From the Ouchless Place to Comfort Central: The Evolution of a Concept

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ABSTRACT

Although the past 20 years have yielded an outpouring of research on pain management in children, this information is often not applied uniformly to children in the hospital. To address this deficiency, we developed a systematic institution-wide program to reduce pain in all children in the hospital. Our goal was to create a setting in which attention to pain control and comfort measures would be inherent in all inpatient encounters. We labeled the inpatient unit in which this concept evolved as the “Ouchless Place” and described the program and its development in a 1997 Pediatrics article. In this article we describe the further evolution of that concept in light of the broader changes that have occurred in the field of pain management and in our community. The development of a new children’s hospital allowed us to examine what we had learned from our previous experience and modify our program on the basis of that review. This new initiative was renamed “Comfort Central,” recognizing that although no inpatient experience could be entirely “ouchless,” we could still pledge to families that we were attentive to pain and would provide the most comfort that we could. Specific changes that were put in place in our model included the acquisition of administrative authority to mandate change; the extension of our program to the laboratory, outpatient clinics, and physician offices; the incorporation of newer, more active educational models; increased emphasis on collaboration with other services; increased visibility of pain-relief efforts; and development of an ongoing quality improvement program that monitors the efficacy of pain-relief initiatives in the institution. The elements of this program may be applicable to other health care systems that desire to develop a more cohesive system-wide approach to pain reduction in those for whom they provide care. Pediatrics 2008;122:S154–S160

TEN YEARS AGO, we published an article in Pediatrics that described the development of a systematic institution-wide program to reduce the pain associated with hospitalization. The concept was to create a uniform multidisciplinary approach so that all children, not just a select few, would benefit from the outpouring of research that had occurred in this area. In this article, we will review the context that fostered the emergence of that approach and examine what has occurred in the intervening years.

BACKGROUND

Pain is one of the most feared consequences of disease and has been of concern to both patients and healers for millennia. Historically, pain has been viewed as an unavoidable consequence of trauma or disease. The assumption was that if the underlying disease process were treated, then the associated pain would dissipate. Therefore, most clinical and research efforts have focused on curing disease and far fewer studies have focused on understanding and relieving the accompanying pain.

That approach, however, was called into question as it became clear that, despite the great advances in medical science, many patients had significant pain problems that dominated their lives and often hindered their recovery. Pain remained a problem in these patients for a number of reasons. Some diseases simply could not be cured; and therefore disease-related pain persisted. For other patients, pain persisted long beyond the elimination of the disease process. Moreover, some individuals experienced pain from chronic conditions that, although not progressive, persisted, such as headache or irritable bowel syndrome. Finally, some individuals reported pain that was not associated with disease or trauma. Regardless of its origin, pain can cause incapacitation and disability.

These situations and others led to the recognition in the 1970s that pain itself was worthy of study and treatment, and the International Association for the Study of Pain was created in 1973 to provide a venue for its scientific exploration. The field of pain management began to blossom at that point. The first major initiative was to catalog what was known about pain from the disparate disciplines that encounter it. This occurred through the development
of multidisciplinary clinical and research teams. Since that time, there has been a steady and remarkable increase in our understanding of the neurobiology of nociception and the assessment and treatment of pain.

The study of pediatric pain really began in the 1980s with the emergence of research that documented, with increasing alarm, that pain in children was treated either minimally or not at all.2-5 The work of Anand et al6-7 and others on infants undergoing ductal ligations with little or no anesthesia was a clarion call to look at our practices.8,9 Additional research documented the negative consequences associated with inadequately treated pain.9,10 These publications prompted an outpouring of additional research and promoted public awareness of the importance of pain management for children as well as adults.10-14

By the mid-1990s, research had addressed many of the unique aspects of pain in children. The developmental neurobiology of pain transmission, particularly at the spinal level, 15 the assessment of pain in most populations of children,16 and the safety, efficacy, and dose response of analgesics and anesthetics17 had all been clarified. The success of behavioral and physical strategies was documented,18,19 and national guidelines were developed that translated this new information for use at the child’s bedside.20-22

Much of the responsibility for integrating this new information into the hospital fell to the pain services, which were emerging in many of the larger children’s hospitals. The configuration of pain services varied from hospital to hospital depending on available personnel and local conditions, but in general they were designed to offer technical expertise for complex pain problems and, by default, to assume the role of change agents within the institution.

The new information that emerged clearly had an impact on pediatric practice. As a result, there was a measurable improvement in both the attitudes of providers and the quality of the pain control received in the hospital. This was particularly evident for acute and predictable pain such as postoperative pain.

It was also clear, however, that this information was far from universally applied. Surveys suggested that there was significant variability among institutions in the management of pain, as well as large variations between practitioners within institutions.23,24 Pain services could consult on only a relatively small number of children, and the pain associated with many conditions fell under their radar screen (procedures, cancer, palliative care). In addition, other areas of the hospital, such as the outpatient clinics, were not traditionally within their purview. Interestingly, the national guidelines and consensus statements that were enthusiastically developed for many pain problems often had minimal impact on practice, because practitioners felt that many of the recommendations were not relevant to their settings.25,26

As a result, in the mid-1990s, pain management in children was still far from ideal despite an outpouring of research and a distinct change in attitude among practitioners.27,28 John Bonica, an anesthesiologist and one of the founders of modern pain medicine, commented on the unevenness of adult postoperative pain management in 1990: “For nearly thirty years, I have studied the reasons for inadequate management of postoperative pain and they remain the same...inadequate or improper application of available information and therapies is certainly the most important reason for inadequate postoperative pain relief.”29 This problem seemed even more pronounced in all aspects of pediatric pain.

THE OUCHLESS-PLACE MODEL

“The difference between what we know and what we don’t know is often exceeded by the difference between what we know and what we do.”—Unknown

It was to address the distinction between what we know and what we do that the ouchless-place model was developed in the mid-1990s at St Francis Hospital and Medical Center, a large urban teaching hospital with a 20-bed pediatric unit. The model was an outgrowth of a series of meetings conducted by a multidisciplinary pain interest group composed of representatives from pediatrics, surgery, anesthesia, nursing, and pharmacy, which met regularly to review impediments to adequate pain management on the inpatient unit. Although we had initiated a number of educational programs, we were concerned about the continued and well-documented unevenness of pain control our patients received, which seemed to stem from a lack of uniformity of approach among providers. Because our desire was to create an inpatient unit that was as pain-free as possible, we established a number of goals that we thought would improve the quality of our pain care. These goals included unifying postoperative pain control and sedation practices, unifying pain assessment, decreasing the pain of needle procedures, and actively involving parents in their child’s pain management.

To address these goals, we embarked on a series of interventions. To unify the approach to postoperative pain control, we culled the national guidelines and consensus statements and developed local protocols for a number of conditions. They were approved by the chief of each involved service and placed prominently on the floor. It was the expectation that they would be the standard of care and that violations would be reported. Uniform documentation of pain was another goal, and this was undertaken by a nursing subcommittee that piloted a number of different instruments. Nurses were polled about which instruments they found easiest to use, and specific scales for children at different developmental phases were selected. Their use was monitored through the quality assurance committee. Needle-stick pain was addressed through mandatory local-anesthetic usage. Parental empowerment was enhanced through brochures, nurse discussion, and recruitment of parents as “coaches” during painful procedures. It was through these interventions that we hoped to provide a unified approach to all patients, regardless of their involvement with the pain service, through all shifts, and by all specialties.

After generating workable goals and implementation strategies, there was a formal ceremony in 1996 an-
nouncing the approach and unveiling a prominently displayed sign over the entrance to the inpatient unit, renaming it the “Ouchless Place.” Initially, there was great enthusiasm for this concept. Nurses felt more empowered to advocate for effective pain management and were less dependent on the sophistication or interest of the various house and attending staff to provide care. Pain assessment became routine, and protocols were used frequently. There was a clear increase in morphine usage and a decrease in meperidine use.

Over the first year or so, however, we watched with alarm as some of the progress we had made began to slip away. We attributed this deterioration to the lack of a “pain czar” with administrative authority to mandate change. Because pain control is a transdisciplinary responsibility, no one person or discipline could be in charge of the Ouchless Place, and change was hard to maintain as a result. It was at this point in 1997 that we wrote a review of this project for Pediatrics.1

The Last 10 Years in the Field of Pain
What has happened in the field of pediatric pain management since the late 1990s? Certainly, the outpouring of research, both bench and clinical, has increased exponentially. Hundreds of articles are now published annually focusing on pediatric pain, a far cry from the sparse attention this topic received just 10 years earlier. Pain topics are often represented in postgraduate medical education programs, and scholarly conferences devoted solely to pediatric pain are well attended. All pediatric textbooks now contain chapters on pain management. Consumer interest in pediatric pain has piqued, and parents routinely request pain control in the hospital and the office. Another factor that has had an impact on pediatric pain management in the United States is the role of the Joint Commission on the Accreditation of HealthCare Organizations (JCAHO). In 2001, the JCAHO stated that hospitals would be evaluated on the adequacy of their pain control as part of the accreditation process.10 Suddenly, hospitals were required to show documentation of the frequency of their pain assessments and of their responses to poorly controlled pain. Such a mandate raised the visibility, and highlighted the importance, of pain management.

Despite this new information and its increased availability, it is clear that pain in children is still not managed optimally. A study of almost one third of Finnish nurses32 in 1999, 2 years after our Ouchless Place article, revealed that although their knowledge base and attitudes supported pain relief, their practice was very inconsistent. Studies that examined other areas within the hospital revealed similar disturbing results. In one study, 21% of the children who had day case surgery left the hospital in severe pain, and one quarter of them were without pain. A study by Ammentorp et al16 examined priorities of the parents of 300 hospitalized children and surveyed how satisfied they were with the attention given to those priorities. “Taking care of pain” was rated as one of the highest priorities for parents, second only to getting the right diagnosis. It was, however, the priority that demonstrated the largest gap between priority rating and the parents’ level of satisfaction with addressing that priority. Finally, other pain problems, such as acute pain associated with sickle cell disease and inflammatory bowel disease, outpatient procedural pain (venous access and immunizations), and chronic pain, suffered from not only a lack of data but also a lack of application of what we already know.37

The Last 10 Years of the Ouchless Place
Although we were pleased to have in place a system to promote institutional change regarding pediatric pain management, it unfortunately was clear that our local experiences mirrored national trends—more recognition of the importance of pain management coupled with more knowledge, yet significant gaps and unevenness of service.

Local circumstances in our community gave us the opportunity to reevaluate the value of our approach. The Ouchless-place model had been initiated in one of the pediatric teaching hospitals in our community. Shortly after its inception, the major teaching facilities in our area combined their pediatric services and created a children’s hospital, the Connecticut Children’s Medical Center. This gave us the opportunity to take a fresh look at our model and adapt it to the needs of a larger and more complex institution. Numerous changes were made initially, and this model has continued to evolve over the past 10 years. Specific areas of change are highlighted below.

Institutional Authority
Our first task in the new hospital was to convince the administration that a systemic approach to pain management should be a cornerstone philosophy of the institution. We had learned from our experience with the Ouchless Place that we could only achieve the goals we desired with administrative support. Our lobbying efforts led to the creation of a Pain Steering Committee, chaired by a hospital vice president, to oversee pain-relief efforts throughout the institution. This body had administrative authority to mandate change, far different from the voluntary group of well-meaning people at our previous setting. Therefore, it would not be the responsibility of an already overextended pain service to monitor pain-management activities but that of a broader multidisciplinary team with the authority to create change.

The Pain Steering Committee quickly recognized that because of the complexity of the symptomatology of pain, no one discipline “owned” it. In many situations, different disciplines (anesthesia, surgery, psychology, general and subspecialty pediatrics, nursing, pharmacy, child life) each have some unique bit of information about pain to contribute. As a result, although they had
administrative responsibility for pain control throughout the institution, members of the Pain Steering Committee recognized from the outset that this was a shared and collective burden and that fostering collaboration was its most important function.

At its first meeting, the group decided to change the name of the institutional pain-management program from the “Ouchless Place” to “Comfort Central.” Although we generated the initial name in good faith, it was clear that, despite our best efforts, pain could never be entirely eliminated in the hospital or in outpatient facilities. Our pledge had to be to provide the most comfort we could while not implying an unrealistic “ouchless” experience.

Changing the Culture and the Environment

Another change that has occurred over the past 10 years in our program is an emphasis on advocacy rather than passivity regarding pain control. Parents receive information about the importance of pain control and their role in advancing it at the initial nursing intake interview. Signs are prominently displayed throughout the hospital to remind parents of our pledge to address pain in their child and urge their continued participation in the process. We have developed a newsletter for staff entitled The Comforter that publicizes pain-relief activities throughout the institution. Our “Pain Buster” award recognizes, in a public forum, staff that made extraordinary contributions in reducing pain. We now organize a pain-awareness day on a yearly basis and provide a number of activities intended to increase the visibility of pain problems in our hospital and provide fora to discuss remedies.

As part of its perceived broad mandate, the Pain Steering Committee also weighed in on issues relating to the hospital environment. Because distraction can help with pain relief, the Comfort-Central initiative helped to increase the amount of artwork scattered throughout the hospital. A particular effort was made in areas where children would be subjected to painful procedures. Through a grant from the hospital auxiliary, both passive and active distraction devices were placed in the treatment rooms and phlebotomy laboratory.

A logical extension of raising the visibility of the issue of pain was extending it beyond the confines of the inpatient unit. If pain can be addressed in the hospital, why not in other pediatric health care facilities? As a result, pain-reduction initiatives were put in place in the phlebotomy laboratory and outpatient clinics. We recently began an educational outreach initiative (sometimes known as “academic detailing”) in pediatric offices affiliated with our hospital and developed an education program to be offered in the office for all staff. These initiatives extend the sphere of influence of Comfort Central beyond the walls of the hospital and reassure children and their parents that efforts will be made by any provider associated with our institution to reduce the fear and anxiety that often accompany medical encounters.

Education

Our educational approach evolved as well. Educational efforts in the Ouchless Place consisted of frequent lectures on pain that, while raising awareness, seemed to have a limited impact on practice patterns. With the emergence of new literature decrying the value of passive education and supporting small case-based discussion at the site of care instead, we shifted our educational efforts to reflect this new information. We scheduled fewer formal lectures and encouraged discussion on the ward and in small case-based seminars. These discussions were frequently repeated, and the suggested interventions were modeled for trainees. As previously mentioned, we now have initiated teaching visits to pediatric offices around the community that are specifically focused on reducing the pain associated with injections. We bring teaching materials that can remain in the office and, not insignificantly, food for the hungry office staff.

Finally, in these past 10 years, we have increased our efforts to educate children and their families about the importance of pain management and their right to it. We have signage throughout the hospital, in the laboratory, and in offices throughout the community encouraging parents to participate in providing comfort for their children. We have developed brochures that are distributed during the initial nursing intake interview and at pediatric offices that contain descriptions of specific strategies to possibly consider on the basis of the unique attributes of each child.

Clinical Services

The field of pain management has changed dramatically since the inception of our program, with a much greater emphasis now being placed on complementary medicine approaches that tend to be less invasive. As a result, additional services were cultivated (eg, acupuncture, biofeedback, and mindfulness meditation) and made available initially for outpatients and, increasingly, for inpatients. Issues of credentialing of complementary medicine providers remains challenging, but these issues are addressed more easily as part of an overall program, as compared with one practitioner at a time.

Increased Collaboration

The final change in emphasis that has occurred since the initiation of the Ouchless Place is the recognition of the critical importance of collaboration in addressing pain-related problems. The field has evolved from its emphasis on a small group of people with specific focused expertise in and responsibility for pain management to a decentralized model in which that small group serves primarily as a catalyst to others who seek to address pain relief for their patients. Such a model in our hospital has allowed for the development of a sedation service, a palliative care service, and specific initiatives in orthopedics and urology, all with the initial impetus stemming from the pain service but with leadership that stems from relevant disciplines and occasional technical assistance from the pain service.
Maintaining Quality

To ensure that these changes actually occur and result in pain reduction for our patients, appropriate quality assurance is vital. The available literature implies that these techniques are moderately successful at producing some change in specific behaviors.\textsuperscript{42–44} Audits and feedback (providing individuals information about how their practices or patient outcomes compare with internal or external standards) are the traditional cornerstones of quality assurance. We and others have found that these techniques may fail if there is no immediate opportunity to use the feedback and no penalty for continued infractions.

We have relied on patient satisfaction as a measure of our quality but have come to realize that there are many problems with this approach. In many studies, patients may report a high level of satisfaction with their pain control on surveys, yet their in-hospital pain ratings may indicate that they had obviously inadequate pain management. In a study by Miaskowski et al,\textsuperscript{45} patients reported a high level of satisfaction with their pain management, but 48\% of them were found by chart review to have had prolonged periods of moderate-to-severe pain. Concomitantly, we have found that some patients may have an unrealistic expectation of the level of comfort they can expect, and a single incident (eg, multiple sticks to gain venous access, some pain on the transition from intravenous to oral medications) may dramatically alter their perceptions and dominate their survey results. We have found this particularly true when evaluating patient-satisfaction surveys.

In summary, the last 10 years has witnessed a significant change in both the model and content of our institutional action plan for improving pain control. Most significantly, we have come to recognize the critical importance of administrative authority in addressing these problems. In addition, we now place increased emphasis on collaboration among services. Unless people in each field recognize the importance of pain control, assume ownership of the problem, and sit together and focus their collective energy and experience, any clinical approach is potentially incomplete. We have reconfigured our educational initiatives and brought them to the site of care wherever possible. We also have broadened the scope of our efforts to include the hospital environment itself, as well as spearheaded the integration of complementary medicine techniques into inpatient and outpatient care. Although we have extended the reach of Comfort Central into new areas and sites, we have also realistically reduced expectations so that parents do not assume that all medical encounters are pain-free.

Obviously, continued refinement of this model is critical. We are presently studying alternative ways to assess pain rather than relying solely on ratings of intensity. We hope for additional collaboration with other services and hope as well to identify funding sources that may help us offset some of the costs of this service.

BUILDING YOUR OWN OUCHLESS PLACE

After publication of our original article in Pediatrics, a number of other institutions adapted the ouchless-place concept to suit the needs of their own clinical programs. An ouchless emergency department was created at St Louis Children’s Hospital. The Comfort Zone and Pain Free Pediatrics were also developed at the Children’s Hospital of Milwaukee and Boston Medical Center, respectively. Other institutions embraced the notion of an institution-wide commitment to pain reduction, although they did not specifically brand their approach.

We feel that the lessons we have learned over the 10-year metamorphosis of the Ouchless Place to Comfort Central may be of benefit to others who are still contemplating an institutional approach to pain reduction. We have distilled a few key principles based on our experience that we hope will be helpful:

- A survey or audit of present practices in selected areas is often a good way to begin. There are benchmarks available so that institutions can compare their outcomes with those of similar institutions. Presenting evidence of poor or inadequate performance to institutional leaders is a way to enlist the support of those who are empowered to create change. Given the emphasis now placed on pain management by the JCAHO and the increasing consumer interest in the area, hospital leadership may be willing to authorize individuals to address these problem areas.

- Although support of physician/nursing leadership is critical, it is also essential to identify champions in different disciplines who can promote interest in this area as well. They are more likely to supply the passion necessary to overcome the barriers that often are present when change is contemplated. Besides physicians and nurses, child life staff, psychologists, and pharmacists can contribute much to pain-reduction efforts.

- It is our suggestion that this multidisciplinary group of champions be incorporated into a pain council led by a person with administrative authority to mandate change. Individuals from the pain service, if one exists, should play an active role and can provide technical support, but the pain council should be broader in its scope and involve people from throughout the institution.

- We suggest that the first task of the pain council be to address the deficiencies identified in the initial survey. This often involves an evaluation of the impediments to adequate pain relief, which may be a result of financial or logistic concerns, quirks of personality or history, or lack of information. It is probably best to focus initially on one or two problems and not create overly high expectations or overextend the time or resources of council members.

- As time goes on, national guidelines and consensus statements can be modified as necessary to address local strengths, weaknesses, and customs so that people can feel comfortable that the algorithm they are using is applicable to the local environment. Those
who will eventually use the protocols should be included in the design team, because those who have had an active role in the process can advocate more effectively for its acceptance. Protocols should be endorsed by the leadership of the relevant disciplines (medicine, surgery, anesthesia, nursing) to lend authority to them and should be placed in easily accessible locations at the site of care or be available electronically. They should not be buried in a binder in a back room.

- Ongoing educational initiatives are critical if change is to occur and be sustained. In addition to lectures, it is helpful if pain becomes a routine item on the patient’s problem list and, therefore, is automatically discussed. In fact, many institutions now consider pain as a fifth vital sign, and pain ratings are prominently displayed on the vital sign sheet. Such an approach not only improves the care of the individual patient but also emphasizes the importance of pain management in general. As previously mentioned, recent data have suggested that educational efforts are far more successful if they are active and not passive, occur in small groups, and are case based. Such an approach should be incorporated for both nursing and medical staff. Studies have suggested that educational programming that uses more than one technique is far more successful than relying solely on one approach.

- It is also critical that parents be incorporated into the action plan. Brochures that highlight the institution’s commitment to pain relief, signage throughout the hospital that emphasizes the child’s right to pain relief, and individual discussion with providers should convey to parents the vital role they have in the process. When parents expect attention to pain and advocate for it, it is easier to convince resistant staff members to comply with hospital philosophy.

- Finally, we have learned that even in those with the best intentions, gradual erosion of the level of attention to pain is often inevitable in the face of increasing patient volume, frequent understaffing, and continued resource limitations. Therefore, a continuous, vigilant quality improvement program monitored by members of the pain council is essential. Gordon et al have offered a number of practical suggestions for how to evaluate the quality of pain care that can be adapted for most institutions.

**CONCLUSIONS**

This article has described the evolution of our pain management program from inception to its current status and outlines the changes that were necessary to keep it current. This program emerged from the recognition that despite enormous increases in our knowledge about pain and its management in children, this information was not being uniformly applied to our patients. Although there were valuable individual initiatives occurring, we felt they would be more sustainable and have greater impact if they were part of an overall institutional plan for pain relief. Our goal was to create an atmosphere in which pain control and comfort measures would be a part of all inpatient encounters and that barriers to pain relief would be identified and removed. The ouchless-place concept was helpful, but we found its efficacy eroded over time. The development of a new pediatric hospital in our community allowed us to modify and enhance what we had learned and, as a result, the Comfort Central program emerged. These changes included acquiring administrative authority to mandate change, casting a wider net beyond solely hospitalized children, incorporating newer educational approaches, emphasizing collaboration with other departments, increasing the visibility of pain-relief efforts, and developing an ongoing quality improvement program that continually monitors the efficacy of our efforts.

We feel that the essential elements of this program are applicable to other institutions, although the specifics may vary depending on local factors. It is our hope that in another 10 years there will be no need for a separate Comfort Central initiative and that its basic premises will be incorporated into the fabric of most pediatric health care institutions; that is, that a coordinated commitment to reducing pain for all children in all of their encounters with the health care system will be considered a routine part of humane medical care, and not unique or exceptional.

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