University Hospitals of Derby and Burton NHS Foundation Trust

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Pain Management - Adults - Full Clinical Guideline

Reference No: CG-PM/788/24

Purpose

Pain is often treated poorly in hospitals. These guidelines aim to reduce the incidence of unrelieved pain for hospital inpatients and highlight the need for adequate resources to promote and maintain a quality service.

Aim and Scope

- To ensure that pain is recognised and assessed, as a priority, and treated accordingly.
- To provide simple and practical analgesia regimes for all patients with unrelieved pain (within the Trust).
- To raise awareness of pain control among all staff, nursing, medical, allied health professionals and trainees.
- To define a consultation process for unresolved pain problems within the Trust.
- To encourage audit of the effectiveness and safety of pain relief

Definitions Used

Analgesic stepladder: an escalating scale of analgesic prescription based on World Health Organisation (WHO) guidelines

Acute pain: pain of recent onset and less than 2 weeks duration, caused by trauma and / or tissue damage.

Chronic pain: pain of prolonged duration, often unresponsive to conventional analgesia, arising from known / unknown causes.

Pain: whatever the patient says hurts.

Patientrack: used to record pain scores.

Abbey Pain Scale: used to assess pain in patients who are unable to verbalise (Appendix1)

Pain AD: Used to assess pain in patients who have Dementia/Alzheimer's disease or cognitive impairment (Appendix 3)

Pain score: visual or descriptive pain score understood by the patient and used by staff to titrate analgesia

Pain Team: consultants, nurses and other professionals from the Pain Service.

Palliative Care Team: consultants, nurses and other professionals from the Palliative Care Service.

EWS: Early Warning Score

Implementing the Guidelines -

All patients will have their pain assessed, using an appropriate tool, at regular intervals, relevant to their condition. Pain scores and interventions must be recorded and evaluated on Patientrack and in patients' notes.
All patients with pain will have appropriate analgesic regimes prescribed. Analgesia must be prescribed regularly – avoid "prn" prescribing other than for break-through pain.

Analgesia will be titrated (if safe to do so) against the pain score at regular intervals with the aim of reducing the score to none or mild, as soon as practical. See analgesic stepladder guidelines: Appendix 1

For the titration of **Oral Morphine** in **Cancer pain** refer to the **Palliative Care Guidelines**

Effectiveness of analgesia will be monitored, recorded and reassessed after relevant time intervals.

Unresolved pain problems should be referred to:

- The **Acute Pain Team** for evaluation and re-assessment of acute and post-operative pain.
- Complex patients with chronic pain, will need assessment and review by the **Chronic Pain Team**.
- If associated with malignancy the **Palliative Care Team** should be involved.

Safety and efficacy of pain management will be audited randomly by the clinical team directly involved with the patients care, and will be reviewed by the Pain Service.

References

Available from: www.ampainsoc.us/advocacy/fifth.htm
Department of Health (2001) **National Service Framework for Older People**
Available from: www.doh.gov.uk/nsf/olderpeople
Derby Cancer Centre
Palliative Care Guidelines (Pain)
McCaffrey M., & Pasero C., (1999) **Pain: Clinical Manual, 2nd. Ed.** Moseby, St. Louis, USA
Report of the Working Party of Pain after Surgery. (1990)
Royal College of Surgeons and College of Anaesthetists.
Derby Hospitals NHS Foundation Trust
Guidelines for the Treatment of Acute Pain using Subcutaneous Morphine or Pethidine
Derby Hospitals NHS Foundation TrustIntravenous Morphine Bolus - Guidelines for Adults (Accident &
Emergency)
Derby Hospitals NHS Foundation Trust
Intravenous Opioid Bolus – Guidelines for Adults (Recovery)
Derby Hospitals NHS Foundation Trust
Patient Controlled Analgesia Guidelines
WHO Analgesic Stepladder for the Treatment of Pain
Available from: http://www.who.int/cancer/palliative/painladder/en/

Appendices

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Abbey Pain Tool (1)
Analgesic Stepladder (2)
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Documentation Controls

Development of Guideline:	Acute Pain Service
Consultation with:	
Approved By:	Surgical Division – 27Th February 2024
Review Date:	June 2025
Key Contact:	Acute Pain Team

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ASSESSMENT OF PAIN WHERE PATIENTS ARE UNABLE TO VERBALISE

(Adapted Abbey Pain Scale)

- Evaluate patient's usual behaviour against examples and record in nursing notes
- Consider variances to usual behaviour when completing assessment of pain

Examples of Usual Behaviour

Vocalisation	Quiet Crying	Groaning Shouting
Body language	Still Withdrawn	Rocking Tense
Behavioural	Confused	Restless Agitated

Vocalisation – expressions of pain without using words e.g. whimpering; crying; groaning; gasps; sighs; grunting			
absent 0 ☐	Mild 1 ☐	Moderate 2 ☐	severe 3 ☐
Facial expression – e.g. wincing; tension; frowning; narrowed eyes; tight lips; teeth clenched; distorted expressions; looking frightened			
absent 0 ☐	Mild 1 ☐	Moderate 2 ☐	severe 3 ☐
Changes to body language – e.g. rocking; guarding part of the body; withdrawn; clutching or holding tight to things			
absent 0 ☐	Mild 1 ☐	Moderate 2 ☐	severe 3 ☐
Behavioural changes – e.g. confusion or increased confusion; restlessness; refusing food or fluids; irritability / agitation or withdrawal; resistance/pushing away			
absent 0 ☐	Mild 1 ☐	Moderate 2 ☐	severe 3 ☐
Physiological change – e.g. altered temperature or BP outside usual pattern; perspiring; flushing; pallor; cold & clammy			
absent 0 ☐	Mild 1 ☐	Moderate 2 ☐	severe 3 ☐
Physical changes – e.g. skin tears/bruising; pressure ulcers; arthritis; contractures; other injury (e.g. fracture); potential injury (e.g. recent fall)			
absent 0 ☐	Mild 1 ☐	Moderate 2 ☐	severe 3 ☐

Match acquired pain score in the table below:

0 – 2 No pain	3 – 7 Mild Pain (1)	8 – 13 Moderate Pain (2)	14 + Severe Pain (3)

Record initial assessment in nursing notes then commence pain scoring as:

No to Mild Pain: Record on standard observation chart. Consider analgesia. Review daily. Increase frequency of review if condition, or score, changes (see below).

Moderate to Severe Pain: Commence Adult Pain Observation Chart & intervention(s)
Review 4 hourly (minimum), or more frequently if required until pain is controlled for at least 24 hours then revert back to observation chart.

Abbey J., De Bellis A., Piller N., Esterman A., Giles L., Parker D., Lowcay B.
The Abbey Pain Scale (Funded by the JH & JD Gunn Medical Research Foundation 1998-2002)

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How to use the Adapted Abbey Pain Scale

The Abbey Pain Scale is a tool designed to assist in the assessment of pain in patients who are unable to communicate or verbalise their needs.

The scale does not differentiate between distress and pain and should therefore be used as a movement- based assessment.

Measuring effectiveness of any intervention is essential.

Assessment

- Complete initial assessment with carer of patient's usual behaviour on admission to ward/dept and record in nursing notes.
- Pain assessment should be conducted using the adapted Abbey Pain Scale while the patient is being moved e.g. pressure area care, bathing, toileting etc and should take less than a minute to complete.
- Document the score on the pain section of the **standard observation chart.**
- If the patient scores 2 (moderate) or 3 (severe) then a formal pain chart must be commenced and used in conjunction with the Abbey Pain Scale.
- Reassess any interventions after one hour for effectiveness and document on the pain chart.
- Assess at least once per shift.
- Revert back to documenting on the **standard observation chart** when pain has been controlled (1 or mild) for at least 24 hours.

For further information and advice please contact the **Acute Pain Team**

At Royal Derby Hospital the pain team can be contacted via the Team mobile (07788 388426) or on bleeps 3365, 3078, or 1283.

At Burton Hospital ……..

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Guidelines for the Management of Pain in Adults
Analgesic Stepladder

Appendix 2

Prescribe analgesia regularly
Use "prn" prescribing for breakthrough pain only

PAIN SCORE 1
'Mild Pain'

Paracetamol 1g 4 – 6 hrly PO/IV
Max. 4g per day

+ / - NSAID

eg Ibuprofen 400mgs TDS orally

PAIN SCORE 2
'Moderate Pain'
Tramadol
50-100mg PO QDS*
Or
Oramorph 10-20mg PO QDS
(limit regular prescription to 5 days)
Or
Codeine Phosphate
30mgs – 60mgs PO QDS

+
Paracetamol 1g PO/IV/PR
+ / - NSAID

PAIN SCORE 3
'Severe pain'

- **Subcutaneous Morphine**
- **Oral Morphine**
  (See Guidelines)

PCA & IV Morphine by competency trained staff only

+
Paracetamol 1g PO/IV/PR

+ / - NSAID

NSAID's WARNING
Refer to BNF Section 10.1.1

NSAID's are contraindicated in patients with:
Known Aspirin or NSAID sensitivity
History of Aspirin sensitive Asthma
History of GI Bleed / ulceration
Anticipated major haemorrhage
Bleeding disorders / taking anticoagulant therapy

Use with caution in:
Renal / cardiac / hepatic impairment,
Asthmatics, history of indigestion. Hiatus Hernia,
Recent acute bony injury,
Elderly patients – consider PPI
Pregnancy (seek advice),
Porphyria (seek advice),

Tramadol contra-indications: uncontrolled epilepsy; acute porphyria.
Increased risk of CNS toxicity when given with SSRIs or Tricyclics.
*Renal Dose: If GFR<20ml/min give tramadol 100mg BD. If GFR<10ml/min then avoid

- Consider 'simple interventions' i.e. patients' comfort needs eg position, full bladder etc.
- Consider age, weight, clinical / drug history when prescribing
- Consider other types of pain & treat accordingly eg neuropathic, spasmodic/colic, wind pain
- Seek medical or appropriate Pain Team advice if unsure about medication, or pain persists
- See individual specific treatment guidelines, eg IV Morphine, PCA, SC Morphine/Pethidine
- Entonox should be considered for procedural pain (see guidelines)

PAIN SCORES AND INTERVENTIONS MUST BE RECORDED AND EVALUATED ON A PAIN CHART / OBSERVATION CHART / EWS OR IN PATIENTS NOTES

Appendix 3

Pain Assessment in Advanced Dementia Scale (PAINAD)

Instructions: Observe the patient for five minutes before scoring his or her behaviors. Score the behaviors according to the following chart. Definitions of each item are provided on the following page. The patient can be observed under different conditions (e.g., at rest, during a pleasant activity, during caregiving, after the administration of pain medication).

Behavior	0	1	2	Score
Breathing Independent of vocalization	• Normal	• Occasional labored breathing • Short period of hyperventilation	• Noisy labored breathing • Long period of hyperventilation • Cheyne-Stokes respirations	
Negative vocalization	• None	• Occasional moan or groan • Low-level speech with a negative or disapproving quality	• Repeated troubled calling out • Loud moaning or groaning • Crying	
Facial expression	• Smiling or inexpressive	• Sad • Frightened • Frown	• Facial grimacing	
Body language	• Relaxed	• Tense • Distressed pacing • Fidgeting	• Rigid • Fists clenched • Knees pulled up • Pulling or pushing away • Striking out	
Consolability	• No need to console	• Distracted or reassured by voice or touch	• Unable to console, distract, or reassure	
			TOTAL SCORE	

(Warden et al., 2003)

Scoring:

The total score ranges from 0-10 points. A possible interpretation of the scores is: 1-3=mild pain; 4-6=moderate pain; 7-10=severe pain. These ranges are based on a standard 0-10 scale of pain, but have not been substantiated in the literature for this tool.

Source:

Warden V, Hurley AC, Volicer L. Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) scale. *J Am Med Dir Assoc*. 2003;4(1):9-15.

Appendix 3

PAINAD Item Definitions

(Warden et al., 2003)

Breathing

1. *Normal breathing* is characterized by effortless, quiet, rhythmic (smooth) respirations.
2. *Occasional labored breathing* is characterized by episodic bursts of harsh, difficult, or wearing respirations.
3. *Short period of hyperventilation* is characterized by intervals of rapid, deep breaths lasting a short period of time.
4. *Noisy labored breathing* is characterized by negative-sounding respirations on inspiration or expiration. They may be loud, gurgling, wheezing. They appear strenuous or wearing.
5. *Long period of hyperventilation* is characterized by an excessive rate and depth of respirations lasting a considerable time.
6. *Cheyne-Stokes respirations* are characterized by rhythmic waxing and waning of breathing from very deep to shallow respirations with periods of apnea (cessation of breathing).

Negative Vocalization

1. *None* is characterized by speech or vocalization that has a neutral or pleasant quality.
2. *Occasional moan or groan* is characterized by mournful or murmuring sounds, wails, or laments. Groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
3. *Low level speech with a negative or disapproving quality* is characterized by muttering, mumbling, whining, grumbling, or swearing in a low volume with a complaining, sarcastic, or caustic tone.
4. *Repeated troubled calling out* is characterized by phrases or words being used over and over in a tone that suggests anxiety, uneasiness, or distress.
5. *Loud moaning or groaning* is characterized by mournful or murmuring sounds, wails, or laments in much louder than usual volume. Loud groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
6. *Crying* is characterized by an utterance of emotion accompanied by tears. There may be sobbing or quiet weeping.

Facial Expression

1. *Smiling or inexpressive*. Smiling is characterized by upturned corners of the mouth, brightening of the eyes, and a look of pleasure or contentment. Inexpressive refers to a neutral, at ease, relaxed, or blank look.
2. *Sad* is characterized by an unhappy, lonesome, sorrowful, or dejected look. There may be tears in the eyes.
3. *Frightened* is characterized by a look of fear, alarm, or heightened anxiety. Eyes appear wide open.
4. *Frown* is characterized by a downward turn of the corners of the mouth. Increased facial wrinkling in the forehead and around the mouth may appear.
5. *Facial grimacing* is characterized by a distorted, distressed look. The brow is more wrinkled, as is the area around the mouth. Eyes may be squeezed shut.

Body Language

1. *Relaxed* is characterized by a calm, restful, mellow appearance. The person seems to be taking it easy.
2. *Tense* is characterized by a strained, apprehensive, or worried appearance. The jaw may be clenched. (Exclude any contractures.)
3. *Distressed pacing* is characterized by activity that seems unsettled. There may be a fearful, worried, or disturbed element present. The rate may be faster or slower.
4. *Fidgeting* is characterized by restless movement. Squirming about or wiggling in the chair may occur. The person might be hitching a chair across the room. Repetitive touching, tugging, or rubbing body parts can also be observed.
5. *Rigid* is characterized by stiffening of the body. The arms and/or legs are tight and inflexible. The trunk may appear straight and unyielding. (Exclude any contractures.)
6. *Fists clenched* is characterized by tightly closed hands. They may be opened and closed repeatedly or held tightly shut.
7. *Knees pulled up* is characterized by flexing the legs and drawing the knees up toward the chest. An overall troubled appearance. (Exclude any contractures.)
8. *Pulling or pushing away* is characterized by resistiveness upon approach or to care. The person is trying to escape by yanking or wrenching him- or herself free or shoving you away.
9. *Striking out* is characterized by hitting, kicking, grabbing, punching, biting, or other form of personal assault.

Consolability

1. *No need to console* is characterized by a sense of well-being. The person appears content.
2. *Distracted or reassured by voice or touch* is characterized by a disruption in the behavior when the person is spoken to or touched. The behavior stops during the period of interaction, with no indication that the person is at all distressed.
3. *Unable to console, distract, or reassure* is characterized by the inability to soothe the person or stop a behavior with words or actions. No amount of comforting, verbal or physical, will alleviate the behavior.

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