpose of any assessment is to allow the nurse to re-evaluate their learning needs. The NZPMNKSF is a tool which expresses levels of practice for Registered Nurses interacting with patients requiring pain management across various clinical settings, and in a variety of roles. Evidence of competence demonstrated can also be utilised within the nurse's Professional Development and Recognition Portfolio (see Table one below). The NZPMNKSF provides the nurse with a structured approach to move up the levels of practice from competent through to expert in the area of pain management.

INPUTS	PROCESSES	OUTPUTS	OUTCOMES
Knowledge and Skills Framework Guidelines Protocols Patient Population Service Infrastructure Library Clinical mentorship 	Service delivery Clinical practice Clinical mentorship Case review Quality assurance Quality improvement Assessment of competence 	Clients treated Service delivered Nurse Portfolio: <ul style="list-style-type: none"> • PDRP • Accreditation • Evaluation Transfer of care 	Competence Confidence Quality pain management care Improved health outcomes 

Developed by Sue Wood, Director of Nursing, MidCentral Health

Table one: Illustrates where the Knowledge and Skills Framework sits utilizing a systems approach. The lists proved are examples and are not limited to the components shown.

Knowledge and Skill Development

The greatest emphasis is on self-directed learning and clinical practice experiences utilising critical reflection. There are a variety of teaching/learning strategies used, including but not limited to clinical experts, self-directed learning, ward rounds, and case review.

Assessment

Assessment is part of the teaching/learning process, designed to assist the nurse to evaluate their own progress, facilitate feedback, assist with the identification of learning needs/re-evaluation and establish that the nurse has achieved the required level of knowledge and skills.

Assessor

It is recommended that the assessor will have completed the level of practice that they are assessing the candidate against.

Professional Development Principles

Recognition of Prior Learning (RPL)

It is the nurse's responsibility to provide evidence of the depth and nature of prior learning and to identify how this knowledge relates to their current practice. Exemptions may be granted on the basis of RPL defined as a process of recognising learning outcomes achieved through formal study, work experiences and/or life experiences. RPL will be granted when a nurse can satisfactorily demonstrate that their prior learning matches current knowledge and skills required for the identified level of practice. The nurse must demonstrate or provide evidence that they meet the pain management nursing knowledge and skills required for their level of practice within the Framework.

The following may be used as evidence for the RPL process:

- The nurse's portfolio provides evidence of the nurse's professional development in the area of pain management nursing. It gives the nurse the opportunity to provide evidence of knowledge and skills gained through prior learning and experiences
- Challenge testing, where knowledge and skills in pain management in an identified area are evaluated in a simulated or clinical setting by a preceptor or peer (see glossary)
- The interview assessment
- Exemplars
- Validated personal statements

All applications for RPL should be made to the relevant body for e.g. PDRP Coordinator/Education Unit who will seek further expert opinion if required.

Process for Completing the NZPMNKSF for Registered Nurses

Process for completing the NZPMNKSF for Registered Nurses:

- All aspects of care relevant to clinical practice are to be completed within a specified time period determined by the nurse and the preceptor.
- Gather, collate and present the evidence required to meet the identified knowledge and skill requirement as per level of practice.
- Discuss/demonstrate knowledge/skills with a preceptor and have them sign in the relevant sections of the assessment template (refer to Appendix 1).
- It is acknowledged that exemptions for specific Aspects of Care may be applicable depending on the nurse's practice setting. For instance, a Registered Nurse working in Primary Health Care, Marae-based Health Services or in an Aged Care facility may be exempt from meeting the competencies associated with the Aspect of Care 5 - Interventional Therapies. Interventional therapies include but are not limited to subcutaneous infusion analgesia, patient-controlled analgesia, epidural, paravertebral and intrathecal analgesia which are only utilised in specific settings and contexts.

Criteria for Clinical Competency Evaluation - The modified Bondy Assessment Tool (refer to page 10)

Competence in practice may be assessed using the modified Bondy (1983) assessment tool. This tool was developed some time ago therefore it has been modified to align the language with current use. The tool allows for objective assessment while providing focused feedback. It also places particular emphasis on the amount of supervision required to perform each task. A variety of methods may be utilised to assess learning outcomes. These include demonstration of knowledge and skills, assessment and care planning, presentations in the form of case review, exemplars, and critical reflection on practice. These activities assist the nurse to develop new knowledge and skills to help with planning their further development.

The following rating scale is used for evaluating pain management nursing knowledge and skills within this Framework. The modified Bondy assessment tool identifies three areas for evaluation:

- Standard of procedure
- Quality of performance
- Level of assistance required

Five levels of competence are identified: (5) *independent*, (4) *supervised*, (3) *assisted*, (2) *marginal* and (1) *dependant*

Independent means meeting the criteria identified in each of the three areas above. It does not mean without observation, as the performance must be observed to be rated independent by someone other than the nurse carrying out the procedure. A nurse can still demonstrate independent judgment if they appropriately request guidance or assistance (Bondy, 1983).

The following terms are clarified for ease when using the modified Bondy assessment tool.

Quality of performance: includes the use of time, space, equipment and expenditure of energy.

Assistance required: cues can be supportive or directive. Cues such as “that’s right” or “keep going” are supportive or encouraging, but do not change what the nurse is doing.

The modified Bondy Assessment Tool

SCALE LABEL	SCORE	STANDARD OF PROCEDURE	QUALITY OF PERFORMANCE	LEVEL OF ASSISTANCE REQUIRED
Independent	5	Safe Accurate Achieved intended outcome Behaviour is appropriate to outcome	Proficient Confident Expedient	No supporting prompts required
Supervised	4	Safe Accurate Achieved intended outcome Behaviour is appropriate to outcome	Proficient Confident Reasonably expedient	Required occasional supportive prompts
Assisted	3	Safe Accurate Achieved most objectives for intended outcome Behaviour generally appropriate to context	Skilful in parts of behaviour Inefficient and unco-ordinated Expend excess energy Within a delayed time frame	Frequent verbal and occasional physical directive prompts required in addition to supportive ones.
Marginal	2	Safe only with guidance Not always accurate Incomplete achievement of intended outcome	Unskilled Inefficient	Continuous verbal and frequent physical prompts required.
Dependant	1	Unsafe Unable to demonstrate behaviour Lacks insight into behaviour appropriate to context	Unskilled Unable to demonstrate procedure/behaviour. Lacks confidence, co-ordination, efficiency	Continuous verbal and physical prompts required
X	0	Not observed		
Recognition of Prior Learning (RPL)	Certifications gained, demonstration, oral presentation, and/or challenge test may be used as evidence			

(Source: Bondy, K.N. (1983) 'Criterion-Referenced Definitions for Rating Scales in Clinical Evaluation', Journal of Nursing Education, 22(9), 376–382.)

Competent level of pain management nursing knowledge and skills for all registered nurses

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Competent Nurses

Roles and Responsibilities in relation to pain management nursing knowledge and skills:

	Met	Not Met
• Applies the principles of the Treaty of Waitangi in nursing practice	<input type="checkbox"/>	<input type="checkbox"/>
• Practises as part of a larger health care team, understands roles and responsibilities in pain management	<input type="checkbox"/>	<input type="checkbox"/>
• Practises nursing in a manner that the person with pain determines as culturally safe	<input type="checkbox"/>	<input type="checkbox"/>
• Assists individuals with pain and their families/whānau to access resources/information	<input type="checkbox"/>	<input type="checkbox"/>
• Provides delegation and direction to Enrolled Nurses and Health Care Assistants in the care of the person who has pain	<input type="checkbox"/>	<input type="checkbox"/>
• Provides information and education about pain and its management to the person with pain and their family/whānau and community groups	<input type="checkbox"/>	<input type="checkbox"/>
• Is aware of local services to seek advice for the person with pain as required	<input type="checkbox"/>	<input type="checkbox"/>
• Is engaged in quality activities related to pain and its management	<input type="checkbox"/>	<input type="checkbox"/>
• Has an awareness of local pain management policies, protocols and guidelines and where and how to access these	<input type="checkbox"/>	<input type="checkbox"/>

In the clinical setting

• Conducts comprehensive health assessment which includes pain assessment	<input type="checkbox"/>	<input type="checkbox"/>
• Assesses and interprets clinical indicators of general health status including pain	<input type="checkbox"/>	<input type="checkbox"/>
• Accurately documents assessment, care plan recommendations, evaluation of response/treatment outcomes	<input type="checkbox"/>	<input type="checkbox"/>
• Communicates clinical care provided and outcomes to patient/family/whānau and to relevant health professionals	<input type="checkbox"/>	<input type="checkbox"/>
• Consults with experts/other health professionals as required and refers to appropriate services when necessary	<input type="checkbox"/>	<input type="checkbox"/>

ASPECT OF CARE	1. Levels of knowledge and skills – Total Pain COMPETENT Name	SELF ASSESSMENT 1 – no previous experience 2 – experienced but need review 3 – experienced 4 – can teach and help others learn
Total Pain	NCNZ: Domain 1 – Professional Responsibility Domain 2 – Management of Nursing Care To deliver competent care to people with pain you will be able to:	
	1.1 Describe the role of the nervous system in the transduction, transmission, perception and modulation of pain	
	1.2 Define the main classifications of pain with examples: <ul style="list-style-type: none"> • Acute pain • Chronic (persistent) pain – cancer and non-cancer 1.2.1 Describe with examples fundamental knowledge of: <ul style="list-style-type: none"> • nociceptive pain • neuropathic pain • visceral pain • somatic pain 	
	1.3 Identify the potential relationship of the following to the person's experience of pain: <ul style="list-style-type: none"> • anxiety • depression • fear/avoidance • spirituality • quality of life 1.3.1 Describe with examples illness behaviours associated with pain	
	1.4 Identify with examples relevant to clinical practice the potential adverse effects of pain from the perspective of: <ul style="list-style-type: none"> • cardiovascular and respiratory systems • gastrointestinal system • musculoskeletal system • endocrine system • genitourinary system • development of chronic (persistent) pain 	

ASPECT OF CARE	2. Levels of knowledge and skills – Pain Assessment COMPETENT Name	SELF ASSESSMENT 1 – no previous experience 2 – experienced but need review 3 – experienced 4 – can teach and help others learn
Pain Assessment	NCNZ: Domain 1 – Professional Responsibility. Domain 2 – Management of Nursing Care. Domain 3 – Interpersonal Relationships. Domain 4 – Interprofessional Health Care and Quality Improvement To assess the person with pain at a competent level you will:	
	2.1 Discuss the rationale for assessment of pain as a multi dimensional experience, and barriers that can occur	
	2.2 Identify special populations with potential challenges to assessment and demonstrate fundamental knowledge of appropriate assessment frameworks/tools where relevant to practice for: <ul style="list-style-type: none"> • Neonates • Children • Older adults • People with: <ol style="list-style-type: none"> i. Mental health and/or addiction issues ii. Cognitive impairment iii. English as a second language iv. Altered level of consciousness 	
	2.3 Demonstrate the ability to undertake a fundamental pain history utilising a validated age appropriate approach to gather comprehensive health data that includes: <ul style="list-style-type: none"> • Onset and duration of pain • Site(s) of pain • Character of pain • Intensity of pain (at rest, with activity/movement) • Timing/temporal factors • Aggravating factors • Associated symptoms (eg nausea, constipation, fatigue) • Health history/co-morbidities and allergy status • Smoking, alcohol and other illicit drug history • Effect of pain on activities of daily living (ADLs) • Modulating factors – pharmacological including Over The Counter (OTC), Traditional Therapies, • Modulating factors - non-pharmacological and spiritual • Anxiety and mood disorders • Personal/family history – schooling, work, relationships 	

2.3.1 Where appropriate for those who identify as Māori, offer a Māori Model of Health in the assessment process, and demonstrate awareness that Māori may have unique cultural needs for example Rongoa Māori (traditional healing practices) acknowledged and incorporated into care.

2.3.2 Within the health history identify situations e.g. complex pain problem/suicidal ideation/memory problems that require a more comprehensive assessment and seek advice or refer as appropriate

2.4 Assess the patient/family/whānau knowledge/understanding of:

- Their condition
- The likely cause(s) or contributing factors to their pain
- Patient goals of pain treatment/management
- Beliefs about pain, expectations about outcome of treatment/management and their preferences for treatment/management

2.5 Discuss clinical rationale for investigations in the assessment of the person with pain such as but not limited to and relevant to practice:

- Haematology profiles
- Biochemistry
- Plain Xray/USS
- CT/MRI
- Bone scan

2.6 Perform a focussed physical assessment using where relevant techniques of inspection, percussion, palpation and auscultation

2.7 Accurately document and communicate assessment data/findings with relevant health personnel

2.7.1 Negotiate and implement a culturally responsive individualised management plan that incorporates a biopsychosocial/spiritual approach to pain management

2.7.2 Document timeline for reassessment of pain and evaluation of pain management interventions

2.7.3 Accurately evaluate effectiveness of the pain management plan in partnership with person in pain and communicate amendments required to appropriate health personnel

ASPECT OF CARE	3. Levels of knowledge and skills – Pharmacological Therapies COMPETENT Name	SELF ASSESSMENT 1 – no previous experience 2 – experienced but need review 3 – experienced 4 – can teach and help others learn
Pharmacological Therapies	NCNZ: Domain 1 – Professional Responsibility Domain 2 – Management of Nursing Care. Domain 3 – Interpersonal Relationships. Domain 4 – Interprofessional Health Care and Quality Improvement For the safe administration and appropriate use of pharmacological therapies at a competent level you will:	
	3.1 Describe the mechanism/s of action of the following classes of drugs used in acute and chronic (persistent) pain management where relevant to practice: <ul style="list-style-type: none"> • Non-opioids • Opioids • Anti-convulsants • Anti-depressants • Anti-spasmodics • Local anaesthetics • Gases – entonox 3.1.1 Give an example from each of these classes of drugs relevant to practice	
	3.2 Demonstrate knowledge of the serious and common side effects of each of these classes of drugs	
	3.3 Understand the clinical signs, symptoms and management of adverse effects 3.3.1 Demonstrate ability to assess for adverse effects	
	3.4 Demonstrate knowledge of indications and contraindications for administration of these drugs	
	3.5 Discuss the concept of balanced analgesia using the principles of the “Analgesic Ladder” (World Health Organisation, 1982) or “Pyramid Plus Ribbon” (AHCPR, 1994)	

3.6 In relation to opioid drugs, describe the meaning of:

- Tolerance
- Physiological dependency
- Pseudoaddiction
- Addiction

3.7 Demonstrate a fundamental knowledge of the following special considerations in the prescription and administration of analgesics:

- Extremes of age
- Opioid tolerance
- Pregnancy and/or breast feeding
- Organ impairment/failure
- Mental health/addiction

ASPECT OF CARE	4. Levels of knowledge and skills – Interventional Therapies COMPETENT Name	SELF ASSESSMENT 1 – no previous experience 2 – experienced but need review 3 – experienced 4 – can teach and help others learn
Interventional Therapies	NCNZ: Domain 1 – Professional Responsibility. Domain 2 – Management of Nursing Care. Domain 3 – Interpersonal Relationships. Domain 4 – Interprofessional Health Care and Quality Improvement For the safe and appropriate management of the person with pain utilising interventional therapies you will:	
	4.1 Demonstrate fundamental knowledge of the role and use of interventions in the treatment of acute and/or chronic (persistent) pain where relevant to practice for example: <ul style="list-style-type: none"> • Subcutaneous/Intravenous infusion analgesia • Patient-controlled analgesia (PCA) • Nurse controlled analgesia (NCA) • Epidural analgesia • Intrathecal analgesia • Wound catheters • Common nerve blocks • Radiotherapy 	
	4.2 Describe the rationale for observations undertaken when interventional therapies are used where relevant to practice	
	4.3 Describe the potential clinical signs, symptoms and management of adverse effects of these therapies where relevant to practice	
	4.4 Discuss/demonstrate how to evaluate the effectiveness of the intervention utilised and rationale for accurate documentation in clinical records	

ASPECT OF CARE	5. Levels of knowledge and skills – Non-pharmacological Interventions COMPETENT Name	SELF ASSESSMENT 1 – no previous experience 2 – experienced but need review 3 – experienced 4 – can teach and help others learn
Non-pharmacological Interventions	NCNZ: Domain 1 – Professional Responsibility. Domain 2 – Management of Nursing Care. Domain 3 – Interpersonal Relationships. Domain 4 – Interprofessional Health Care and Quality Improvement For the competent management of the person with pain utilising non-pharmacological interventions you will:	
	5.1 Demonstrate fundamental knowledge with examples of common non-pharmacological interventions in the treatment of acute or chronic (persistent) pain including but not limited to: <ul style="list-style-type: none"> • Environment modification • Physical strategies • Psychological and behavioural strategies 	
	5.2 Access and utilise, where available, practice-based guidelines to discuss the role, advantages and limitations of such interventions in pain management with the patient/family/whānau	
	5.3 Demonstrate using an example the incorporation of non-pharmacological interventions into clinical practice or where appropriate refer for specialist assistance	

ASPECT OF CARE	5.1 Levels of knowledge and skills – Physical Strategies COMPETENT Name	SELF ASSESSMENT 1 – no previous experience 2 – experienced but need review 3 – experienced 4 – can teach and help others learn
Physical Strategies	NCNZ: Domain 1 – Professional Responsibility Domain 2 – Management of Nursing Care. Domain 3 – Interpersonal Relationships. Domain 4 – Interprofessional Health Care and Quality Improvement In order to promote, maintain or restore the physical well-being and manage pain you will:	
	5.1.1 Describe how the use of the following physical strategies and/or modalities assists pain management and helps to improve/maintain function from the perspective of: <ul style="list-style-type: none"> • Range of motion, muscle strength and endurance • Cardiovascular fitness • Pain relief • Appetite and weight • Activities of daily living including sleep • Mood 	
	5.1.2 Discuss with patient/family/whānau the rationale for the use of physical strategies and/or modalities to manage pain and to improve/maintain function.	
	5.1.3 Describe how the use of the following physical strategies and/or modalities assists pain management and helps to improve/maintain function. <ul style="list-style-type: none"> • Turning and positioning • Wound support • Reach devices • Heat/cold • Massage • Manipulation of joints and bones • Mobilization • Transcutaneous Electrical Nerve Stimulation (TENS) • Hydrotherapy/Exercise 	
	5.1.4 Be familiar with the roles and responsibilities of other healthcare professionals with expertise in the area of activity and function.	

ASPECT OF CARE	5.2 Levels of knowledge and skills – Psychological and Behavioural Strategies COMPETENT Name	SELF ASSESSMENT 1 – no previous experience 2 – experienced but need review 3 – experienced 4 – can teach and help others learn
Psychological and Behavioural Strategies	NCNZ: Domain 1 – Professional Responsibility Domain 2 – Management of Nursing Care. Domain 3 – Interpersonal Relationships. Domain 4 – Interprofessional Health Care and Quality Improvement In order to maximise and support improvement in the person’s pain and quality of life you will:	
	5.2.1 Describe how psychological, behavioural and/or spiritual factors can contribute to pain and how these factors may influence pain management/treatment 5.2.1.2 Demonstrate awareness of Māori models of health for people who identify as Māori	
	5.2.2 Discuss how psychological, behavioural and spiritual factors influence the experience of pain with patient/family/whānau	
	5.2.3 Discuss strategies used in nursing practice to care for patient’s psychological/spiritual wellbeing	
	5.2.4 Demonstrate knowledge of the availability of local psychological, occupational, recreational, spiritual, community support services	
	5.2.5 Discuss process for referral to appropriate services	

Proficient level of pain management nursing knowledge and skills for all registered nurses

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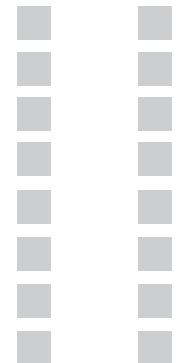
Proficient Nurses

Roles and Responsibilities in relation to pain management nursing knowledge and skills (as for competent and):

Met Not Met

Clinical

- Facilitates nursing diagnosis of pain through comprehensive assessment
- Provides physiological, psychosocial and spiritual care to the person with pain who has health needs of increasing complexity
- Facilitates referrals to pain management specialists/other health professionals when necessary
- Utilises sound judgement to advise on or develop clinical management plans for the person with pain
- Uses a collaborative approach to negotiate care/changes in care or management plan
- Actively imparts evidence-based knowledge of pain and its management in a variety of settings
- Leads or participates in clinical audit of pain management within practice setting
- Leads or contributes to local and/or regional clinical protocol/guideline development, or service developments



ASPECT OF CARE	1. Levels of knowledge and skills –Total pain PROFICIENT Name	SELF ASSESSMENT 1 – no previous experience 2 – experienced but need review 3 – experienced 4 – can teach and help others learn
Total Pain	NCNZ: Domain 1 – Professional Responsibility Domain 2 – Management of Nursing Care To deliver proficient care to people with pain you will be able to:	
	1.1 Demonstrate an in-depth knowledge of the biopsychosocial model of pain and relationship to pain behaviours. 1.1.1 Discuss the concept of total pain and the implications for practice that involves: <ul style="list-style-type: none"> • sensation • emotion • cognition, and • sociocultural and political factors 	
	1.2 Demonstrate knowledge of the pathophysiology of: <ul style="list-style-type: none"> • Nociceptive pain • Neuropathic pain • Visceral pain • Somatic pain 	
	5.3 Discuss using knowledge of pain pathophysiology and psychology, the two main classifications of pain: <ul style="list-style-type: none"> • acute pain • chronic (persistent) pain 1.3.1 Demonstrate knowledge of the terms “neural plasticity” and “central sensitization”	
	1.4 Discuss the potential adverse physiological and psychological effects of acute and persistent pain from the perspective of: <ul style="list-style-type: none"> • cardiovascular and respiratory systems • gastrointestinal and genitourinary systems • metabolic and neuroendocrine systems • wind-up (hyperalgesia and allodynia) • mood, activities of daily living (ADLs) 	

ASPECT OF CARE	2. Levels of knowledge and skills – Pain Assessment PROFICIENT Name	SELF ASSESSMENT 1 – no previous experience 2 – experienced but need review 3 – experienced 4 – can teach and help others learn
Pain Assessment	NCNZ: Domain 1 – Professional Responsibility Domain 2 – Management of Nursing Care. Domain 3 – Interpersonal Relationships. Domain 4 – Interprofessional Health Care and Quality Improvement To assist with the assessment of the person with pain at a proficient level you will:	
	2.1 Demonstrate knowledge of the rationale for, and barriers to assessment and evaluation of pain from the perspective of health professionals, patient/family/whānau and general public	
	2.2 Demonstrate proficiency in the use of appropriate frameworks/tools for special populations as required and relevant to practice for the assessment of pain in: <ul style="list-style-type: none"> • Neonates • Children • Older adults • People with: <ul style="list-style-type: none"> i. Mental health and/or addiction issues ii. Cognitive impairment iii. Aphasia/dysphasia iv. English as a second language v. Altered level of consciousness 	
	2.3 Undertake a comprehensive pain history to gather health data to inform nursing diagnoses across a range of complex pain presentations: <ul style="list-style-type: none"> • Onset and duration of pain • Site(s) of pain • Character of pain • Severity of pain • Timing/temporal factors • Aggravating factors • Associated symptoms (eg nausea, constipation, fatigue) • Health history/co-morbidities and allergy status • Smoking, alcohol and other illicit drug history • Effect of pain on activities of daily living • Modulating factors – pharmacological including Over The Counter (OTC), Traditional Therapies 	

- Modulating factors - non-pharmacological and spiritual
- Anxiety and mood disorders
- Personal/family history – schooling, work, relationships

2.3.1 Where appropriate for those who identify as Māori, offer a Māori Model of Health in the assessment process, and demonstrate awareness that Māori may have unique cultural needs acknowledged and incorporated into care.

2.4 Within the health history identify actual or potential for pain-related:

- Anxiety/depression/catastrophizing
- Fear avoidance behaviours
- Persistent pain
- Medication misuse/abuse
- Self harm
- Abuse

2.5 Assess the patient/family/whānau knowledge of:

- Beliefs about pain, coping strategies, expectations about outcomes of treatment/management, preferences for and goals of, treatment/management
- Their condition
- The likely cause(s)/contributing factors to their pain
- Patient strengths
- Their role in pain management

2.6 Demonstrate rationale for appropriate laboratory investigations in response to patient's clinical condition including but not limited to and where relevant to practice:

- FBC
- Coagulation
- Biochemistry
- HbA1C

2.6.1 Discuss rationale for specific radiological investigations as part of diagnostic work-up for the person with pain where relevant to practice, for example:

- Plain XRay
- USS
- CT/MRI/bone scan

2.7 Demonstrate recognition of abnormal laboratory results, and identify potential explanation and the implications for pain management therapy

	<p>2.8 Perform a focussed physical assessment incorporating where relevant techniques of inspection, percussion, palpation and auscultation</p>	
	<p>2.9 Negotiate and implement a culturally responsive individualised management plan that incorporates a biopsychosocial/spiritual approach to pain management.</p> <p>2.9.1 Demonstrate an awareness that Māori have a unique culture and explain barriers/opportunities to integrate Rongoa Māori (traditional healing practices) into care plan</p>	
	<p>3.0 Document timeline for reassessment of pain and re-evaluation of pain management interventions</p>	
	<p>3.1 Accurately evaluate effectiveness of the pain management plan in partnership with person in pain and communicate amendments required to appropriate health personnel and services</p>	

ASPECT OF CARE	3. Levels of knowledge and skills – Pharmacological Therapies PROFICIENT Name	SELF ASSESSMENT 1 – no previous experience 2 – experienced but need review 3 – experienced 4 – can teach and help others learn
Pharmacological Therapies	NCNZ: Domain 1 – Professional Responsibility Domain 2 – Management of Nursing Care. Domain 3 – Interpersonal Relationships. Domain 4 – Interprofessional Health Care and Quality Improvement For the safe administration and appropriate use of pharmacological therapies at a competent level you will:	
	<p>3.1 Describe mechanism/s of action of the following classes of drugs, <u>as well as those classes of medicines listed in 3.1 for the competent nurse</u>, and give examples where relevant to practice:</p> <ul style="list-style-type: none"> • Membrane stabilisers • Alpha-2 agonists • Salmon calcitonin • Ketamine • Gases – methoxyflurane <p>3.1.1 Discuss some of the common over the counter (OTC) products, herbal and homeopathic remedies used in pain management where relevant to practice.</p>	
	<p>3.2 Discuss common side effects of each of the classes of medicines identified in 3.1 above and explain their cause(s) as well as those identified in 3.1 for the competent nurse</p>	
	<p>3.3 Demonstrate ability to identify the clinical signs and symptoms of side effects and demonstrate knowledge of how to minimise and/or manage any adverse effects of these medicines</p>	
	<p>3.4 Demonstrate knowledge of indications and contraindications for administration of the classes of drugs outlined in 3.1 above</p> <p>3.4.1 Discuss how and why pharmacological management of acute pain and cancer pain may differ from chronic (persistent) non-cancer pain using these medicines</p>	
	<p>3.5 Discuss the strengths and weaknesses of the “Analgesic Ladder” and “Pyramid Plus Ribbon” in relation to the treatment of pain, be it cancer or non-cancer</p>	

3.6 In relation to opioid drugs, explain the features of and key differences between:

- Tolerance
- Physiological dependency
- Pseudoaddiction
- Addiction

3.6.1 Discuss what is meant by the term “opioid-induced hyperalgesia”

3.7 Act as a resource to other nurses and health care staff in relation to special considerations in the prescription and administration of analgesics where relevant to practice:

- Extremes of age
- Opioid tolerance
- Pregnancy and/or breast feeding
- Renal and liver impairment/failure

3.7.1 Discuss pain medicines that require special authority, including specific criteria required for funding approval

ASPECT OF CARE	4. Levels of knowledge and skills – Interventional Therapies PROFICIENT Name	SELF ASSESSMENT 1 – no previous experience 2 – experienced but need review 3 – experienced 4 – can teach and help others learn
Interventional Therapies	NCNZ: Domain 1 – Professional Responsibility. Domain 2 – Management of Nursing Care. Domain 3 – Interpersonal Relationships. Domain 4 – Interprofessional Health Care and Quality Improvement For the safe and appropriate management of the person with pain utilising interventional therapies you will:	
	4.1 Demonstrate an in-depth knowledge of the role and use of interventions in the treatment of acute or chronic (persistent) pain where relevant to practice for example: <ul style="list-style-type: none"> • Subcutaneous/intravenous infusion analgesia • Patient-controlled analgesia (PCA) • Nurse controlled analgesia (NCA) • Neuraxial blockade • Common peripheral nerve blocks • Trigger point injections • Neuromodulation e.g. Spinal cord stimulators 	
	4.2 Demonstrate an in-depth knowledge and understanding of the required monitoring and its rationale when these interventional pain management strategies are used	
	4.3 Demonstrate the ability to critically interpret the potential clinical signs and symptoms, and institute appropriate management of adverse effects of these therapies where relevant to practice	
	4.4 Critically evaluate effectiveness of intervention used, communicate with key personnel and document accurately in clinical record	

ASPECT OF CARE	5. Levels of knowledge and skills – Non-pharmacological Interventions PROFICIENT Name	SELF ASSESSMENT 1 – no previous experience 2 – experienced but need review 3 – experienced 4 – can teach and help others learn
Non-pharmacological Interventions	NCNZ: Domain 1 – Professional Responsibility. Domain 2 – Management of Nursing Care. Domain 3 – Interpersonal Relationships. Domain 4 – Interprofessional Health Care and Quality Improvement For the proficient management of the person with pain utilising non-pharmacological interventions you will:	
	5.1 Demonstrate drawing on best practice where available, and where relevant to clinical practice, an in-depth knowledge of the role and use of common non-pharmacological interventions in the management of acute or chronic (persistent) pain for example: <ul style="list-style-type: none"> • Environment modification • Physical strategies • Psychological and behavioural strategies including cognitive behavioural strategies 	
	5.2 Access and utilise where available, practice-based guidelines to explain the rationale for therapies utilised and discuss their practical use, benefits and limitations in pain management with the patient/family/whānau	
	5.3 Competently and confidently incorporate such therapies into clinical practice or where appropriate refer for specialist assistance	

ASPECT OF CARE	5.1. Levels of knowledge and skills – Physical Strategies PROFICIENT Name	SELF ASSESSMENT 1 – no previous experience 2 – experienced but need review 3 – experienced 4 – can teach and help others learn
Physical Strategies	NCNZ: Domain 1 – Professional Responsibility Domain 2 – Management of Nursing Care. Domain 3 – Interpersonal Relationships. Domain 4 – Interprofessional Health Care and Quality Improvement In order to promote, maintain or restore the physical and physiological well-being and manage pain you will:	
	<p>5.1.1 Act as a resource to other health care staff by demonstrating/sharing an in-depth knowledge of the importance of using physical strategies and/or modalities to assist pain management and to help improve/maintain function:</p> <ul style="list-style-type: none"> • Range of motion, muscle strength and endurance • Cardiovascular fitness • Pain relief • Appetite and weight • Activities of daily living including sleep • Mood • Activity tolerance including goal setting and pacing <p>5.1.1.2 Discuss the difference between active versus passive patient participation in relation to the use of physical strategies and/or modalities to manage pain and to improve/maintain function</p> <p>5.1.1.3 Discuss the difference between physical capacity and physical function in relation to physiological and psychological parameters</p>	
	<p>5.1.2 Discuss with other health care staff, the patient/family/whānau why improving and/or maintaining function is important in the management of pain in relation to the physiological, pathological and psychological effects of unrelieved pain</p>	
	<p>5.1.3 Demonstrate the ability to integrate the patient assessment into an appropriate management plan using physical strategies and/or modalities.</p> <ul style="list-style-type: none"> • Turning and positioning • Wound support • Reach devices 	

- Heat/cold
- Massage
- Manipulation of joints and bones
- Mobilization
- Transcutaneous Electrical Nerve Stimulation (TENS)
- Acupuncture
- Other (biofeedback, comprehensive rehabilitation approaches)

5.1.3.1 Act as a resource to other health care staff in the utilisation of these strategies/ techniques as appropriate/required

5.1.4 Promote the merits of interdisciplinary/multidisciplinary collaboration and initiate referrals as appropriate.

ASPECT OF CARE	5.2 Levels of knowledge and skills – Psychological and Behavioural Strategies PROFICIENT Name	SELF ASSESSMENT 1 – no previous experience 2 – experienced but need review 3 – experienced 4 – can teach and help others learn
Psychological and Behavioural Strategies	NCNZ: Domain 1 – Professional Responsibility Domain 2 – Management of Nursing Care. Domain 3 – Interpersonal Relationships. Domain 4 – Interprofessional Health Care and Quality Improvement In order to maximise and support improvement in the person’s pain and quality of life you will:	
	5.2.1 Act as a resource and demonstrate an in-depth knowledge and understanding of how psychological, behavioural and/or spiritual factors can contribute to pain and how these factors may influence the success of pain management/treatment 5.2.1.2 Demonstrate awareness of Māori Models of Health to health for people who identify as Māori	
	5.2.2 Sensitively discuss how psychological, behavioural and spiritual factors influence pain and outcomes of management with patient/family/whānau	
	5.2.3 Act as a resource and demonstrate strategies used in nursing practice to care for patient’s psychological/spiritual wellbeing	
	5.2.4 Act as a resource to other health care staff about the availability of local psychological/ recreational/occupational/spiritual/community support services	
	5.2.5 Discuss process for referral to appropriate services	

Expert level of pain management nursing knowledge and skills for all registered nurses

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Expert Registered Nurses – Roles and Responsibilities 40

Aspect of Care

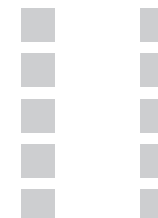
1.0	Total Pain	41
2.0	Pain Assessment	42
3.0	Pharmacological Therapies	45
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Expert Nurses

Roles and Responsibilities in relation to pain management nursing knowledge and skills (as for competent and proficient, and):

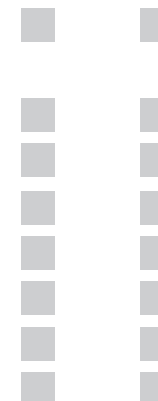
- Guides others to apply the Treaty Of Waitangi and to implement culturally safe practices
- Demonstrates advanced clinical judgement and decision making, role modelling best practice
- Provides expert clinical care and advice to people with pain of increasing complexity and who may have significant co-morbidities
- Documents comprehensive clinical assessment using differential diagnoses, care/management plan, evaluation and referrals
- Communicates advanced evidence-based knowledge of pain and its management in a variety of settings

Met Not Met



Leadership and Management:

- Demonstrate consistently effective nursing leadership, management and consultancy, working across settings and within interdisciplinary environments
- Recognises team diversity and utilises other team members for their strengths/area of expertise
- Contributes nationally to the development, implementation and evaluation of clinical practice guidelines in pain management
- Identifies service deficits, develops strategic plan for the service and continually evaluates aspects of service provision
- Initiates and leads research, and promotes evidence-based nursing practice
- Represents nursing at a strategic level of interdisciplinary planning, advocating for and promoting nursing practice
- Demonstrates collaborative relationships with tertiary educational institutes and other educational providers
- Ensures quality assurance systems are in place to monitor the standard of services for people with pain



ASPECT OF CARE	1. Levels of knowledge and skills –Total pain EXPERT Name	SELF ASSESSMENT 1 – no previous experience 2 – experienced but need review 3 – experienced 4 – can teach and help others learn
Total Pain	NCNZ: Domain 1 – Professional Responsibility Domain 2 – Management of Nursing Care To deliver expert care to people with pain you will be able to:	
	1.1 Demonstrate knowledge and comprehensive understanding of the total pain experience as evidenced by the successful completion of a post-graduate paper in pain management.	
	1.2 Demonstrate leadership in the utilisation of a biopsychosocial/spiritual approach to pain management in practice	
	1.3 Act as a role model to guide and teach other health care staff about the rationale for incorporating a biopsychosocial/spiritual approach to pain management	

ASPECT OF CARE	2. Levels of knowledge and skills – Pain Assessment EXPERT Name	SELF ASSESSMENT 1 – no previous experience 2 – experienced but need review 3 – experienced 4 – can teach and help others learn
Pain Assessment	NCNZ: Domain 1 – Professional Responsibility Domain 2 – Management of Nursing Care. Domain 3 – Interpersonal Relationships. Domain 4 – Interprofessional Health Care and Quality Improvement To assist with the assessment of the person with pain at an expert level you will:	
	2.1 Demonstrate leadership in the use of appropriate frameworks/tools relevant to clinical practice for the comprehensive assessment of pain in: <ul style="list-style-type: none"> • Neonates • Children • Older adults • People with: <ul style="list-style-type: none"> i. Mental health and/or addiction issues ii. Cognitive impairment iii. Aphasia/dysphasia iv. English as a second language v. Altered level of consciousness 	
	2.2 Complete a comprehensive pain history to gather and critically analyse subjective and objective health data to inform differential diagnoses across a range of complex pain presentations: <ul style="list-style-type: none"> • Onset and duration of pain • Site(s) of pain • Character of pain • Severity of pain • Timing/temporal factors • Aggravating factors • Associated symptoms (eg nausea) • Health history/co-morbidities and allergy status • Smoking, alcohol and other illicit drug history • Effect of pain on activities of daily living • Modulating factors – pharmacological including Over The Counter (OTC), Traditional Therapies • Modulating factors - non-pharmacological and spiritual • Anxiety and mood disorders • Personal/family history – schooling, work, relationships, hobbies/interests, financial situation, accommodation, exercise, sexuality 	

	<p>2.2.1 Where appropriate for those who identify as Māori, offer a Māori Model of Health in the assessment process, and demonstrate awareness that Māori may have unique cultural needs acknowledged and incorporated into care.</p> <p>2.2.2 Act as a role model to guide and teach other health care staff about the importance of a comprehensive pain history, the approaches to taking this and the formulation of differential diagnoses for the complex pain patient</p>	
	<p>2.3 Within the health history identify and formally assess risk factors for:</p> <ul style="list-style-type: none"> • Anxiety/depression/catastrophizing • Suicidal ideation • Persistent pain • Medication misuse/abuse – licit and illicit • Cognitive impairment/confusion/delirium <p>2.3.1 Act as a role model to guide and teach other health care staff about the importance of assessment, identification and where possible appropriate management of risk factors in the health history</p>	
	<p>2.4 Assess the patient/family/whānau knowledge of and provide individualised information/education as appropriate on:</p> <ul style="list-style-type: none"> • Beliefs and perceptions about pain, expectations about and preferences for treatment/management • Their condition • The likely cause(s)/contributing factors to and/or explanation for their pain • Their role in pain management 	
	<p>2.5 Complete a focussed physical assessment using inspection, percussion, auscultation and palpation techniques demonstrating comprehensive understanding of rationale for use</p> <p>2.5.1 Act as a role model to teach and/or demonstrate techniques of focussed physical assessment and their rationale for use</p>	
	<p>2.5 Demonstrate in-depth knowledge of the clinical rationale for laboratory tests and radiological investigations in response to patients' clinical presentation, abnormal results/findings and implications for treatment including but not limited to:</p> <ul style="list-style-type: none"> • Haematology profiles • Coagulation 	

- Biochemistry
- HbA1C
- Plain Xray
- USS
- Gastroscopy
- CT/MRI/bone scan
- Nerve conduction studies

2.6.1 Initiate appropriate referrals in response to abnormal findings and ensure that patients are followed up appropriately

2.6.2 Comprehensively and critically evaluate effectiveness of pain management interventions at agreed follow-up, modify plan/therapy and/or referrals accordingly, and communicate with appropriate staff/services.

ASPECT OF CARE	3. Levels of knowledge and skills – Pharmacological Therapies EXPERT Name	SELF ASSESSMENT 1 – no previous experience 2 – experienced but need review 3 – experienced 4 – can teach and help others learn
Pharmacological Therapies	NCNZ: Domain 1 – Professional Responsibility Domain 2 – Management of Nursing Care. Domain 3 – Interpersonal Relationships. Domain 4 – Interprofessional Health Care and Quality Improvement For the safe administration and appropriate use of pharmacological therapies at an expert level you will:	
	<p>3.1 Demonstrate a comprehensive knowledge of the pharmacodynamics and pharmacokinetics of the classes and sub-classes of analgesic medications in the treatment of acute and chronic (persistent) pain, including effects, side effects, interactions, contra-indications, doses, modes of administration and monitoring parameters</p> <p>3.1.1 Discuss with other health care staff and patients/family/whānau the uses of over the counter (OTC) products, herbal and homeopathic remedies in pain management and drawing on available scientific evidence, identify their risks and benefits</p>	
	<p>3.2 Utilise available evidence to integrate research of pharmacological interventions into clinical teaching and patient care</p>	
	<p>3.3 Demonstrate comprehensive clinical and theoretical knowledge of the signs, symptoms and management of adverse effects to different pharmacological therapies</p>	
	<p>3.4 Demonstrate utilising available evidence, comprehensive knowledge of indications and contraindications for utilisation of these drugs</p> <p>3.4.1 Demonstrate comprehensive understanding of how pharmacologic management of acute pain and cancer pain may differ from chronic (persistent) non-malignant pain using the different classes of drugs</p>	
	<p>3.5 Demonstrate comprehensive knowledge and understanding of:</p> <ul style="list-style-type: none"> • Tolerance • Physiological dependency • Pseudoaddiction • Addiction • Opioid-induced hyperalgesia 	

3.5.1 Demonstrate expert knowledge of processes to identify and address medication abuse and/or misuse and guide other health care professionals in their assessment and management of such clinical issues

3.6 Demonstrate a comprehensive knowledge and understanding of the following special considerations in the prescription, dispensing and administration of analgesics:

- Extremes of age, including the implications of frailty in the older adult
- Opioid tolerance/misuse/abuse
- Pregnancy and/or breast feeding
- Organ impairment/failure – acute or chronic
- Mental health/addiction
- Polypharmacy

3.6.1 Role model best practice in teaching other health care professionals and patients/family/whānau about the rationale for special considerations in these populations.

ASPECT OF CARE	4. Levels of knowledge and skills – Interventional Therapies EXPERT Name	SELF ASSESSMENT 1 – no previous experience 2 – experienced but need review 3 – experienced 4 – can teach and help others learn
Interventional Therapies	NCNZ: Domain 1 – Professional Responsibility. Domain 2 – Management of Nursing Care. Domain 3 – Interpersonal Relationships. Domain 4 – Interprofessional Health Care and Quality Improvement For the safe and appropriate management of the person with pain utilising interventional therapies you will:	
	4.1 Demonstrate a comprehensive knowledge of the role and use of various intervention therapies in the treatment of acute or chronic (persistent) pain, including benefits, risks, limitations and contraindications: <ul style="list-style-type: none"> • Subcutaneous/intravenous infusion analgesia • Patient-controlled analgesia (PCA) • Nurse controlled analgesia (NCA) • Epidural and paravertebral analgesia • Intrathecal analgesia • Common nerve blocks • Spinal cord stimulators 	
	4.2 Comprehensively consult with and assess patients referred for interventional therapies when appropriate and where relevant to practice setting	
	4.3 Demonstrate a comprehensive knowledge and understanding of the required monitoring when any of these interventional pain management strategies are used and teach/guide other health professionals and/or patients, family/whānau about appropriate monitoring	
	4.4 Undertake critical assessment and interpretation of clinical signs and symptoms of potential side effects and institute appropriate management if needed 4.4.1 Teach health professionals and/or patients, family/whānau where relevant about how to assess for potential signs and symptoms of side effects and how to institute appropriate management if needed	
	4.5 Comprehensively evaluate effectiveness of intervention used, document accurately in clinical record and communicate with relevant staff/services.	

ASPECT OF CARE	5. Levels of knowledge and skills – Non-pharmacological Interventions EXPERT Name	SELF ASSESSMENT 1 – no previous experience 2 – experienced but need review 3 – experienced 4 – can teach and help others learn
Non-pharmacological Interventions	NCNZ: Domain 1 – Professional Responsibility. Domain 2 – Management of Nursing Care. Domain 3 – Interpersonal Relationships. Domain 4 – Interprofessional Health Care and Quality Improvement For the expert management of the person with pain utilising non-pharmacological interventions you will:	
	5.1 Utilise evidence to demonstrate a comprehensive knowledge of the role, benefits, limitations, contraindications and practicalities of a range of non-pharmacologic pain management interventions in the treatment of acute or chronic (persistent) pain	
	5.2 Access and utilise where available evidence-based guidelines/research to teach and/or discuss the role, benefits, limitations, and the practicalities of such interventions in pain management with other health care staff, the patient/family/whānau	
	5.3 Competently incorporate such interventions into clinical teaching and patient care or where appropriate refer for specialist management	

ASPECT OF CARE	5.1 Levels of knowledge and skills – Physical Strategies EXPERT Name	SELF ASSESSMENT 1 – no previous experience 2 – experienced but need review 3 – experienced 4 – can teach and help others learn
Physical Strategies	NCNZ: Domain 1 – Professional Responsibility. Domain 2 – Management of Nursing Care. Domain 3 – Interpersonal Relationships. Domain 4 – Interprofessional Health Care and Quality Improvement In order to promote, maintain or restore physical and physiological well-being and manage pain you will:	
	5.1.1 Demonstrate a comprehensive knowledge and understanding of the importance of restoring and maintaining function in the management of pain from the perspective of: <ul style="list-style-type: none"> • Activities of daily living (ADLs) • Activity tolerance • Sleep and sleep hygiene • Relationships including intimacy and sexuality • Reintegration into work (paid and unpaid employment) 5.1.1.2 Incorporate this knowledge and understanding into guiding and teaching in a variety of settings.	
	5.1.2 Provide comprehensive consultation with patient/family/whānau about the importance of using physical strategies and/or modalities to manage pain and to improve/maintain function.	
	5.1.3 Demonstrate comprehensive knowledge and understanding of the benefits of different functional activities that can assist people to manage pain and improve and/or maintain function	
	5.1.4 Demonstrate comprehensive knowledge and understanding about how to incorporate cognitive-behavioural interventions into functional activities	
	5.1.5 Provide current information on, and discuss referral to/collaboration with appropriate services for functional assessment and management	

ASPECT OF CARE	5.2 Levels of knowledge and skills – Psychological and Behavioural Strategies EXPERT Name	SELF ASSESSMENT 1 – no previous experience 2 – experienced but need review 3 – experienced 4 – can teach and help others learn
Psychological and Behavioural Strategies	NCNZ: Domain 1 – Professional Responsibility Domain 2 – Management of Nursing Care. Domain 3 – Interpersonal Relationships. Domain 4 – Interprofessional Health Care and Quality Improvement In order to maximise and support improvement in the person’s pain and quality of life you will:	
	<p>5.2.1 Demonstrate comprehensive knowledge and understanding of how psychological, behavioural and spiritual factors contribute to pain and how these factors may influence the success of pain management/treatment, incorporate into teaching other health care staff and discuss with patient/family/whānau</p> <p>5.2.1.1 Demonstrate awareness of the significance of a Māori Model of Health for people who identify as Māori</p>	
	<p>5.2.2 Utilise information taken during the health history in relation to psychological (emotional and cognitive processes) state to consult with patient re appropriate psychological/spiritual care</p> <p>5.2.2.1 Integrate knowledge that Māori have a unique culture and may choose to be treated by Māori using Rongoa Māori (traditional healing practices) and where appropriate incorporate into care plan</p>	
	<p>5.2.3 Initiate referral to local psychological/recreational/occupational/spiritual/community support services as appropriate, and act as a resource to assist other health care staff to initiate appropriate referrals when needed</p>	

Appendix 1. Assessment Templates

VALIDATION KEY: C = Competence assessed in practice (use modified Bondy Tool) R = Reviewed policy/resource documents E = Exemption request T = Challenge Test D = Demonstration S = Simulation I = Inservice O = Other (specify) RPL (recognition of prior learning)	COMMENTS OF ASSESSOR Name	DATE	SIGNATURE
Total Pain 1.1			
1.2			
1.3			
1.4			

VALIDATION KEY: C = Competence assessed in practice (use modified Bondy Tool) R = Reviewed policy/resource documents E = Exemption request T = Challenge Test D = Demonstration S = Simulation I = Inservice O = Other (specify) RPL (recognition of prior learning)	COMMENTS OF ASSESSOR Name	DATE	SIGNATURE
Pain Assessment 2.1			
2.2			
2.3			
2.4			
2.5			
2.6			

2.7			
2.8			
2.9			
3.0			
3.1			

VALIDATION KEY: C = Competence assessed in practice (use modified Bondy Tool) R = Reviewed policy/resource documents E = Exemption request T = Challenge Test D = Demonstration S = Simulation I = Inservice O = Other (specify) RPL (recognition of prior learning)	COMMENTS OF ASSESSOR Name	DATE	SIGNATURE
Pharmacological Therapies 3.1			
3.2			
3.3			
3.4			
3.5			

3.6			
3.7			

VALIDATION KEY: C = Competence assessed in practice (use modified Bondy Tool) R = Reviewed policy/resource documents E = Exemption request T = Challenge Test D = Demonstration S = Simulation I = Inservice O = Other (specify) RPL (recognition of prior learning)	COMMENTS OF ASSESSOR Name	DATE	SIGNATURE
Interventional Therapies 4.1			
4.2			
4.3			
4.4			
4.5			

VALIDATION KEY: C = Competence assessed in practice (use modified Bondy Tool) R = Reviewed policy/resource documents E = Exemption request T = Challenge Test D = Demonstration S = Simulation I = Inservice O = Other (specify) RPL (recognition of prior learning)	COMMENTS OF ASSESSOR Name	DATE	SIGNATURE
Non-Pharmacological Interventions 5.1			
5.2			
5.3			

VALIDATION KEY: C = Competence assessed in practice (use modified Bondy Tool) R = Reviewed policy/resource documents E = Exemption request T = Challenge Test D = Demonstration S = Simulation I = Inservice O = Other (specify) RPL (recognition of prior learning)	COMMENTS OF ASSESSOR Name	DATE	SIGNATURE
Physical Strategies 5.1.1			
5.1.2			
5.1.3			
5.1.4			
5.1.5			

VALIDATION KEY: C = Competence assessed in practice (use modified Bondy Tool) R = Reviewed policy/resource documents E = Exemption request T = Challenge Test D = Demonstration S = Simulation I = Inservice O = Other (specify) RPL (recognition of prior learning)	COMMENTS OF ASSESSOR Name	DATE	SIGNATURE
Psychological and Behavioural Strategies 5.2.1			
5.2.2			
5.2.3			
5.2.4			
5.2.5			

Supporting literature and guidelines

Total Pain

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Useful websites

- International Association for the Study of Pain www.iasp-pain.org
- The Australian Pain Society www.apsoc.org.au
- The British Pain Society www.britishpainsociety.org
- The New Zealand Pain Society www.nzps.org.nz