

PAIN RECOGNITION AND MANAGEMENT AUDIT

Part 2: Training - Final report

Background

In 2007-2008 Beacroft & Dodd (2010, in press) carried out an audit within a range of Learning Disability Services in Surrey looking at Pain Recognition and Management. Beacroft & Dodd interviewed staff working in residential services, day service staff, carers and people with learning disabilities from across Surrey. Results of the audit were discussed by a multi-agency and multi-disciplinary pain steering group. The pain steering group rated the results against 9 standards that had been drawn from the literature. For residential services 6 standards were rated as red (standard not met), and 3 were rated as amber (standard almost met). No standards were rated green (standard met), whilst for day services 7 standards were rated as red and 2 as amber.

Figure 1: Table showing standard ratings from Beacroft & Dodd's 2008 Audit of Pain in Surrey

<u>Standards</u>	Residential	Day Service	Carer
1. Staff and family carers recognise that people with learning disabilities do not have a higher pain threshold than people in the general population.	A	A	R
2. People with learning disabilities have the right to have their pain managed independent of staff's beliefs.	A	A	A
3. People with learning disabilities should have their pain recognised.	R	R	A
4. People with learning disabilities have the right to have their pain managed effectively. This will include having appropriate, timely and regular pain medication, as well as access to alternative treatments.	R	R	R
5. People with learning disabilities should have pain recognition and management specified in their Health Action Plan.	R	R	R
6. Staff and family carers should have access to training and information surrounding pain recognition and management.	R	R	N/A
7. Staff and family carers should have access to appropriate communication aids when discussing pain with people with learning disabilities.	R	R	R
8. Staff and family carers should share information regarding pain recognition and management with other services that a person with learning disabilities uses.	R	R	A
9. Services should have policies in place for how to manage a person's pain, both in the service and when out in the community or whether at another service.	A	R	N/A

The main findings for each standard were:

Standard 1: Staff and family carers recognise that people with learning disabilities do not have a higher pain threshold than people in the general population.

1/3 of residential staff interviewed agreed with the statement that people with learning disabilities have a higher pain threshold.

Standard 2: People with learning disabilities have the right to have their pain managed independent of staff's beliefs.

The results of the audit showed that a significant number of staff believe that people with learning disabilities should not take medication for a headache. Some of these staff also did not take medication for a headache themselves, suggesting that they are letting their own beliefs influence how they help people with learning disabilities. It appeared that some staff assume that a person with learning disabilities will say they are in pain for attention, and that staff will make the decision as to how bad a pain is, rather than listening to the person with learning disabilities.

Standard 3: People with learning disabilities should have their pain recognised.

The people with learning disabilities who were interviewed in the audit said that staff, carers or doctors rarely used pictures to help them talk about pain. Half of the people interviewed said that they would speak to staff if they were in pain, but a small number said that they would not want to bother anybody about it. Staff said that they rely on people with learning disabilities telling them they are in pain, or behaviour changes to recognise when someone is in pain. Only 16% of staff said that they use any form of pain recognition tools or communication aids.

Standard 4: People with learning disabilities have the right to have their pain managed effectively. This will include having appropriate, timely and regular pain medication, as well as access to alternative treatments.

The results of the audit suggested that people with learning disabilities were not being given appropriate pain medication. Staff were asked whether they themselves had used any non-prescribed medication for pain in the last three months, 79% of residential staff had. 66% of staff believed that the person with learning disabilities that they were discussing had received non-prescribed medication for pain in the last 3 months. In fact on checking medicine records, only 39% of people with learning disabilities who were discussed had received medication for pain. Of the people with learning disabilities who were interviewed only 30% thought that they had received as required medication in the last 3 months. Only 20% of residential staff said that they gave homely remedies. Less than 5% of staff mentioned any alternatives to medication.

Standard 5: People with learning disabilities should have pain recognition and management specified in their Health Action Plan.

Only 30% of the people with learning disabilities interviewed had a Health Action Plan at all, of these only 23% said that they had helped to make their Health Action Plan. Staff said that only around 50% of the people they discussed had a Health Action Plan, and only 31% had a completed Pain section.

Standard 6: 'Staff and family carers should have access to training and information surrounding pain recognition and management.

Only 2 people interviewed had received any training on pain recognition or management, and this had not been undertaken in relation to their work with people with learning disabilities.

Standard 7: Staff and family carers should have access to appropriate communication aids when discussing pain with people with learning disabilities.

Half of the staff interviewed discussed people with learning disabilities who were non-verbal, or who had limited communication, but only 16% used communication aids. The communication aids used were picture cards or Makaton sign language.

Standard 8: Staff and family carers should share information regarding pain recognition and management with other services that a person with learning disabilities uses.

Only 10% of residential staff said that they shared information with the day services that a person with learning disabilities used.

Standard 9: Services should have policies in place for how to manage a person's pain, both in the service and when out in the community or whether at another service.

88% of residential services had a policy in place, of which only 2/3 of these included management of pain.

Recommendations from original audit

16 recommendations were made for residential and day services staff and family carers as a result of the original audit. The Pain Steering Group recommended that these should be addressed via the development of pain booklets and through training for staff and family carers. Two 'I feel pain' booklets were developed - one for staff and family carers, and one for people with learning disabilities. The Partnership Board agreed to fund training on pain recognition and management for staff and carers working with people with learning disabilities across Surrey. A literature search and request through the Learning Disability Health Network failed to produce any available training packages covering pain recognition and management for staff and carers of people with learning disabilities. As a result the pain training pack was devised specifically to meet our needs.

Design of training pack

The Pain Training pack was designed to help address the deficits in performance from the standards described above.

The pack has 10 tasks which arise from the standards. The tasks employ a variety of different methods including role play; discussions; scenarios; a quiz and a checklist.

Tasks 1 & 2

The belief about pain thresholds is the first issue that the Pain Training Pack aims to explore, with an interactive sorting task to look at staff beliefs on which groups in society feel more or less pain. This is followed with a discussion on the reasons that people may believe that people with learning disabilities have a higher pain threshold, and the evidence against this belief.

Task 3

The Pain Training Pack aims to address the issue of recognising pain by looking at the interpretation of a scenario when it is related to either a member of the public or a person with learning disabilities.

Tasks 4 & 5

The Pain Training pack introduces staff to the different methods that can be used to recognise pain in people with learning disabilities. The different possible signs of pain are also explored, first using role play for a number of common conditions, and then discussing the variety of signs that people may show when they are in pain. A number of pain recognition tools and communication aids are introduced, and includes a short role play to practise using them. The Pain Training Pack introduces the communication cards from Feeling Poorly (Dodd & Brunner, 1999), which can also be found in the I Feel Pain booklets.

Tasks 6, 7 & 8

The Pain Training pack looks at how staff manage their own pain, use of homely remedies and what is included in medicine policies, and alternative methods of pain management. The pack especially emphasises the use of alternative methods of pain management to go alongside medication, and that it can be a good idea to give paracetamol if someone has a reason to be in pain, even if they are not showing the normal signs of being in pain.

Task 9

This task looks at what should be included in a Health Action plan for pain, and asks staff to write the pain section of a Health Action Plan for themselves, and the pain section of a Health Action Plan for someone they work with who has learning disabilities. The Pain Training Pack suggests that information such as Health Action Plans should be shared, where possible, between all services that a person with learning disabilities accesses. This message is reinforced at the follow-up.

The Pain Training Pack does not look in detail at other policies, as these are organisation-wide documents; however the aim of the pack is to encourage staff to include recognition and management techniques in local strategies and everyday practice.

Task 10

The final task focuses on evaluation of the training they have just finished, and completion of the checklist on how they think their service currently meets the needs of people with learning disabilities regarding pain recognition and management. It also goes through the future expectations with regard to cascading the training and further audit of results.

Procedure

1. Training

The Pain Training was targeted at managers of all residential, day and supported living services for people with learning disabilities within Surrey.

It had been noted that in previous training that was designed to be cascaded within services that the training was not being passed on to other staff effectively. The staff that attended the training tended to be less senior members of staff who did not have any control over organising training sessions to pass on the information. The decision was taken to target managers with this training as they would have, as the senior member of staff, responsibility for cascading the training to all their staff. It was also felt that by training the managers about the issues regarding pain recognition and management they would be able to integrate the awareness and good practice into the service's everyday ways of working.

Initially Home Managers were invited to specific training sessions in their area, but after finding this strategy unsuccessful all managers were sent dates and venues of training sessions, which they then booked onto for a convenient time.

Letters of invitation were sent to all known residential, day and supported living services for people with learning disabilities in Surrey using a pre-existing database which was cross checked against the CSCI listings for Surrey.

Managers or deputy managers attended an initial training session of 2-3 hours, where they were taken through the Pain Training pack information and activities so that they were aware of the format, content and possible ways of delivering the information.

At the end each service received the Pain Training Pack, a copy of the 'I Feel Pain' booklet (Beacroft & Dodd, 2008) for Staff and Carers, and copies of 'I Feel Pain' booklets for people with Learning Disabilities (Beacroft & Dodd, 2008). Managers took enough copies of the booklets for people with learning disabilities to be able to give one to each of their service users.

Follow-up

Managers were informed at the time of training that a follow-up would take place three months after training. They were told that a follow-up checklist would be posted to them, and that a small selection of homes would be contacted to receive a visit for a follow-up audit. These checklists were posted 3 months after training, and a random sample of 10 residential homes were selected for a visit once checklists had been returned. The visit looked for the physical evidence within the service that the information given on follow-up checklists was correct and whether medicines policies and Health Action Plans were completed and available to view.

Results

1. Results from Training sessions

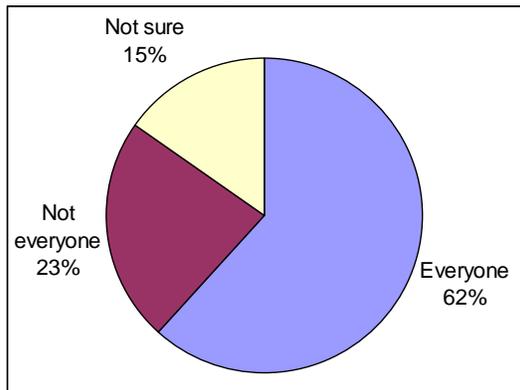
In total, 275 services for people with learning disabilities were offered the training, with 197 services (72%) sending at least one person to the training. In total 252 people attended the training, some larger services sent 2 members of management to make the cascading easier to manage, and some healthcare and social care professionals chose to attend the training as well. 78 services did not attend the training. Some did not reply to the invitations to training, though they were contacted 3 times by letter and email. Some did book onto a session, but were unable to attend or send anyone else due to illness or staff shortages. In total 32 training sessions took place over 5 months in 5 different locations around Surrey. Group sizes ranged from 2 people - 21 people.

At the end of the training session managers were asked to complete a checklist that asked whether services currently used various pain recognition tools and management strategies, whether service users have Health Action Plans, what the health action plans say, and what information medication and homely remedy policies contain.

Question 1: Pain thresholds

Question 1 on the checklist was whether all staff in the service knew that people with Learning Disabilities do not have a higher pain threshold than people without a learning disability. 62% of people thought that everyone in the service knew this, 23% of people did not think that everyone knew this, and 15% were not sure if everyone knew.

Figure 2: Pie-chart showing staff responses as to whether everyone they work with knows that people with learning disabilities do not have a higher pain threshold.

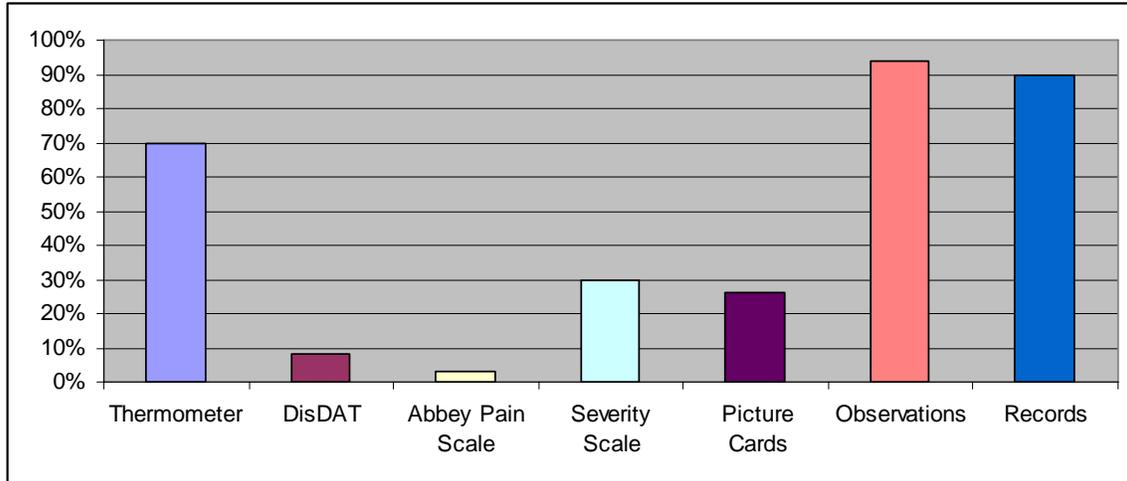


Question 2: Methods of pain recognition

Question 2 asked whether staff used various methods of recognising pain. 70% said that they used thermometers to recognise if someone was in pain. Only 8% used the DisDAT and 3% used the Abbey Pain Scale. 30% said that they use some type of severity scale

and 26% use picture cards to aid communication. Reassuringly 94% of people said they use observations of behaviour and 90% use records of pain.

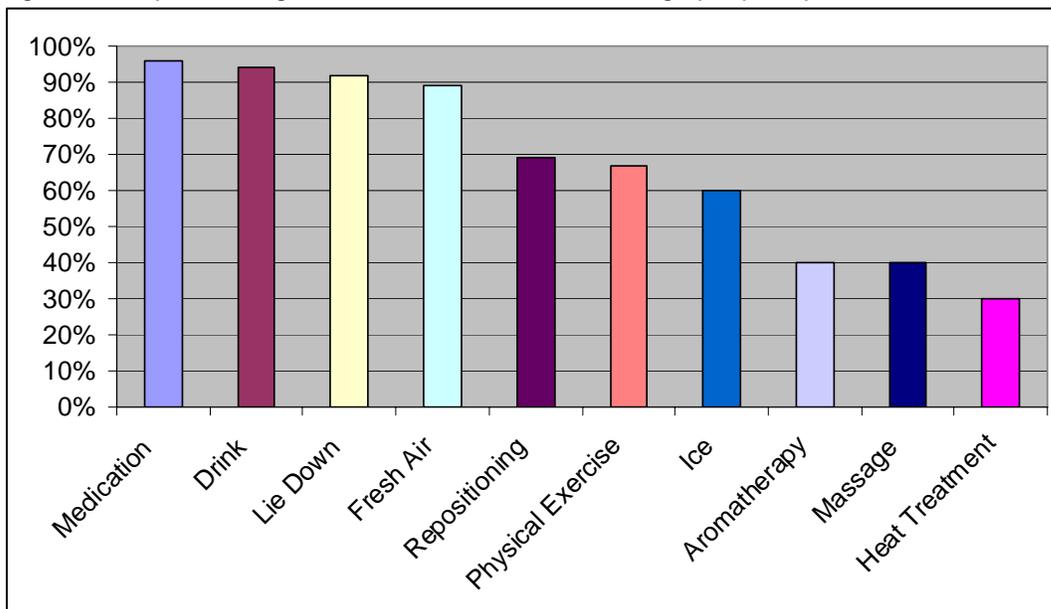
Figure 3: Graph showing methods that staff use to recognise pain.



Question 3: Pain Management strategies

Question 3 looked at what pain management strategies staff were currently using. The most commonly used methods of pain management were: medication (96%), a drink (94%), a lie down (92%), and fresh air (89%). Repositioning was used by 69% of people, physical exercise by 67% of people, and ice by 60%. Only 40% of people use aromatherapy and massage, whilst only 30% of people said that they use heat treatment.

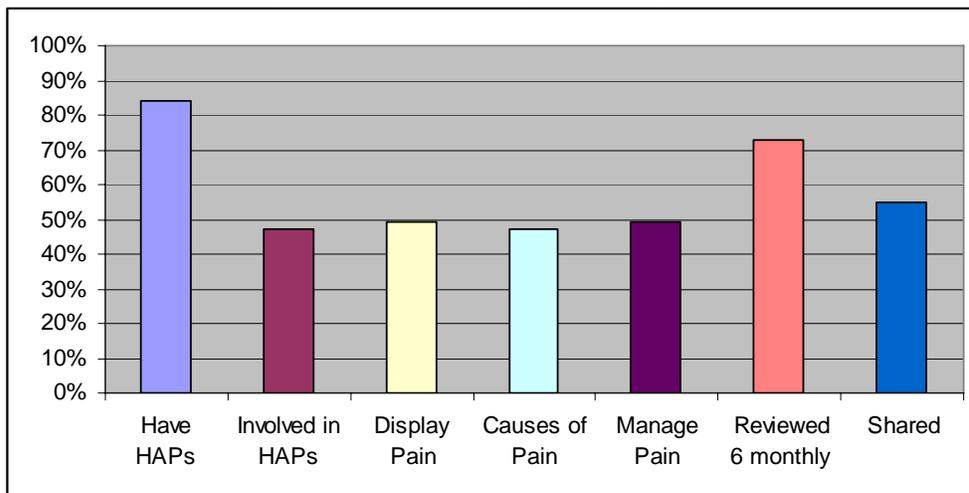
Figure 4: Graph showing methods that staff use to manage people's pain.



Questions 4 – 8: Health Action Plans

Questions 4-8 asked about Health Action Plans. 84% of people said that all their service users have Health Action Plans, and 47% of people said that all service users were involved in making their Health Action Plan. When asked specifically about the pain section of the Health Action Plans, staff said that 49% mention how the person displays pain, 47% mention the possible causes of pain, and 49% mention how to manage the pain. 73% of staff said that Health Action Plans are reviewed at least every 6 months, and 55% of staff said that the Health Action Plans had been shared with other relevant services.

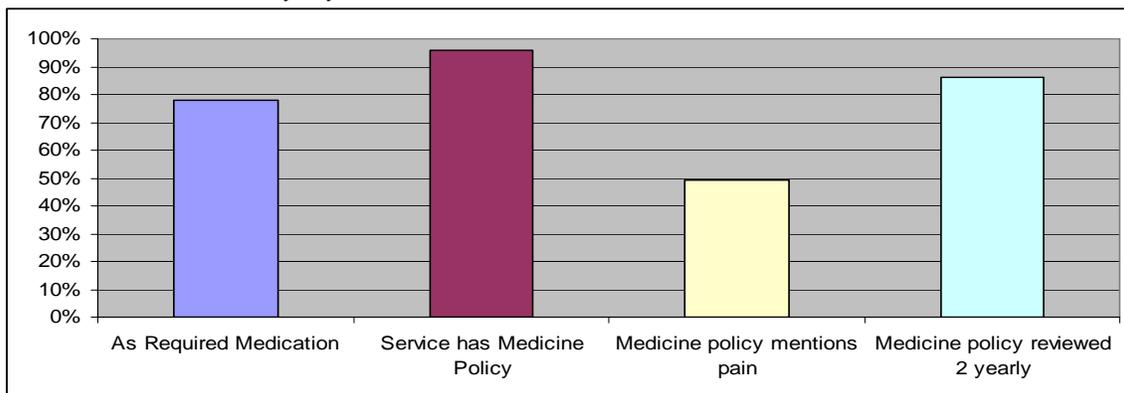
Figure 5: Graph showing staff responses to questions regarding Health Action Plans.



Questions 9 – 13: Medication and Medicines policies

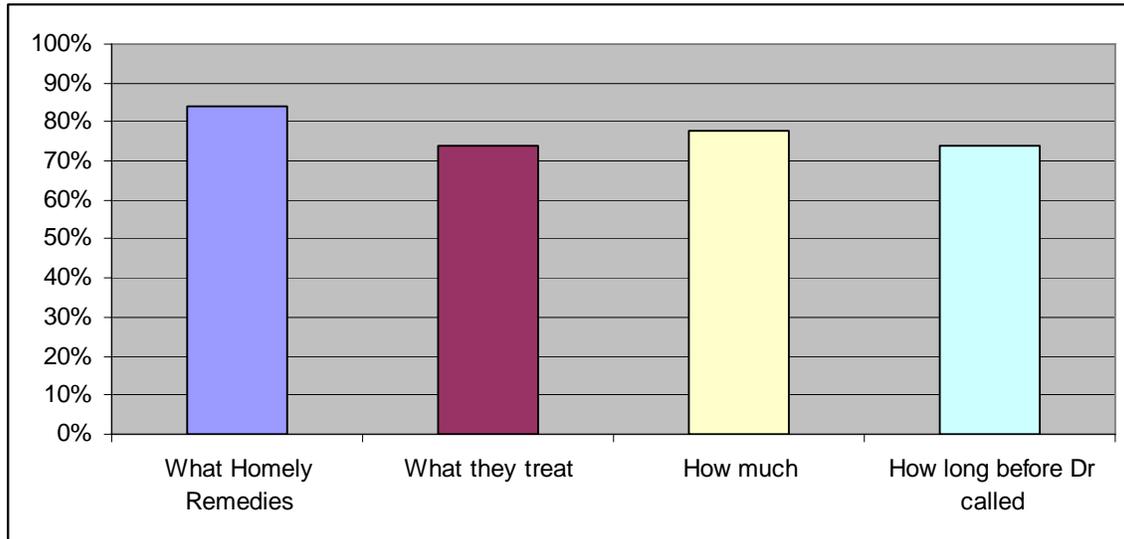
Questions 9-13 asked about medication and medicines policies. Staff said that 78% of service users are written up for 'as required' medication. 96% of staff thought that their service has a Medicines Policy, but only 49% thought that their policy specifically mentioned pain. 86% of people thought that their medicines policy was reviewed every 2-3 years.

Figure 6: Graph showing percentage of staff who thought that: everyone was written up for As Required Medication, their service has a Medicine policy, their Medicine policy mentions pain and is reviewed at least every 2 years.



84% of people thought that their medicines policy states what homely remedies can be used, 74% that it states what the homely remedies can be used to treat, 78% that it states how much of the homely remedies staff can give, and 74% that it says how long staff can use the homely remedies for before staff call the Doctor.

Figure 7: Graph showing percentage of staff who thought that their Medicine Policy did include information about Homely Remedies.



Evaluation of the pain training sessions

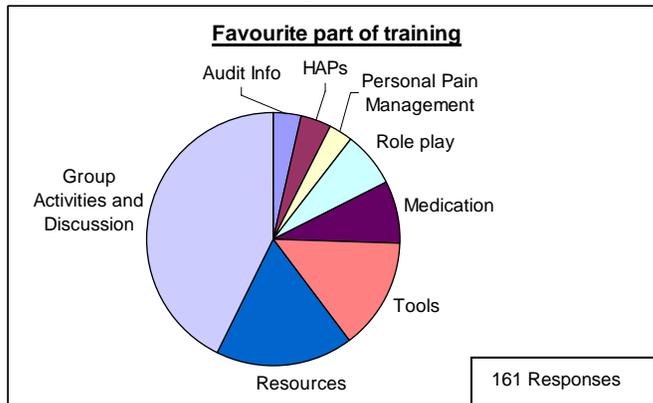
Staff were given an evaluation form to complete at the end of the training session. Staff were asked to rate certain aspects of the training from 0 (Very unhelpful/Very poor) to 10 (Very helpful/ Very Good). Mean ratings can be seen in the table below:

Figure 8: Table showing mean ratings from evaluation forms.

Question	Rating (0-10)
What did you think of the format of the training?	8.43
What did you think of the resources used?	8.55
What did you think of the content of the training?	8.56
What did you think of the trainer's ability to run the group?	8.63

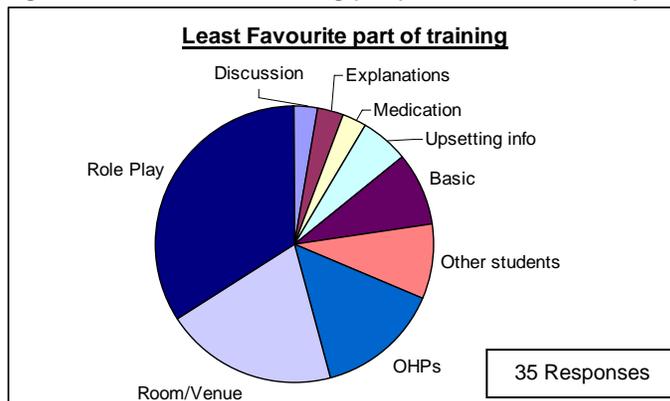
The majority of staff thought that the length of the training was right, with 237 people saying it was a good length. People were asked what their favourite part of the training was, and the most popular part was the group discussions and activities.

Figure 9: Pie-chart showing people's favourite parts of the training.



People were also asked what their least favourite part of the training was and most people said that they enjoyed it all or did not respond. Only 35 people named a least favourite part. The least favourite part was, as expected, the role play, followed by the room/venue.

Figure 10: Pie- chart showing people's least favourite part of training.



The final question asked about the staff's beliefs on whether they could cascade the training. 95% of staff thought that they could implement the training within their service, and that the training would change staff attitudes about pain in people with Learning Disabilities.

Comments from staff that attended the training:

- This has really helped me to understand how to manage pain and also to train my staff on how to support the residents.
- Dislike mandated training for something that should be part of practice. Seems to be aimed at lower levels of staff.

- Felt it was very basic for a group of managers, could just as easily sent the file to home and gone through it.
- Really informative, lots of good info and resources. I learnt a lot!
- The information packs are brilliant, this will help me in delivering training to my staff team.
- Very informative. A lot discussed that I took for granted prior to this training.
- Really accessible and relevant to the people we support.
- Really valid and subject long overdue for discussion.

2. Results from follow-up

Follow-up checklists were sent to all services that attended the training sessions. 111 out of 197 services (56%) sent back completed checklists. Services that did not reply were sent a further copy of the checklist on 3 more occasions. Several homes reported that the manager was off sick, or that staff had moved on to other places. Follow-up visits were conducted with 10 residential homes, which confirmed the responses these homes had made on their checklists, and showed that the pain information was easily accessible for staff and people with learning disabilities.

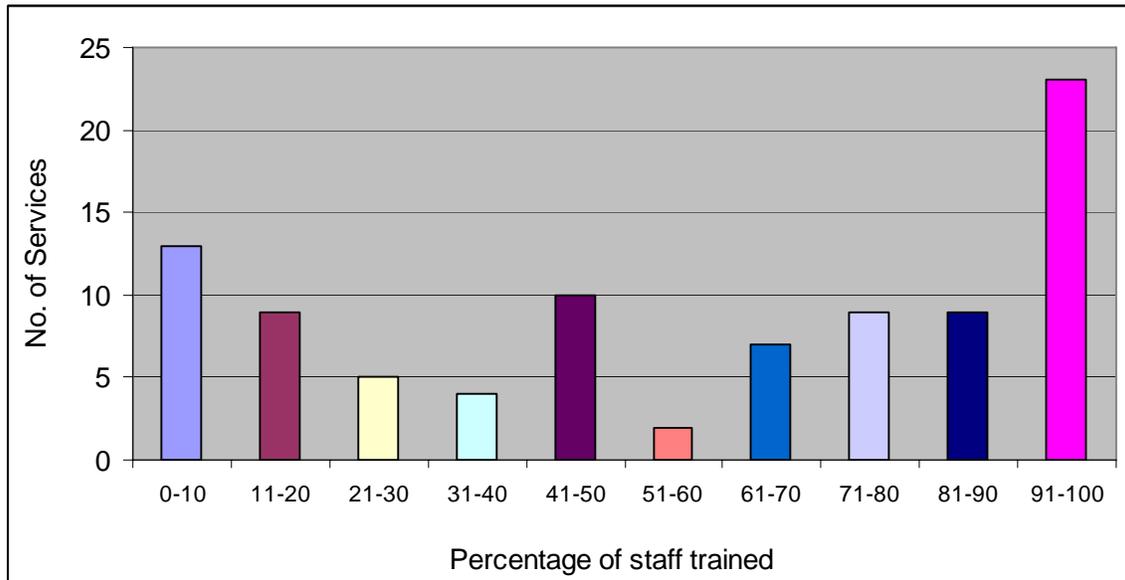
The checklists used for the follow-up were the same as the ones filled out at the training session, with an additional question asking how many of their staff had been trained using the Pain Training Pack.

The information below shows only the responses of those services that completed and returned their follow-up checklist, comparing their answers at training to those at follow-up.

Staff Trained

91 services responded to the question asking them how many staff they had in total, and how many of these had been trained using the pain training pack. These responses show that the training has been cascaded to 693 out of a total of 1418 staff in the services that responded to this question, which is 48.9%. 21 services had managed to cascade the training to everyone who worked there, and more than half of services who answered this question had trained 50% or more of their staff. Figure 11 shows the percentage of staff trained in services.

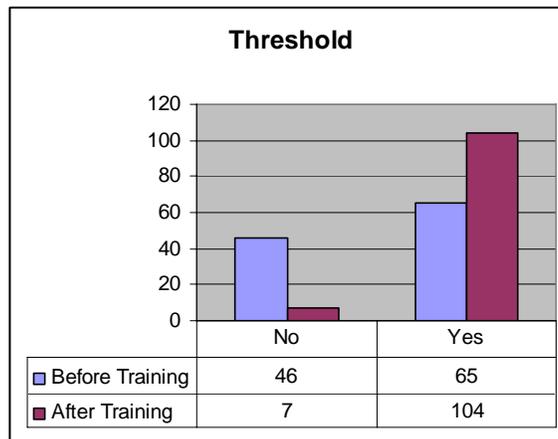
Figure 11: Graph showing the frequencies of percentage of staff that have been trained in a service



Question 1: Pain thresholds

After training, 39 more managers thought that everyone they work with knows that people with learning disabilities do not have a higher pain threshold than other people. A paired samples t-test showed this is statistically significant, $t(110) = -7.173$, $p = 0.000$.

Figure 12: Graph showing how many managers think that everyone in their service do, or do not know that people with a learning disability do not have a higher pain threshold, before and after training.

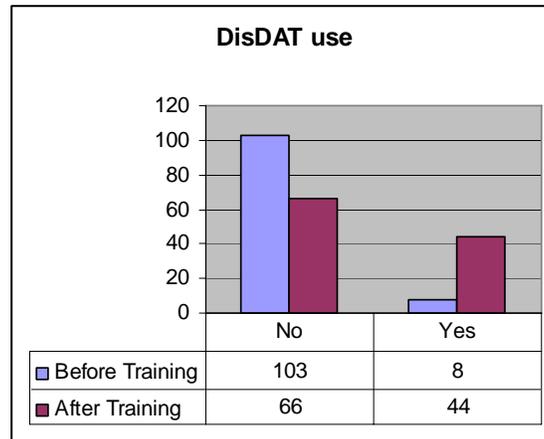


Question 2: Methods of pain recognition

The follow-up showed a small increase in the number of services using thermometers and recording instances of pain. There has been no change in the number of services using observations. Most services were already using these methods before the training.

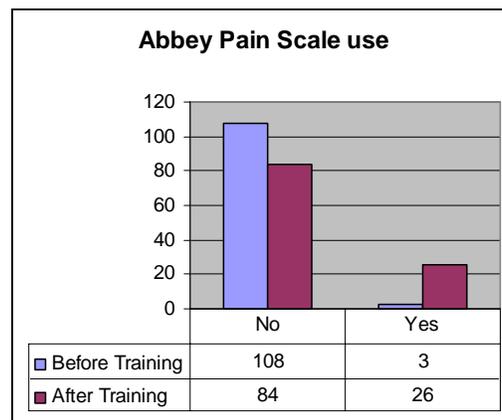
After training 36 more services are using the DisDAT form to help recognise pain. A paired samples t-test showed this is statistically significant, $t(109) = -6.999$, $p = .000$.

Figure 13: Graph showing how many services do and do not use the DisDAT, before and after training.



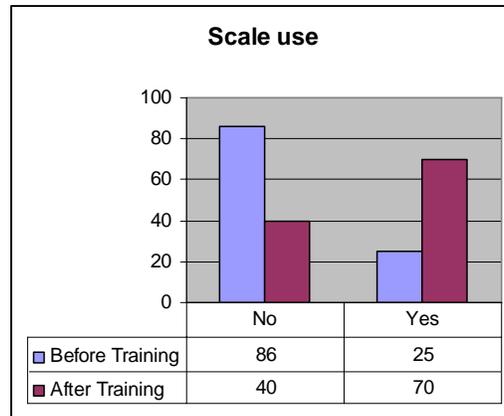
After training, 23 more services are using the Abbey Pain scale. A common explanation of why people were not using the Abbey Pain scale was that the service users were verbal and would say if they were in pain so the scale would not be appropriate for them. The increase in services using the Abbey Pain Scale was shown to be statistically significant by a paired samples t-test: $t(109) = 5.368$, $p = .000$.

Figure 14: Graph showing how many services do and do not use the Abbey Pain scale, before and after training.



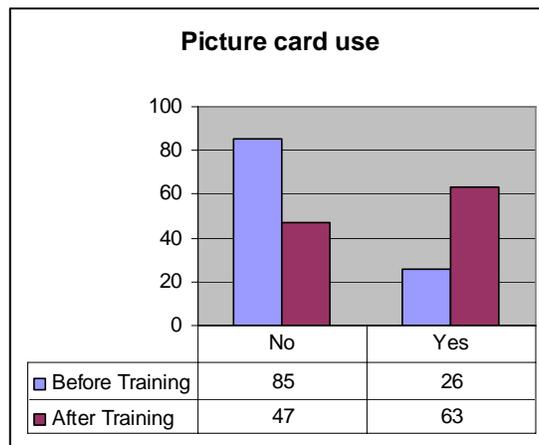
45 more services were using a picture scale after training. This was shown to be statistically significant by a paired samples t-test, $t(109) = -7.405$, $p = .000$.

Figure 15: Graph showing how many services do and do not use picture scales, before and after training.



37 more services are using the picture cards for communication after training. This was shown to be statistically significant by a paired samples t-test, $t(109) = -6.092$, $p = .000$.

Figure 16: Graph showing how many services do and do not use Picture cards, before and after training.



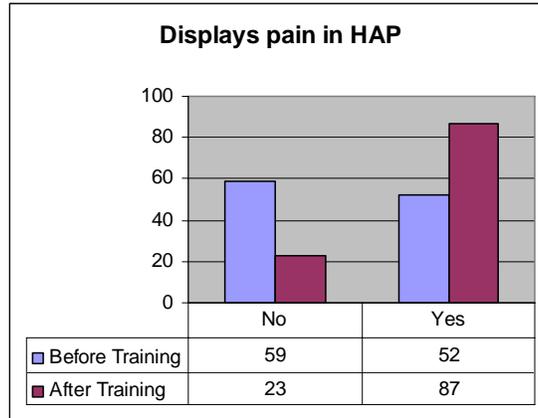
Question 3: Pain Management strategies

The follow-up showed a small increase in the number of services using aromatherapy, massage and fresh air to manage pain. A small decrease was seen in the number of services using medication, lying down, a drink, exercise, repositioning, heat packs and ice packs to manage pain.

Questions 4 – 8: Health Action Plans

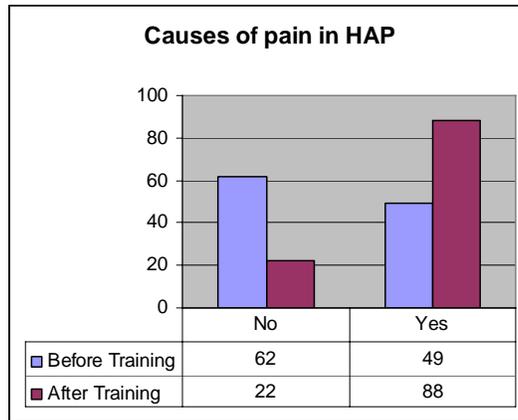
Following training, 35 more services have included how a person displays pain in their health action plan. This was shown to be statistically significant by a paired samples t-test, $t(109) = -6.519, p = .000$.

Figure 17: Graph showing in how many services every person's Health Action Plan includes information on how the person displays pain, before and after training.



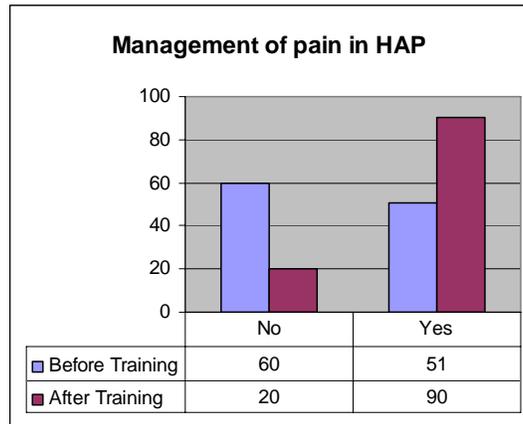
Following training, 39 more services included possible causes of a person's pain in their Health Action Plan. $t(109) = -7.100, p = .000$.

Figure 18: Graph showing in how many services every person's Health Action Plan includes information on possible causes of a person's pain, before and after training.



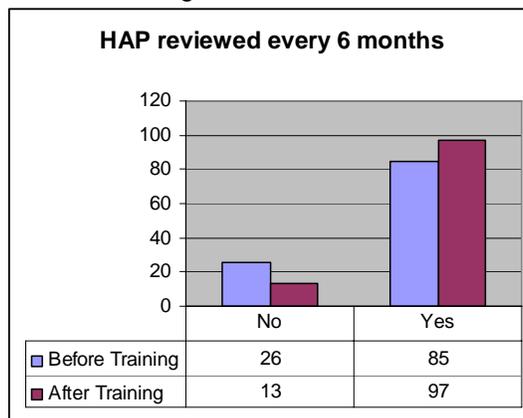
Following training, 39 more services have included how to manage someone's pain in their Health Action Plan. $t(109) = -6.506, p = .000$.

Figure 19: Graph showing in how many services every person's Health Action Plan includes information on how to manage the person's pain, before and after training.



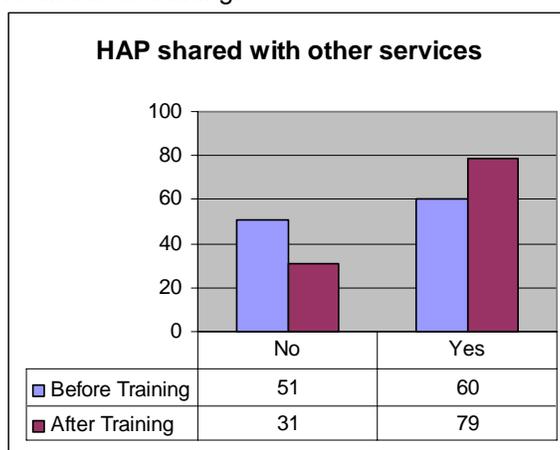
12 more services are reviewing Health Action Plans at least every 6 months, following training. $t(109) = -2.933$, $p < 0.005$.

Figure 20: Graph showing how many services do, and do not review Health Action Plans at least every six months, before and after training.



19 more services have shared HAPs with other services that a person uses. $t(109) = -3.214$, $p < 0.005$.

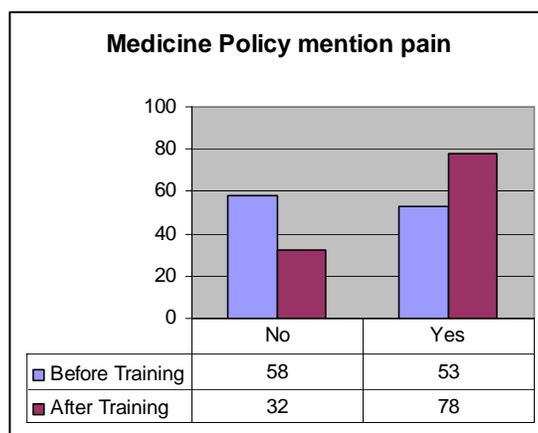
Figure 21: Graph showing how many services have, and have not, shared Health Action Plans with other services, before and after training.



Questions 9 – 13: Medication and Medicines policies

At follow-up, 25 more services' Medicine Policies mention pain following training. $t(109) = -3.969, p = .000$.

Figure 22: Graph showing how many service's Medicine policies do and do not mention pain, before and after training.



There have also been small increases in the number of Medicine policies that mention what homely remedies may be used, how much may be used, and for how long they may be used before a Doctor is called.

Discussion

The results of the follow-up were encouraging. They suggest that the Pain Training has helped to change staff attitudes towards managing pain in people with learning disabilities, and has helped staff to recognise this pain.

The training has been cascaded to nearly half the staff in the services that responded to the follow-up in Surrey. Follow-up visits suggested that the main reason for not

cascading the training is staff shortages, caused by sickness and high turnovers of staff. Several services explained on their checklist that training was planned for the near future.

Standard 1 from the original pain audit in Surrey said that staff should recognise that people with learning disabilities do not have a higher pain threshold than people in the general population. The results of the follow-up show that 94% of people that returned their checklist think that everyone they work with now knows that people with a learning disability do not have a higher pain threshold.

Standards 3 & 7 stated that People with learning disabilities should have their pain recognised, and people should have access to appropriate communication aids when discussing pain. The training provided people with communication aids and recognition tools that they had not come across before. There were particularly small numbers of people using the DisDAT and the Abbey Pain Scale before training, compared to other pain recognition tools. The follow-up showed a significant increase in the numbers of services using these tools, however 60% were still not using the DisDAT and 76% had not used the Abbey Pain Scale. At the follow-up visits, those homes that had responded that they were not using DisDAT were generally either just in the process of completing the DisDAT, or were using a similar tool, such as a written Pain Profile instead. People also generally gave the reason for not using the Abbey Pain Scale as having had no need to yet, though the blank form was available in people's files should it be needed.

More services are now using the picture communication cards and picture scales to talk about pain with service users. Verbal feedback at follow-up visits suggests that the 'I Feel Pain' booklets have been very useful because of the communication cards that can be found at the back of the booklets, and can be kept in an accessible place for both staff and service users.

There were not many changes in the number of people using various pain management strategies, though most methods remained at high numbers of people using them. A possible reason for the small changes is that some methods require high staffing levels if they are to be freely available, such as fresh air and exercise and some methods require specialist training for staff or outside trained professionals to deliver them, such as massage and aromatherapy. These methods are therefore limited by money and availability of staff. However, with the exception of exercise, these methods did show small increases. Other methods are controlled by service policy, such as medication, and heat and ice packs. Day services are generally unable to provide pain medication, and several organisations have banned the use of heat packs for health and safety reasons. These types of methods would need an overall policy change, rather than change in individual services. The only statistically significant change for pain management methods was for the decrease in the number of services using repositioning. It is unclear why people have stopped using this method since training, though it is possible that this is due to the method only being necessary for people who stay in bed or use a wheelchair.

A large number of services have improved the information that is contained within a person's Health Action Plan (HAP) to include information about how people display pain, what the causes of the pain may be and how to manage pain. At the follow-up visits a number of these were viewed, with services producing HAPs containing all the

suggested information, and are including the service users in the process where possible.

At training staff members were encouraged, with the service user's permission, to share parts of the Health Action Plans with other services that people with learning disabilities use, especially day services and health professionals. 19 more services in Surrey are now sharing their Health Action Plans, and people have commented how useful they are for taking to the GP or Hospital.

25 more services now have medicine policies that mention pain. It is unlikely that these services have changed their policy since training, but the training does seem to have encouraged people to look at their medicine policy more closely. At the follow-up visits some managers had realised that their policy does not actually mention pain, whilst others had found that their policy did. 2 of the managers visited were in the process of adding information about pain to the home's medicine policy.

Carers Training

The Pain Training was also offered to Carers. Mencap was contacted, but was unable to give any information about Mencap support groups in Surrey. Letters were sent to each of the 10 Surrey Carer Support groups offering the training to any carers who wished to attend. Only Woking Carers Support requested a training session. Information about pain was sent as a reference to all other groups, and copies of the 'I Feel Pain!' booklets to those that requested it. The training session for Woking was held in November 2009 at The Cornerhouse in Woking. 8 people attended the training, which consisted of some of the tasks from the Pain Training Pack, and information from the Surrey Audit. Carers were also talked through the 'I Feel Pain!' booklets, and received copies of both booklets. Several copies of the booklets were also given to the Carer Support Worker for those Carers who could not attend the training session.

Carers completed an evaluation form and their comments on the training are below:

- Very useful. Will be able to use the well thought out booklets.
- Encouraging to see the NHS has done this pioneering work.
- Wonderfully illuminating - what a fantastic resource for carers, teachers and medical professionals.
- A tremendous amount of hard work is being put into this very helpful project.
- Such a small group enabled people to speak freely.

Other Events

The information about pain in people with learning disabilities has been presented or displayed at several events through 2009:

- 'Strictly Good Health' Conference, March 2009.
- Providers Forum, March 2009.

- End of Life Think Tank Day, April 2009.
- Go 4 It Event, May 2009.
- Partnership Board Open Meeting, July 2009.
- Specialist Therapies Conference, October 2009.
- South West Valuing People Health event, September 2009.
- East Surrey Valuing People Group meeting, November 2009.
- DES training for Primary Care Practices 2009 and 2010.

Conclusion

This part of the pain audit aimed to complete the audit cycle by delivering training to address many of the original 16 recommendations, and to check whether these had been implemented in services.

Most training programmes delivered to staff are usually open access, with no commitment from managers to either attend themselves or to implement the learning from the training. Recognition and management of pain for people with learning disabilities requires not only knowledge, but also a change in attitudes and practice. For this reason, the decision was taken to target the training at managers, who would then be required to cascade to their whole staff team, and to require changes in practice from them.

The results of the training programme have been very promising.

72% of services sent at least 1 management representative to the training after a written invitation. The evaluations of the training programme were also very positive, with no element scoring less than 8.43 out of 10. Results from the initial checklists indicated that many of the concerns found in the original audit were valid across services, in relation to pain thresholds, recognition, management and inclusion in Health Action plans.

Attendees were contacted 3 months after training and asked to complete a follow-up checklist with regard to their service. 56% of services responded in the timescale and were included in the analysis.

Results indicated that 693 staff had been trained using the Pain Training pack in these services, an average of 48.9% of all their staff. 21 services had achieved full compliance with cascading the training, and more than half of services had trained at least half their staff.

The analyses from training and follow-up checklists showed highly significant improvements in most areas, particularly with regard to pain thresholds, use of DisDAT, Abbey pain scale, picture scales and picture cards, information in health action plans and identification of pain issues in medication policies. Changes in pain management strategies showed less change, but these were already at high levels for the use of medication and other strategies according to the original checklists.

Anecdotal evidence from other sources also reinforces the success of this training, with Health Action planning trainers reporting that staff attending already knew about putting pain signals and management in a person's health action plan.

Although training for carers was offered to all known carers groups, the take-up was very poor. However the carers who did attend were very impressed and positive about the whole project.

Future recommendations

1. Services will need reminding regularly about the content of the training, and to train new staff as they join their service. New services will need to be identified and pain training packs given to them.
2. A further follow-up could be completed to see whether the effects of the training are maintained.
3. Further thought is needed in how to access family carers.
4. The booklets should continue to be available to staff and family carers and to people with learning disabilities.
5. A future audit could be undertaken of the use of the picture communication cards in primary care practices and other generic health settings.
6. Other forms of training should be delivered using a similar system with the managers being trained first to ensure their commitment to change practice.

References

Beacroft M & Dodd K (2008) 'I feel pain!' – Information about pain. Surrey and Borders Partnership NHS Foundation Trust.

Beacroft M & Dodd K (2008) 'I feel pain!' – Information for Staff and Carers on Pain recognition and management with people with learning disabilities. Surrey and Borders Partnership NHS Foundation Trust.

Beacroft M & Dodd K (2010) Pain in people with learning disabilities in residential settings - the need for change. British Journal of Learning Disabilities – in press.

ELLEN MACKEY
Assistant Psychologist

DR KAREN DODD
**Associate Director - Specialist
Therapies, Learning Disabilities
and Older People's Mental Health**

20th January 2010.