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Commentary

Identifying Best Practices in Pain Assessment and Management for Intensive Care Unit Patients

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INTRODUCTION

Over the last 30 years, the focus on pain in intensive care unit (ICU) patients has shifted from recognizing pain as a co-occurring condition with ICU disease and treatment to the establishment of evidence-based guidelines to assist pain assessment and therapy. The use of self-report or behavior observation pain assessment scales validated for ICU use is recommended as a standard aspect of practice for all ICU patients. Furthermore, recommendations encourage the use of analgesic therapies that are tailored to the specific needs of each patient. While opioids are listed as the preferred analgesic in the guidelines, there is a rising emphasis on the use of multimodal analgesia. The goal of this review is to examine current developments in ICU pain evaluation and management, with an emphasis on analgosedation and multimodal analgesia, while also emphasising areas that require more research [1].

There was no information on how to use pain behaviour scales for brain-injured ICU patients until recently. There is preliminary evidence that the pain behaviours of traumatic brain-injured patients differ from those of other ICU patients, particularly in terms of facial expressions and state of consciousness. While this research, as well as those on pain behaviours in non-trauma-related brain damage, shows promise, a pain behaviour scale for brain-injured patients is not yet refined enough for ICU use. Patients with motor response limitations, such as quadriplegia or other spinal cord injuries, patients with burn injuries, especially to the face, patients with a history of chronic pain or chronic substance abuse, those receiving neuromuscular blocking agents, and patients with dementia or other cognitive deficits. Clinicians can use study findings from non-ICU settings to assess pain in ICU patients with cognitive deficits until more research on pain assessment methods for them is completed. Patients with cognitive impairment, for example, may be able to appropriately report pain. Those with severe cognitive impairment report less intense pain and fewer pain complaints than those with mild cognitive impairment. When expressly asked, cognitively impaired individuals will report pain if it is present and many can understand a self-assessment scale like the NRS or a verbal rating scale. Unfortunately, cognitively challenged individuals are less likely to request and get analgesics, and prophylactic analgesics are less common [2].

Pain management is not just a humanitarian approach to ICU patient care; it also helps to minimise both short- and long-term morbidities associated with increased physiological and psychological stress. Analgosedation and multimodal analgesia are two techniques to pain management in ICU patients that are currently gaining popularity. ICU clinicians continue to face difficulties in assessing and treating pain. Adoption of well-validated pain assessment methodologies and a uniform organisational approach to evaluation, documentation, and communication of patient pain across ICU team members can help address these issues. Because analgesia may eliminate the need for other medications, the notion of "analgesia first" ensures that pain is managed before sedatives and hypnotics are used. Multimodal analgesia strategies emphasise the good effects of a mix of opioids and non-opioids while minimising their negative effects [3].

More study is needed to show that these approaches to pain evaluation and management are useful in a diverse range of ICU patients. As a result, invasive procedures in intensive care patients may necessitate the use of a sedative and analgesic during procedures such as intubation, tracheal aspiration, medical dressing, and position exchange. A wide spectrum of these medications can have side effects, such as longer intensive care stays and immunosuppression. As a result, it must be cautious when choosing a drug and administering it. In critical patients, pain treatment minimises stress responses, mortality, and morbidity. The treatment plan should be created based on the clinical status of the patient. Both pharmacological and non-pharmacological approaches can be employed on the same patient in multimodal analgesia techniques. The patient must be observed on a regular basis when evaluating the effectiveness of the treatment strategy.

REFERENCES

1. Rose L, Smith O, Gélinas C, Haslam L, Dale C, Luk E, et al. Critical care nurses' pain assessment and management practices: a survey in Canada. Am J Crit Care. 2012;21(4):251-259.

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2. Puntillo KA, Max A, Timsit JF, Vignoud L, Chanques G, Robleda G, Roche-Campo F, Mancebo J, Divatia JV, Soares M, Ionescu DC. Determinants of procedural pain intensity in the intensive care unit. The Europain study. Am J Resp Crit Care. 2014;189(1):39-47.

3. Payen JF, Bru O, Bosson JL, Lagrasta A, Novel E, Deschaux I, et al. Assessing pain in critically ill sedated patients by using a behavioral pain scale. Crit Care Med. 2001;29(12):2258-2263.