Clinical Evaluation of the ASPAN Pain and Comfort Clinical Guideline

ASPAN Pain and Comfort SWT:
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The ASPAN Pain and Comfort Clinical Guideline was created because of the urgent need for a standardized evidence-based approach to the management of patients' pain and comfort in all perianesthesia settings. The purpose of the research presented here was to test the content of the ASPAN Pain and Comfort Clinical Guideline, which included the domains of assessment, intervention, and outcomes. Each domain was rated on clarity, usability, and feasibility using a Likert scale, which ranged from 1 (strongly disagree) to 4 (strongly agree). A survey design was used with a convenience sample of 215 perianesthesia nurses. The results of the study demonstrated a mean score of clarity, usability, and feasibility in all perianesthesia settings ranging from 3.54 (SD) to 3.80 (SD). There were no differences in the clarity, usability, or feasibility of the guideline between perianesthesia settings. The results of this study support that the ASPAN Pain and Comfort Clinical Guideline has practical utility for perianesthesia nurses in all settings. Use of this guideline in perianesthesia settings will standardize pain and comfort management and has the potential to positively impact pain and comfort in perianesthesia patients.

COMPREHENSIVE PAIN and comfort management is a foundational aspect of nursing care and a fundamental right of all patients. A survey design study conducted by the ASPAN Research Committee in April 2001 revealed an urgent need to develop a pain and comfort clinical guideline. The recommendations of the ASPAN Pain and Comfort Clinical Guideline[1] are based on the findings of the 2001 survey commentary during a consensus conference that focused on pain and comfort, expert opinions, and published research. The consensus conference included a panel composed of nurse experts in pain management, comfort management, and clinical guideline development; representatives from the American Society of Anesthesiologists (ASA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); the ASPAN Pain and Comfort Guideline Strategic

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Work Team; and perianesthesia nurses from various geographical locations.

Purpose and Hypothesis

The purpose of this study was to evaluate the ASPAN Pain and Comfort Clinical Guideline for clarity, usability, and feasibility in the Preoperative Phase, PACU Phase I, PACU Phase II, and PACU Phase III. The hypothesis stated that the ASPAN Pain and Comfort Guideline would be clear, usable, and feasible across all perianesthesia settings.

Selected Literature Review

Clinical Guidelines

Clinical practice guidelines are systematically developed recommendations that provide a framework for decision making in clinical practice. According to the ASA, guidelines provide basic recommendations that are supported by analysis of current literature and a synthesis of expert opinion, open forum commentary, and clinical feasibility data.[2,3]

Research studies validate that clinical practice guidelines improve patient outcomes by reducing variance in practice.[2,4,5] A reduction in negative or adverse outcomes and lowered health care costs are possible when clinicians follow the recommendations of well-designed clinical practice guidelines.[6]

Perianesthesia nurses practice in a variety of settings including office-based surgery, freestanding centers, and inpatient medical center facilities. In addition, they vary significantly in terms of knowledge base, work experience, and clinical skills. Clinical practice guidelines present policy statements that outline a standardized, uniform approach that can be used to guide every nurse in providing high-quality nursing care to patients across the continuum of care in all perianesthesia settings.

The ASPAN Pain and Comfort Clinical Guideline represents a summary and subsequent testing of scientific research findings and expert opinion regarding pain and comfort management. It defines the purpose, resources, education, performance improvement parameters, and pathway documentation necessary for safe and effective management of pain and comfort in perianesthesia patients.[7] Defining the purpose provides rationale for establishing and utilizing a standardized approach to assess and manage pain and comfort. The guideline identifies and furnishes essential educational materials that help to reinforce important aspects of care, such as home care instructions. It serves to establish and maintain high-quality nursing practices and reduce the incidence of adverse outcomes by recommending methods for evaluating performance and implementing improvements in practice. Its recommendations for pathway documentation provide a method to clearly communicate the pain and comfort treatment plan and its effectiveness to all members of the multidisciplinary team, including the patient.

Pain Management

Despite the release of the Agency for Health Care Policy and Research (AHCPR) Acute Pain Management Guideline over 10 years ago[4] and the JCAHO standards in 2000,[8] research shows that nurses continue to lack basic pain management knowledge. In 2002 subscribers of a nursing journal were asked to complete and submit a 30-item pain management knowledge and attitude test.[9] The questions focused on what the researchers considered to be key concepts that nurses must understand to provide safe and effective pain management. A total of 3,282 nurses responded. Less than half (42.2%) were given a "passing score" for correctly answering 80% or more of the questions. Questions that related to pain pharmacology and adverse effects of analgesics received the highest percentage of incorrect responses. A disturbing finding was that only 53.9% of those surveyed correctly responded that the risk of developing opioid addiction was less than 1% when opioids are taken for pain relief. Almost 2% of the sample incorrectly responded that 100% of individuals who take opioids for 3 to 6 months are addicted. The researchers concluded that the findings strongly suggest the need to provide pain

management content in basic and continuing education for nurses.

The need for a standardized approach for educating patients, such as the one presented in the ASPAN Pain and Comfort Guideline,[1] is reinforced in the literature. One group of researchers evaluated the effect of preoperative pain management education on postoperative pain and anxiety.[10] The study used a convenience sample of 74 patients. Half of the patients were given preoperative information about pain management and half were not. Those who received the preoperative education experienced less anxiety and lower postoperative pain scores as measured on the visual analogue scale (VAS). The researchers concluded that the patients who received preoperative education also had a quicker recovery process and were discharged earlier than those who did not receive education.

One of the most difficult issues for perianesthesia nurses in the PACU Phase I setting is to care for patients who are experiencing severe pain on admission to the PACU. The challenge lies in expeditiously assessing a patient that the nurse has not seen or assessed before. The assessment process might be simplified if there was a method for predicting postoperative pain severity during the preoperative phase of care. In a recent study, researchers developed what they called "a preoperative prediction rule," which is a set of specific key patient indicators that can be used to predict the severity of postoperative pain.[11] The results of this study demonstrated that specific variables (age, gender, surgical procedure, preoperative pain severity, expected incision size, and two preoperative anxiety scores) had a direct relationship to the severity of patients' postoperative pain. Further research is needed to generalize the findings to all populations of patients.

Interviews of 30 postoperative patients regarding their pain management experiences revealed that patients have difficulty communicating their pain management needs.[12] The patients cited a variety of reasons for this, including the desire to avoid adverse analgesic effects, not wanting to complain or take the health care provider away from other patients, and a desire not to take drugs. The authors of this study proposed that clinicians design specific interventions aimed at helping patients communicate their pain management needs better, which could improve patients' postoperative experiences.

The ASPAN Pain and Comfort Clinical Guideline underscores the need for tracking patient assessments, interventions, and related outcomes to continually improve perianesthesia pain and comfort management. The literature strongly supports the use of such a guideline. Starck and colleagues proposed identifying, classifying, and addressing incidences of pain mismanagement as medical errors.[13] The researchers suggested the following categories for tracking pain mismanagement errors: assessment and documentation, treatment and management, and patient education.

Comfort Management

Over the past few years, nursing literature has demonstrated increased interest in the concept of comfort management.[14-19] The ASPAN Pain and Comfort Clinical Guideline, based on Kolcaba's work, provides a logical, systematic approach to providing comfort care for perianesthesia patients.

Kolcaba describes comfort as the state of being strengthened by having the human needs for relief, ease, and transcendence addressed in the physical, psychospiritual, sociocultural, and environmental contexts in which comfort is experienced.[14-17] A 3×4 taxonomic grid is provided as a visual illustration and useful tool for meeting the three types of comfort needs experienced in the four contexts. An important concept is that the taxonomic structure represents comfort needs and relief from the patient's point of view. Three basic assumptions under-

lying Kolcaba's theory of comfort are: 1) human beings have realistic responses to complex stimuli; 2) comfort is a desirable holistic outcome; and 3) human beings strive to meet, or to have met, their basic comfort needs.

Methodology

A cross-sectional survey was conducted by using a convenience sample of 215 perianesthesia nurses who responded to a call for volunteers in the ASPAN newsletter, *Breathline.* The newsletter is distributed to ASPAN members, most of whom work in perianesthesia settings in different geographical locations in the country. Inclusion criteria were that the participant had to be a perianesthesia nurse with a minimum of 1 year of expeience who was actively working in a perianesthesia area (Preoperative Phase or PACU Phases I, II, or III) in an inpatient or outpatient hospital or ambulatory setting (community and academic) or freestanding facility. Table 1 provides an overview of nursing roles and responsibilities in these settings. The subjects also had to be able to read and understand English.

Table 1. Definition of Nurse's Role in the Perianesthesia Settings

PAT (Preadmission Testing): Preparation of the patient and family or significant other physically, psychologically, socioculturally, and spiritually for the surgical or anesthesia experience. This phase may occur before surgery.

PREP (Day of Surgery/Procedure Preparation): Validation of existing information and completion of the preparation of the patient and family or significant other physically and emotionally for the surgical or anesthesia experience.

PACU Phase I (Postanesthesia Phase I): Provision of nursing care to the patient in the immediate postanesthesia period and transitioning the patient to Phase II, the in-patient setting, or to an intensive care setting for continued care.

PACU Phase II (Postanesthesia Phase II): Preparation of the patient and family or significant other for patient care in the home, PACU Phase III, or an extended care environment.

PACU Phase III (Postanesthesia Phase III): Provision of ongoing care for patients who require extended observation or interventions after discharge from Phase I or Phase II.

Data from ASPAN.[21]

Instrument

The instrument used in this study was a demographic questionnaire and a survey developed from care items related to assessment, interventions, and outcomes in the ASPAN Pain and Comfort Clinical Guideline.[1] A Likert scale ranging from 1 to 4 (1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree) was used to rate each item for clarity (easily understood), usability (useful within the context of the activity), and feasibility (capable of being executed or implemented). These criteria were chosen because of their importance in operationalizing concepts.

Twelve pain and comfort management experts (anesthesiologists, nurse researchers, perianesthesia nurse managers, perianesthesia nurses, and a perianesthesia nurse educator) estimated a validity index with a resulting score of 93. Fifteen nurses who were actively working at the bedside participated in a pilot study of the survey. These nurses were among the responders to the ASPAN *Breathline* call for volunteers and were from different perianesthesia settings and work locations. Revisions were made as a result of this pilot study.

Protection of Human Subjects

This study was reviewed and approved by the Institutional Review Board of the Johns Hopkins Hospital in Baltimore, Maryland. Each study participant completed a written informed consent before completing the survey.

Results

Instrument reliability was high with a Cronbach's alpha .98. Tables 2, 3, 4, and 5 describe the total mean scores for the various items of the guideline that were tested for each phase. Overall, mean scores were high (3.55 to 3.80), indicating agreement with the guideline item

Table 2. Descriptive Statistics and ANOVA for Difference Between Preoperative Phase

Variables	*N*	Mean	Standard Deviation	*df*	*F*	Significance
Clarity	166	3.68	.32	3	.186	.906
Usability	166	3.64	.33	3	.388	.798
Feasibility	166	3.55	.36	3	.689	.569
Valid *N* (listwise)	166					

clarity, usability, and feasibility in all the perianesthesia settings. No significant differences in clarity, usability, and feasibility were found among the perianesthesia settings or different practice locations. There were 215 respondents in the total sample; however, the sample size varied in each of the phases, reflecting the number of respondents who were working in those areas. Respondents rated items only in the phases where they worked.

In the Preoperative Phase, there was a total of 30 care items, which consisted of 11 assessment, 14 intervention, and 5 outcome items. Examples of the assessment care items were vital signs with self-reported pain and comfort levels, patients' acceptable pain and comfort goal levels, history (medical, pain, comfort, analgesic), pain behaviors, patients' preferences, educational needs, cultural language preferences, and pertinent laboratory results. Some of the intervention care items were identification of patient, review of physician's orders, reporting and coordinating resources, and discussions with patients and family members about assessment, intervention modalities, and misconceptions. Examples of expected outcomes included patients' verbalization or demonstration that educational information was understood.

The overall mean ratings for the Preoperative Phase ranged from 3.55 to 3.68 (Table 2). In examining the mean score of individual care items, the lowest was 3.22 and the highest was 3.89. There were no items rated below 3.0, indicating a high level of clarity, usability, and feasibility. The lowest mean rating was a feasibility of 3.22 for obtaining pain and comfort histories. The highest score on all of the variables was 3.89 for obtaining analgesic history and encouraging parents to be present with their minor children.

In the PACU Phase I, there was a total of 41 care items, which consisted of 16 assessment, 19 intervention, and 6 outcome items. Care items in this phase reflect a continuum from the Preoperative Phase. Examples of assessment care items included type of surgery and anesthesia technique, intraoperative pain and comfort information, adverse symptoms, mobility, and pain and comfort levels. Examples of intervention care items were identification of patient and pharmacologic and nonpharmacologic approaches. Outcome care items included hemodynamic stability, achievement of pain relief and comfort, and patient's demonstration that instructions were understood.

Table 3. Descriptive Statistics and ANOVA for Difference Between PACU Phase I

Variables	*N*	Mean	Standard Deviation	*df*	*F*	Significance
Clarity	161	3.68	.36827	3	.392	.759
Usability	161	3.59	.35936	3	.114	.952
Feasibility	161	3.55	.34886	3	.144	.933
Valid *N* (listwise)	160					

Table 4. Descriptive Statistics and ANOVA for Difference Between PACU Phase II

Variables	*N*	Mean	Standard Deviation	*df*	*F*	Significance
Clarity	161	3.78	.33122	3	.834	.477
Usability	161	3.61	.32187	3	.269	.848
Feasibility	161	3.71	.33761	3	.375	.771
Valid *N* (listwise)	160					

The overall mean ratings in PACU Phase I ranged from 3.55 to 3.68 (see Table 3). The lowest mean score for individual care items was 2.89 and the highest was 3.9. Two care items were rated 2.89 and 2.99 for clarity and usability. These items were related to recommended treatments for neuropathic pain (continuous and intermittent pain symptoms). Vital signs with pain and comfort levels, patient identification, and pharmacologic interventions had the highest mean rating score (3.9) of all of the variables.

In PACU Phase II, there was a total of 22 care items, which consisted of 4 assessment, 9 intervention, and 9 outcome items. Care items of PACU Phase II reflect a continuum from Preoperative Phase to PACU Phase I. Examples of assessment care items were the achievement of pain relief and comfort goals, educational and resource needs, and adverse symptoms. Intervention care items included patient identification, pharmacologic and nonpharmacologic interventions, education, and discussion of misconceptions. Outcome care items were meeting the desired level of pain relief and comfort, and understanding of education and instructions given during follow-up telephone calls.

The overall mean ratings in Phase II ranged from 3.61 to 3.78 (Table 4). The lowest mean score was 3.45 for feasibility related to discussion of misconceptions; the highest score was 3.89 for both patient identification and demonstration of understanding of education and instructions. There were no mean ratings below 3.0.

Results were combined for Phases II and III because patients in these areas have the same characteristics except length of stay. The overall mean ratings ranged from 3.72 to 3.80 (Table 5). Analysis of the individual care items revealed that the lowest mean score of 3.60 was for the feasibility of patient education, and the highest mean score of 3.90 was for both clarity and usability of patient education.

Discussion and Implications

Preoperative Phase

This survey revealed that the most difficult care items to implement in the Preoperative Phase were obtaining patients' pain and comfort histories and goal levels. Although the clarity and usability were rated high for these care items, feasibility was rated low. Those surveyed identified a lack of time to obtain pain and comfort histories and goal levels as an important influ-

Table 5. Descriptive Statistics and ANOVA for Difference Between Post Anesthesia Phase III

Variables	*N*	Mean	Standard Deviation	*df*	*F*	Significance
Clarity	129	3.8018	.33259	3	.139	.936
Usability	128	3.7507	.32616	3	.048	.986
Feasibility	128	3.7211	.34120	3	.086	.968
Valid *N* (listwise)	128					

encing factor. Brief patient contact time is characteristic of the Preoperative Phase; nurses must manage several patients within an extremely short time period. This is becoming more of a concern for perianesthesia nurses as health care facilities strive for efficiency and increasingly rapid patient turnover along with the expectation that surgical procedures will start on time in the OR. Consequently, the nurses reported that it was difficult to obtain information such as patients' pain and comfort histories and treatment preferences in addition to performing patient education and answering questions related to misconceptions.

The 2001 ASPAN survey revealed that only 37% of nurse respondents distributed patient educational materials, and the lack of a standardized approach to patient education was cited as a factor.[20] This finding and the comments of the nurses in the current survey indicate the need to develop and distribute well-designed educational materials for patients in the perianesthesia setting, in which the time for face-to-face education is limited.

The lack of sufficient time with patients also warrants the development of tools that can facilitate the collection of patient history information. One option may be to create and use a pain and comfort history form that can be completed by patients while they wait to be admitted or seen at their preoperative visit. This patient-reported history could be validated by the primary nurse during the initial interview and become a permanent part of the medical record.

ASPAN pain and comfort guidelines emphasize obtaining a patient history of postoperative nausea and vomiting (PONV), temperature, and positioning in the comfort assessment.[1] The comfort assessment should address the 4 contexts in which comfort occurs (physical, sociocultural, psychospiritual, and environmental). However, some respondents commented that they did not know or understand all of the contexts. Although they were easily able to implement interventions in the physical domain, they reported having difficulty implementing interventions in the sociocultural domain. One reason cited for the difficulty was that their institutions lacked sufficient numbers of interpreters for non-English-speaking patients. Another problem the nurses mentioned was that interpreters were not available throughout the continuum of care. Some of the nurses reported that they depended on patients' family members to interpret for them. Clearly, this is an area ripe for institutional performance improvement. Deficits in this area have significant implications for patients' rights and could present organizational legal liability.

Nurses also reported problems implementing the psychospiritual comfort domain. The difficulty appeared to be related to the availability of spiritual counselors and lack of time to talk with patients. In such cases, nurses can try to implement other spiritual comfort measures. For example, they can encourage patients to use a rosary or other religious objects, if appropriate, or provide patients with the opportunity to pray or have a moment of silence with their family members prior to being transported to the OR.

The nurses who cared for a high volume of patients in a physically small unit reported difficulty meeting comfort needs related to environment and privacy. Many of the nurses commented that the open physical layout, customary of many preoperative settings, did not lend itself to privacy. Some institutions offer private rooms for patients or have structures that can be used to divide the patient care area and allow for more privacy. Using a low tone of voice and providing as much physical space as possible between patients are 2 environmental comforting strategies that nurses can use. Assessment and recognition of patients' privacy needs and subsequent communication to the patient of the plan to meet those needs are important interventions in all perianesthesia set-

tings. For example, drawing a patient's curtain communicates the effort to provide privacy. Another example is to ensure that patients and their family members have private time together, especially when the clergy is not available to see that this comfort measure is implemented.

The resource in the ASPAN standards includes the assessment of pain and comfort goal levels in the perianesthesia settings. However, the ASPAN survey conducted in April 2001 showed that the respondents completed preoperative pain and comfort goal assessments at frequencies of 20% and 21%, respectively.[20] The nurses surveyed in April 2001 reported that they thought their performance of this standard could be improved if their institutions offered in-services on how to perform pain and comfort goal assessments and the importance of performing them. Furthermore, they stated that institutions should provide educational materials or handouts that will assist patients in understanding pain and comfort goals and yield realistic and achievable outcomes. Like the respondents of the 2001 survey, respondents of the current survey expressed support for the value of pain and comfort assessments, yet they also express concern for the feasibility of performing such assessments given the limited amount of time that they have with patients.

Perianesthesia nurses evaluate laboratory results, anticipate potential problems, and report abnormal findings to physicians during the Preoperative Phase. Results of this study demonstrated that nurses recognized the importance of these functions; however, 5 nurses questioned the usability and feasibility of assessing abnormal laboratory results, in particular hematology reports. They expressed the opinion that evaluation of laboratory results is a physician's, not a nurse's, responsibility. Although the number of nurses was small, their comments are of concern because they reflect a lack of appreciation for significant potential patient harm, such as an epidural hematoma in a patient who undergoes epidural catheter placement and has an overlooked laboratory report showing an increased bleeding time. It is important for nurses of all specialties to recognize that review and evaluation of laboratory reports are shared responsibilities between physicians and nurses, undertaken to ensure the delivery of the safest possible patient care.

PACU Phase I

In PACU Phase I, neuropathic pain assessment and interventions for continuous and intermittent symptoms were rated low on clarity (2.8 and 2.9). These were the only care items that had a mean rating below 3.0 in this phase. The nurses who participated in the April 2001 survey also rated these care elements low for clarity.[20] On the basis of those findings, the researchers revised the care elements to make them clearer for the current study. The ASPAN Pain and Comfort Strategic Work Team and selected members of the expert panel at the 2003 ASPAN national conference discussed the findings of the current study and again decided that these care items would be retained in the Guideline.

Patients with neuropathic pain present unique challenges to the perianesthesia care team, which rarely cares for this type of pain. The nurses' comments reflected the feeling that they lack knowledge in the treatment of neuropathic pain. These findings suggest that patients with neuropathic pain may be at risk for undertreated pain in the perianesthesia setting and underscore the need for perianesthesia nurses to ensure adequate assessment of their pain and comfort.

Some of the greatest challenges for perianesthesia nurses postoperatively are in implementing the interventional care elements in complex patients. Nurses in this study identified several "difficult to manage" patients, including those with underlying chronic neuropathic pain and patients with the disease of drug addiction. Education may help nurses handle these chal-

lenges more confidently. For example, pain experts currently promote a multimodal analgesic approach to managing pain, and nurses need to be educated in the implementation of this concept. Although opioids are commonplace and first-line analgesics in the perianesthesia settings, some nurses are less familiar with the practice of combining nonopioids and opioids to treat acute pain and the use of anticonvulsants and antidepressants for treatment of chronic neuropathic pain. There is also a need for education about the use of long-acting opioid formulations for extended pain relief after transfer or discharge.

Nurses can be instrumental in promoting the use of pain specialists, particularly for complex patients; implementing preemptive analgesia; and laying out a clear treatment plan for the continuum of care. Initiating these types of measures in the Preoperative Phase is proactive, rather than reactive, and may enhance pain relief and comfort in the postoperative phases and ensure a smooth transition from one phase to the next for many perianesthesia patients.

PACU Phase II

Discharge education and home care instructions are given during PACU Phase II when patients are awake and able to understand. Although the mean ratings of feasibility, clarity, and usability were all above 3.0 for discussing patients' misconceptions, the feasibility mean score (3.45) for this care item was the lowest of all of the care items in Phase II. The participants' comments revealed 2 factors that likely influenced the score: 1) an inadequate amount of time available to teach patients and 2) the nurse's lack of knowledge related to adverse effects of drugs and the management of complex patients, such as those with chronic pain or the disease of addiction.

Another challenge the participants of this study identified was the safe discharge of patients. Patients are informed in the Preoperative Phase of the importance of having a companion available at discharge who can drive them home and help with their care during the first 24 hours. However, nurses stated that some patients do not have companions when going home, which poses a significant safety concern.

As part of the continuum of care, perianesthesia nurses often make follow-up telephone calls to patients after discharge. In fact, the ASPAN April 2001 survey revealed that 72% of perianesthesia nurses made such calls.[20] As in the 2001 survey, nurses in the current survey rated this postoperative care item high for clarity, usability, and feasibility. They commented that the follow-up call was considered an important element of safe practice. The nurses also proposed reasons for why some patients are difficult to reach, including that patients sometimes provide incorrect telephone numbers, return to work immediately after surgery, or have physical limitations that interfere with their ability to answer the telephone.

PACU Phase III

PACU Phase III responses were similar to those expressed by Phase II respondents. Education had high mean scores for clarity, usability, and feasibility. An interesting finding was that feasibility of implementing education had the lowest score among all the care elements in Phase III, yet the highest score on clarity and usability. The low score appeared to be influenced primarily by the limited amount of time the nurses had to educate patients. This finding underscores the need to develop and use creative methods to teach patients, such as videos and well-written, concise educational handouts that can be provided preoperatively in physicians' offices or in Same Day Prep, and reinforced during preoperative telephone calls. As some of the respondents noted, these measures depend on institutional support for high-quality patient education.

Explaining the adverse effects of medications is important to prepare patients for care after discharge; however, the nurses in this study com-

mented that, in addition to not having enough time to teach patients, they did not feel knowledgeable enough to discuss drug adverse effects and potential interactions with other drugs. The nurses recommended collaboration with pharmacists on patient discharge teaching, which can benefit both nurses and patients. They commented that readily accessible written educational materials would be an acceptable alternative when pharmacists are not available or not routinely involved in the PACU discharge teaching process.

Suggestions for Future Research

Further research is needed to evaluate the effect of the ASPAN Pain and Comfort Clinical Guideline on patient outcomes, including comfort and pain relief, patient and staff satisfaction, and length of stay. It is likely that valuable clinical information would be gleaned from evaluating the Guideline in different populations, such as elders, patients undergoing rehabilitation, and patients with chronic pain. Testing the guideline in other clinical settings, such as intensive care units and medical and surgical inpatient areas, may provide insight on its applicability as well. The ASPAN Pain and Comfort Clinical Guideline will need to be continually reviewed and retested as advances are made in the fields of pain and comfort management.

Conclusion

Pain and comfort continue to be undertreated and poorly managed. ASPAN is the first professional organization to release a comprehensive guideline addressing the nurse's role in providing pain relief and comfort care. The findings of this survey validate that the ASPAN Pain and Comfort Clinical Guideline has a high degree of clarity, usability, and feasibility in all perianesthesia settings.

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