Interprofessional education to improve pain management

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CRD summary
This review assessed the effect of interprofessional continuing education (IPE) interventions on patient-reported pain and health professionals' use of pain assessment scales. The authors' conclusion, that the role of IPE in improving pain management in the community is unclear, reflects the limitations of the evidence and appears appropriately cautious.

Authors' objectives
To determine whether interprofessional continuing education (IPE) programmes on pain management lead to changes in practice and patient outcomes.

Searching
MEDLINE, CINAHL, British Nursing Index, the Cochrane Library and EMBASE were searched from inception to June 2005; the search terms were reported. The Journal of Interprofessional Care was handsearched and experts in the field were consulted in order to locate additional studies. Non-English language reports were excluded.

Study selection
Study designs of evaluations included in the review
Randomised controlled trials (RCTs) and quasi-experimental studies (including uncontrolled before-and-after studies) were eligible for the review.

Specific interventions included in the review
Studies of IPE, defined as programmes in which two or more professions learn from and about each other to improve collaboration and the quality of care, were eligible for the review. The interventions in the included studies were a 15-month cancer pain management programme, a programme of three educational sessions on acute pain, revising pain assessment guidelines using a quality improvement approach, and a series of roundtables on pain management.

Participants included in the review
Studies of health care professionals exposed to IPE, or of patients treated by professionals exposed to IPE, were eligible for the review. The health care participants in the included studies were physicians, nurses, pharmacists, psychologists, physical therapists and clergy. The studies also included cancer patients, surgical patients and haematology/oncology patients.

Outcomes assessed in the review
The studies were required to assess the use of pain assessment scales by professionals, or pain as reported by patients. Assessments of both types of outcome were included in the review. Comparisons with baseline or with a control group not exposed to IPE were eligible.

How were decisions on the relevance of primary studies made?
The authors did not state how the papers were selected for the review, or how many reviewers performed the selection.

Assessment of study quality
Validity was assessed using specified separate tools for RCTs and quasi-experimental studies. The authors did not state how many reviewers performed the validity assessment. The results of the validity assessment were not reported, although some aspects of validity were mentioned in the text.

Data extraction
The authors did not state how the data were extracted for the review, or how many reviewers performed the data extraction.

**Methods of synthesis**
- How were the studies combined?
  The studies were combined in a brief narrative.

- How were differences between studies investigated?
  Differences between the studies were discussed in the text.

**Results of the review**
Two cluster RCTs (involving six communities and six hospitals, respectively) and two quasi-experimental studies (68 staff pre-intervention and 82 staff post-intervention and 85 staff and 173 patients, respectively) were included.

One RCT in cancer patients reported no significant differences in patient pain scores between treatment groups before or after the intervention. The other RCT reported that IPE for carers of surgical patients was associated with a significant increase in documentation of pain compared with a control intervention. One quasi-experimental study in haematology/oncology patients reported no significant change in patient-reported pain immediately after and 1 year after the IPE intervention compared with baseline. The other quasi-experimental study in surgical patients reported a significant improvement in patient-reported pain after the intervention compared with before.

**Authors' conclusions**
The evidence was broadly supportive of IPE but was not helpful in determining the best way of improving pain management in the community.

**CRD commentary**
This review addressed a clear question and the inclusion criteria were clear. The search covered a range of appropriate sources but was restricted to English language material, and there was little attempt to search for unpublished studies; the review may therefore be at risk of language and publication bias. Methods used for the review were not reported, which means that the risk of bias and errors arising during the review process was difficult to assess. Adequate details of the included studies were presented in the text and tables. The validity of the included studies was assessed and aspects of validity were discussed in the text, although full results were not reported.

The studies were discussed in a narrative, which seems appropriate in view of the variation in setting, design and methods among the included studies. The authors' conclusion, that the role of IPE in improving pain management in the community is unclear, reflects the limitations of the evidence and appears appropriately cautious.

**Implications of the review for practice and research**
The authors did not state any implications for practice or further research.

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