

East Midlands Ambulance Service NHS Trust

Pain Management Standard Operating Procedure

Links

The following documents are closely associated with this policy:

- Medicines Management Policy
- Drug Management Procedure
- Implementation of National Guidance and Information Policy
- Community First Responder Policy
- Medical First Responder SOP
- Untoward Incident Reporting Procedure
- End of Life Clinical Management Procedure

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<i>Pain Management Standard Operating Procedure</i>		Page:	Page 1 of 8
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2.0				
2.1				

<i>Pain Management Standard Operating Procedure</i>		Page:	Page 2 of 8
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Contents	Page
1. Introduction	4
2. Objectives	4
3. Scope	4
4. Definitions	4
5. Responsibilities	4
6. Clinical Significance	5
7. Clinical Performance Indicators	5
8. Identification and Assessment of Pain	6
9. Non-Pharmacological Management of Pain	7
10. Pharmacological Management of Pain	7
11. Pain Management in Palliative Care	8
12. Documentation and professional Responsibility	9
13. Consultation	9
14. References	9
15. Monitoring Compliance and Effectiveness	9

Appendix 1 - Dissemination Plan

Appendix 2 – Pain Management Procedure

Appendix 3 – Analgesia Options by Clinical Grade

<i>Pain Management Standard Operating Procedure</i>		Page:	Page 3 of 8
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1. Introduction

1.1. East Midlands Ambulance Service NHS Trust is committed to providing high quality, safe and effective care to all service users.

1.2. Pain is one of the most common presentations to UK Ambulance Services yet management of pain is variable and often inadequate.

2. Objectives

2.1. The objectives of this procedure is to:

- Ensure that all patients with identified pain receive safe and effective care in a timely manner.
- Ensure that all patients with pain or suspected pain have the pain level assessed in an objective manner and suitable care plan implemented.

3. Scope

3.1. This procedure document applies to all pre-hospital practitioners attending a patient with pain or suspected pain in line with their identified scope of practice. It also applies to Community First Responder Schemes/ Medical First Responder Schemes and by all Voluntary Aid Societies and Private Providers deployed by East Midlands Ambulance NHS Trust dependent upon scope of practice and contractual agreements.

4. Definitions

4.1. **Pain:** “an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage”.

Or

“..whatever the experiencing person says it is, existing whenever the experiencing person says it does”.

4.2. **Acute Pain:** a symptom with a discernible cause and usually subsides when injured tissues heal.

4.3. **Chronic Pain:** pain that persists beyond the time of healing.

5. Responsibilities

5.1. The **Medical Director** is responsible for ensuring:

5.1.1. This procedure is monitored and reviewed in line with current clinical guidance on an annual basis.

5.1.2. That related Clinical Key Performance Indicators and subsequent action plans are regularly reviewed by the clinical team in collaboration with the Divisions.

5.1.3. Advice is provided to the Director of Workforce and Organisational Learning on the requirements of training for all staff.

5.1.4. Advice is provided to the General Managers on the requirements for equipment

5.2. **Consultant Paramedics** are responsible for ensuring:

5.2.1. That care management detailed in this procedure is appropriate and appraised against current evidence.

5.2.2. That information and guidance is cascaded to operational staff to ensure awareness, understanding and compliance.

5.3. **Locality Managers and Locality Quality Managers** are responsible for ensuring:

5.3.1. The provision of suitable and sufficient equipment and medicines as per Trust recommendations/requirements.

5.3.2. Staff within their area of responsibility attend training on pain management in line with the approved Education Training plan.

5.3.3. Key clinical performance Indicators are monitored and subsequent action plans are developed.

5.3.4. Action plans are implemented, actions are completed and reports on progress and outcome are produced for the relevant committee.

5.4. **The Director of Workforce** is responsible for:

5.4.1. The provision of suitable pain management (or related topics) educational opportunity as per the Trust's training needs analysis and annual training plan.

5.4.2. The production of regular reports on training to include both attendance and non-attendance in relation to pain management (or related topics).

5.5. Operational Staff are responsible for:

5.5.1. Adherence to this procedure

5.5.2. Raising concerns as per Untoward Incident Reporting Procedure (where applicable)

6. Clinical Significance

6.1. Pain is a significant symptom presented to UK ambulance services, the control of such pain is important for humanitarian reason and clinical reasons.

6.2. The alleviation of pain can prevent deterioration, allow for better assessment and reduce the psychological impact of injury or disease.

6.3. There is no reason to delay the relief of pain and there is no link between the presence of pain and improved diagnosis.

7. Clinical Performance Indicators

7.1. There are key clinical performance indicators that address the provision of appropriate care for patients with pain as a symptom. These clinical performance indicators focus upon:

- Pain severity assessment (pain scoring) – pre and post intervention assessment.
- The provision of pain relief appropriate to chief complaint (i.e. morphine for neck of femur fracture)
- The use of splinting in suspected limb fractures.

8. Identification and assessment of pain

8.1. General Principles of Pain Assessment

8.1.1. All patients who report pain as a symptom should have their pain appropriately assessed.

8.1.2. An assessment should be made of the requirements of the individual. Pain is complex and shaped by gender, cultural, environmental, social and experiential factors.

8.1.3. Clinicians should seek and accept the patients' self-report of pain and clinician estimation of pain should be avoided.

8.1.4. Pain description should be achieved using the mnemonic SOCRATES (see appendix 2).

8.1.5. Pain severity **MUST** be reassessed regularly and recorded on the patient record. A minimum of 2 pain scores (pre and post analgesia) **MUST** be recorded.

8.1.6. There are a number of validated methods for the assessment of pain across the age range and pre-existing conditions. To ensure consistency and safety a limited range will of tools are recommended.

8.2. Pain Assessment in Adults

8.2.1. Pain severity **MUST** be assessed in ALL patients who have a pain symptom.

8.2.2. The severity **MUST** be assessed using a 10 point numerical value scale in all patients with the capacity to understand and respond. This scale should be used to gauge the appropriate level of analgesia required for each patient and should be repeated to ensure the effectiveness of any intervention.

8.2.3. In patients without the ability to communicate a FLACC score should be used. (see appendix 2)

8.3. Pain Assessment in Children

8.3.1. Pain severity **MUST** be assessed in ALL patients who have a pain symptom or are suspected of having pain.

8.3.2. Pain severity should be assessed using a FLACC score (see appendix 2).

8.4. Pain Assessment in the Cognitively Impaired

8.4.1. Pain severity MUST be assessed in ALL patients who have a pain symptom or are suspected of having pain.

8.4.2. Pain severity should be assessed using the PAINAD score (see appendix 2).

9. Non-Pharmacological Management of Pain

9.1. It is important to ensure that non-pharmacological methods of pain relief are used as part of an inclusive pain management strategy as they have clear patient care benefits. This should include:

- Immobilisation of an injured limb or body part (this should be applied wherever possible unless not clinically appropriate or if refused)
- Ice and elevation (with care to avoid over cooling of the patient or burns)
- Explanation of the cause of pain and likely outcomes to reduce anxiety
- Calming measures
- Distraction techniques / play
- Treat the underlying cause
- In the event that any of the above measures are used they should be clearly documented in the patient record.

10. Pharmacological Management of Pain

10.1. The medicines available for use to each clinical grade are detailed in appendix 3.

10.2. The Analgesic Ladder

10.2.1. Pain management is typically applied in an incremental way with the goal of removing pain without exposing the patient to more potent analgesic agents.

10.2.2. Analgesia therapy should be applied with consideration to the level of pain and the timeliness of onset of actions.

10.2.3. At all times the goal should be to remove pain in a timely manner with as little risk as possible and limiting adverse effects.

10.2.4. All drug treatment MUST be used within EMAS / Association of Ambulance Chief Executives [AACE] guidelines.

10.2.5. Care must be taken not to exceed stated drug dosages (included patients own administered analgesia).

10.3. Mild Pain (1-3)

10.3.1. This should typically be managed using oral paracetamol (as per guidelines).

10.3.2. Non-steroidal anti-inflammatory drugs such as ibuprofen are a suitable alternative in the event of contraindications to paracetamol use (as per guidelines). .

10.3.3. Paracetamol and Non-steroidal anti-inflammatory drugs (NSAIDs) can be given in combination if further analgesia is required (as per guidelines).

10.3.4. Inhaled nitrous oxide and oxygen (Entonox) is also a suitable analgesic agent in the treatment of mild pain.

10.4. **Moderate Pain (4-6)**

10.4.1. This should be managed using simple methods initially where possible. Bridging analgesia can be provided with inhaled nitrous oxide/oxygen (entonox) whilst other agents take effect.

10.4.2. Paracetamol, NSAIDs and Oramorph OR Codeine (ECP only) are suitable analgesic agents for this pain range and a clinical judgement should be made on the most appropriate based upon the patients' need.

10.4.3. In the event of a requirement for more rapid analgesia that is **not managed** by inhaled nitrous oxide (entonox) or pain management through other methods is unsuccessful then IV Paracetamol should be considered as per guidelines.

10.4.4. In the event that this does not alleviate pain analgesic options should be escalated to the severe pain guidelines.

10.5. **Severe Pain (7-10)**

10.5.1. Severe Pain should be managed with consideration of previous medical history and individual patient requirements.

10.5.2. Bridging and adjunctive analgesia can be provided by entonox administration, this will allow time for alternative analgesic drugs to take effect or provide further pain relief above other analgesics.

10.5.3. Intravenous Paracetamol or Morphine may be used. IV Paracetamol is a potent analgesic so may reduce morphine requirements.

10.5.4. Intravenous analgesia may be supplemented by oral NSAIDs or Paracetamol (unless prior Paracetamol administration).

11. **Pain Management in Palliative Care**

11.1. Pain management in palliative care should adhere to this procedure – **UNLESS** there is a patient specific care plan available.

11.2. Pain management should be provided in line with a patient specific care plan when provided.

11.3. This may require the provision of medications that are not a part of this procedure. The provision of medicines in palliative should be managed as per **End of Life Clinical Management Procedure**.

12. Documentation and Professional Responsibility

12.1. The assessment of pain and pain severity **MUST** be documented on every patient with a pain or suspected pain symptom.

12.2. A pain severity assessment **MUST** be undertaken and documented on at least 2 occasions and **ALWAYS** before and after any pain management intervention.

13. Consultation

13.1. This procedure has been shared with the Clinical Effectiveness Group and Standard Operating Procedure Working Group.

14. References

- Joint Royal Colleges Ambulance Liaison Committee (2013) Clinical Practice Guidelines.
- Royal College of Nursing (2009) *The Recognition and Assessment of Acute Pain in Children*. RCN, London.

15. Monitoring Compliance and Effectiveness

15.1. This policy will be reviewed through the Clinical Effectiveness Group.

15.2. Performance metrics and compliance will be monitored by Clinical Performance Indicators (Neck of Femur Fracture, Single Limb Fracture).

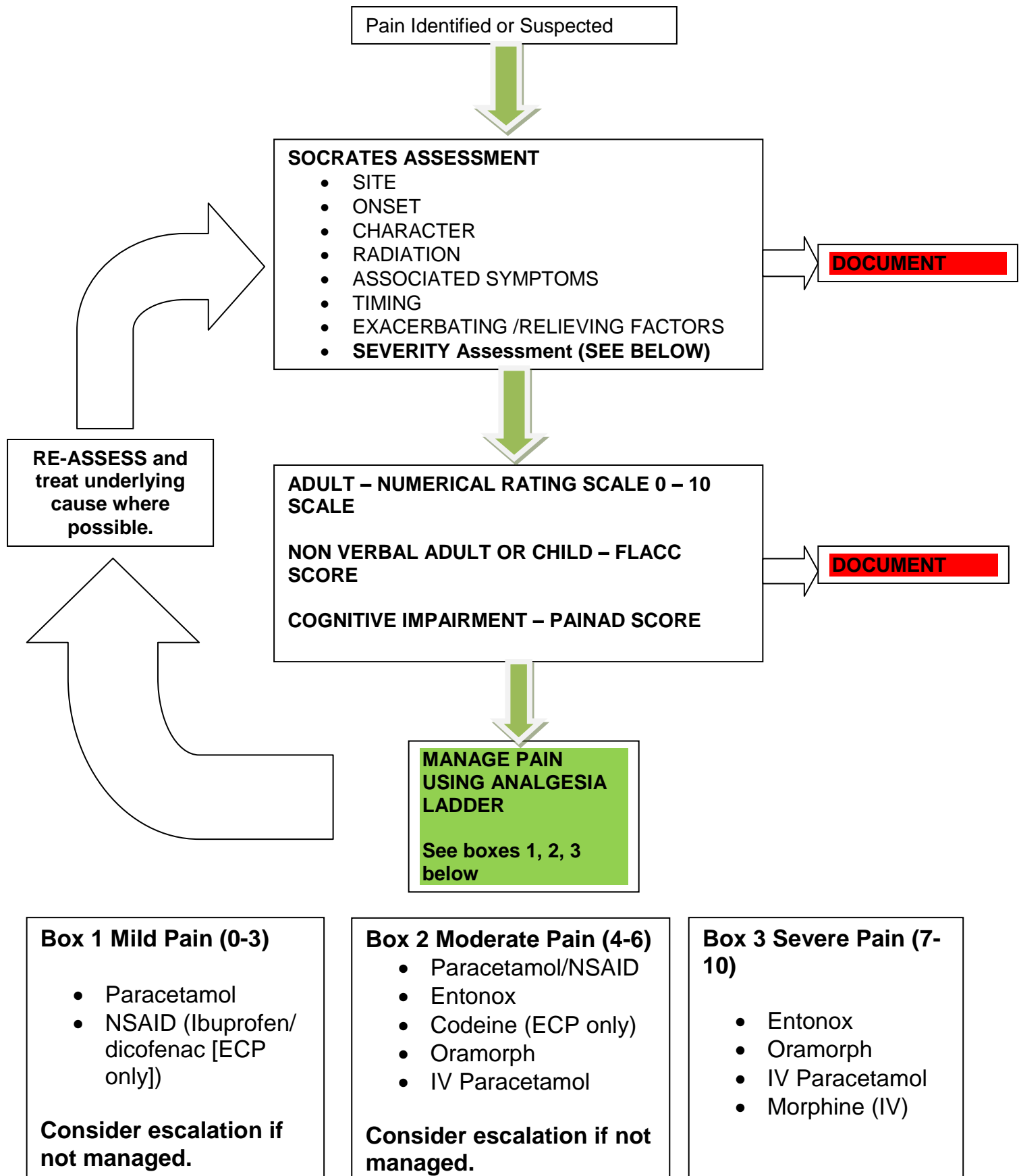
Plan for Dissemination of Procedural Document

To be completed and attached to any procedural document when submitted to the appropriate approving group for consideration and approval.

Title of document:	Pain Management Procedure		
Version Number:	1.0	Dissemination lead: Print name, title and contact details	Ian Mursell
Previous document already being used?	Yes / No (Please delete as appropriate)		
Who does the document need to be disseminated to?	All clinical staff		
Proposed methods of dissemination: Including who will disseminate and when Some examples of methods of disseminating information on procedural documents include: <i>Information cascade by managers</i> <i>Communication via Management/ Departmental/Team meetings</i> <i>Notice board administration</i> <i>Articles in bulletins</i> <i>Briefing roadshows</i> <i>Posting on the Intranet</i>	<ul style="list-style-type: none"> • Distribute to education centres / LQM/ CTM / local management teams for cascade • Inclusion in clinical newsletter • Mention in CEO bulletin • Local CPD events • Bulletin to stations • Intranet inclusion 		

Note: Following approval of procedural documents it is imperative that all employees or other stakeholders who will be affected by the document are proactively informed and made aware of any changes in practice that will result.

Pain Management Procedure:



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

(Warden et al., 2003)

Categories	Scoring		
	0	1	2
FACE	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested.	Frequent to constant quivering chin, clenched jaw.
LEGS	Normal position or relaxed.	Uneasy, restless, tense.	Kicking, or legs drawn up.
ACTIVITY	Lying quietly, normal position moves easily.	Squirming, shifting back and forth, tense.	Arched, rigid or jerking.
CRY	No cry, (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams or sobs, frequent complaints.
CONSOLABILITY	Content, relaxed.	Reassured by occasional touching hugging or being talked to, distractable.	Difficulty to console or comfort

DRUGS FOR CLINICAL GRADE

Drug	ECA	Technician	Paramedic	ECP
Entonox	x	x	x	x
Paracetamol (oral)		x	x	x
Ibuprofen (Oral)		x	x	x
Diclofenac (Oral/IM/PR)				x
Codeine (Oral)				x
Paracetamol (IV)			x	x
Oral Morphine (10mg/5ml)			x	x
Morphine Sulphate			x	x