

**Acute Pain Assessment and Management in**

**Adults (Including the Abbey Pain Scale for use**

**With Patients who are Cognitively Impaired or Unable to Communicate or Verbalise)**

**Clinical Guideline**

|  |  |  |  |
| --- | --- | --- | --- |
| Document No. | *EDRMS000421C* | Version No. | *2.0* |
| Approved by | *Policy Governance Group* | Date approved | *29/06/2016* |
| Ratified by | *Associate Medical Director* | Date ratified | *06/07/2016* |
| Date Implemented | *07/07/2016* | Next Review Date | *06/07/2019* |
| Status | | *Approved* | |
| Target Audience (who does the document apply to and who should be using it) | | All employees who provide face to face care | |
| Accountable Director | | Medical Director | |
| Policy Author/Originator - **Any comments on this document should, in the first instance be addressed to the author.** | | Pain Management Nurse Specialist | |
| Implementation Lead | | Pain Management Specialist Nurse | |
| If developed in partnership with another agency, ratification details of the relevant agency | | None | |

**Equality Impact**

Great Western Hospitals NHS Foundation Trust strives to ensure equality of opportunity for all service users, local people and the workforce. As an employer and a provider of health care, the Trust aims to ensure that none are placed at a disadvantage as a result of its policies and procedures. This document has therefore been equality impact assessed in line with current legislation to ensure fairness and consistency for all those covered by it regardless of their individuality. This means all our services are accessible, appropriate and sensitive to the needs of the individual.

**Special Cases**

This guideline does not apply to children under the age of 16

A separate document is available for the assessment of pain in children (Ref 1)

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# Instant Information - Scales and Charts

**The Trust Acute Pain Assessment Tool**

Use this pain assessment scale when asking the patient about their pain

|  |  |  |  |
| --- | --- | --- | --- |
| No pain on movement  Score 0 | Mild pain on movement  Score 1 | Moderate pain on movement  Score 2 | Severe pain on movement  Score 3 |

**The Abbey Pain Scale (Ref 1)**

Use this assessment tool when assessing patients with communication or cognitive difficulties (including dementia)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **The Abbey Pain Assessment Scale** | | | | |
| **Vocalisation** e.g. whimpering, groaning, crying | | | | |
| Absent - 0 | Mild – 1 | Moderate - 2 | Severe - 3 | |
| **Facial expression** e.g. looking tense, frowning, grimacing, looking frightened | | | | |
| Absent - 0 | Mild – 1 | Moderate - 2 | Severe - 3 | |
| **Change in body language** e.g. fidgeting, rocking, guarding part of the body, withdrawn | | | | |
| Absent - 0 | Mild – 1 | Moderate - 2 | | Severe - 3 |
| **Behavioural changes** e.g. increased confusion, refusing to eat, alterations in usual pattern | | | | |
| Absent - 0 | Mild – 1 | Moderate - 2 | Severe - 3 | |
| **Physiological changes** e.g. temperature, pulse or blood pressure outside normal limits, perspiring flushing or pallor | | | | |
| Absent - 0 | Mild – 1 | Moderate - 2 | Severe - 3 | |
| **Physical changes** e.g. skin tears. Pressure areas. Arthritis, contractures, previous injuries | | | | |
| Absent - 0 | Mild – 1 | Moderate - 2 | Severe - 3 | |
| Total the scores and record on observation chart | | | | |
| (0-2)  No pain  Score 0 | (3-7)  Mild pain  Score 1 | (8-13)  Moderate pain  Score 2 | (14+)  Severe pain  Score 3 | |

# Instant Information - The World Health Organisation (WHO) Analgesia Ladder

This tool will assist with prescribing decisions when managing acute pain.

|  |  |  |
| --- | --- | --- |
|  | **STEP 2**  **Weak opioid** | **STEP 3**  **Strong opioid**  Morphine  (e.g.Oramorph) |
| **STEP 1** | Codeine  or Tramadol | + NSAID |
| **Non-Opioid** |  | + Paracetamol |
| NSAID | + NSAID |  |
| Paracetamol | +Paracetamol | **SEVERE PAIN** |
|  |  |  |
|  | **MODERATE PAIN** |  |
|  |  |  |
| **MILD PAIN** |  |  |
|  |  |  |
|  |  |  |

Non-Steroidal Anti-Inflammatory Drug - NSAID

# Document Details

## Introduction and Purpose of the Document

This document provides Great Western Hospitals NHS Foundation Trust (the Trust) employees with best practice guidelines, relevant assessment and management tools for the management of acute pain in patients who can communicate with staff and for adults unable to communicate or have significant cognition problems (e.g. dementia and learning difficulties).

This document aims to ensure accurate, standardised pain assessment and subsequent prescribing of analgesia for the management of acute pain, throughout the Trust.

## Glossary/Definitions

The following terms and acronyms are used within the document:

|  |  |
| --- | --- |
| **IP&C** | Infection Prevention and Control |
| **NEWS** | National Early Warning Score |
| **NHS** | National Health Service |
| **NSAID** | Non-Steroidal Anti-Inflammatory Drug |
| **WHO** | World Health Organisation |

# Main Policy Content Details

## General Points regarding Acute Pain Assessment and Management in Adults:

* Pain assessment and on-going pain management is an essential part of care for all patients and is the responsibility of all clinical employees.
* Pain assessment must be carried out on admission to the hospital by the responsible clinical employee
* The patient where possible should be directly asked to score their pain, in accordance with the tool
* Pain scores must be recorded on the appropriate Trust chart. This is the National Early Warning Score (NEWS) chart.
* The employee completing the assessment should initial the NEWS chart as evidence that the assessment has been done.
* The employee must indicate on the NEWS chart whether the acute pain assessment scale or the abbey pain scale has been used.
* The pain score must be easily accessible to all members of the healthcare team providing care to the patient
* Pain must be assessed and recorded with regular observations, as clinically indicated and at 30 minutes after any intervention, including administration of analgesia. This is to establish effectiveness of an analgesia regimen.
* Pain must be reassessed, by the responsible clinical employee, with any new report of pain.
* Associated symptoms, such as nausea, vomiting and sedation must be assessed by the responsible clinical employee and managed accordingly.
* Pain assessment must be continuous until discharge.
* Patients must be discharged with prescribed analgesia and instructions on administration.

## How to complete a Pain Assessment in Adults who are able to Communicate Verbally

* The acute pain assessment tool is a verbal descriptive scale.
* Patients must be asked to score their own pain as they move.
* This will be recorded according to the acute pain assessment tool:

(0 = no pain, 1 = mild pain, 2 = Moderate pain 3 = Severe pain)

* The responsible clinical employee should be prepared to discuss with the patient any factors that may affect their pain experience. This may include psychological status, previous experiences and expectations.
* Assessment tools in different languages are available through the British Pain Society website (Ref 3) and are also available on the pain management pages of the Trust intranet.

## How to Complete Pain Assessment in Adults with Impaired Cognition or Communication

* Patients with moderate to severe communication or cognition problems must be offered additional assistance through the use of suitably validated scales and by appropriately trained clinical employees.
* The Abbey Pain Scale is an accepted and validated pain assessment tool
* It is a behavioural based, observational assessment designed to assist in the assessment of pain in patients who are unable to clearly articulate their needs
* Pain behaviours differ between individuals. Therefore assessment should include insights from family members and familiar carers regarding behaviours. These insights can be documented on the “This is Me” document (Ref 4).
* Patients pain must be assessed as they move, mobilise or are repositioned.
* The Abbey Pain Scale does not distinguish between distress and pain, so it is essential that the effectiveness of pain relieving interventions are evaluated.
* The scale should be completed and the score recorded in the patients record.
* Employees should assess each of the six domains individually as detailed below:

|  |  |
| --- | --- |
| **Behavioural Domain** | **Each domain is graded individually using the score** |
| Vocalisation |  |
| Facial expression | 0 - Absent |
| Change in body language | 1 – Mild |
| Behavioural change | 2 – Moderate |
| Physiological change | 3 - Severe |
| Physical change |  |

The individual totals from all six domains should be added together to produce a final pain score

## Analgesia for Acute Pain Prescribing Guideline

* The prescribing guideline, the analgesia ladder and the pain assessment tools are designed to complement each other.
* The World Health Organisation (WHO) three step analgesia ladder (Ref 5) I a prescribing tool for use in acute pain (see section 1.3)
* There are five guiding principles for the application of the WHO 3 step analgesia ladder which makes it a useful tool. These are summarised as:

1. By mouth’ – oral forms of analgesics is preferred wherever possible. ‘By the clock’ – analgesia should be given at regular intervals rather than on demand.
2. By the ladder’ – The principles of the ladder should be adhered to.
3. For the individual’ – there is no standardised dosage and therapy and should be based around the level of the patient’s reported pain.
4. Attention to detail’ – refers to the close monitoring of the patient’s pain as well as the bio psychosocial factors that may be impacting upon their pain.

* Changes up or down the ladder may be appropriate for individualised care.
* Further advice on prescribing of analgesia may be found on the on the intranet and the 3Ts formulary (Ref 6).
* Specialist advice from the Pain Management Service may be sought if conventional analgesia is not effective or pain not adequately controlled.

The Pain Management Service can be contacted on bleeps 1196, 1015, 1720. Out of hours for emergency advice contact the on-call anaesthetist via switchboard.

# Duties and Responsibilities of Individuals and Groups

## Chief Executive

The Chief Executive is ultimately responsible for the implementation of this document.

## Deputy Divisional Directors

All Deputy Divisional Directors are to ensure that the list of new or revised policies, competencies, clinical guidelines, strategies, plans, protocols or procedural documents published each month is on the agenda at Divisional meetings to ensure that the documents are drawn to the attention of managers and general users. All Deputy Divisional Directors must ensure that employees within their area are aware of the document; able to implement the document and that any superseded documents are destroyed.

## Document Author and Document Implementation Lead

The document Author and the document Implementation Lead are responsible for identifying the need for a change in this document as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and resubmitting the document for approval and republication if changes are required.

## Target Audience – As indicated on the Cover Page of this Document

The target audience has the responsibility to ensure their compliance with this document by:

* Ensuring any training required is attended and kept up to date.
* Ensuring any competencies required are maintained.
* Co-operating with the development and implementation of policies as part of their normal duties and responsibilities.

# Monitoring Compliance and Effectiveness of Implementation

The arrangements for monitoring compliance are outlined in the table below:

| **Measurable policy objectives** | **Monitoring / audit method** | **Monitoring responsibility** (individual / group /committee) | **Frequency of monitoring** | **Reporting arrangements** (committee / group to which monitoring results are presented) | **What action will be taken if gaps are identified?** |
| --- | --- | --- | --- | --- | --- |
| Pain score is documented with every set of observations  Pain score recorded as 0 -1 | Patient feedback forms  Complaints and  IR1 forms where it is reported pain not effectively managed  Pain assessment audit  Matrons monthly walk about and spot check | Pain Management Service  Matrons | On going  Annual | Matrons meetings  Escalated to Divisional Director of Nursing | Escalate any non-compliant areas  Patient experience committee to advise on action  The Pain Management Service will establish a programme of re-education  Encourage employees to undertake dementia training on training tracker |

# Review Date, Arrangements and Other Document Details

## Review Date

This document will be fully reviewed every three years in accordance with the Trust’s agreed process for reviewing Trust-wide documents. Changes in practice, to statutory requirements, revised professional or clinical standards and/or local/national directives are to be made as and when the change is identified

## References, Further Reading and Links to Other Policies

The following is a list of other policies, procedural documents or guidance documents (internal or external) which employees should refer to for further details:

| **Ref. No.** | **Document Title** | **Document Location** |
| --- | --- | --- |
| 1 | Pain Assessment in Children Guideline Document | Intranet |
| 2 | The Abbey Pain Scale: a 1-minute numerical indicator for people with end-stage dementia.  Abbey et Al | International Journal of Palliative Care 2004 Jan; 10 (1): 6-13 |
| 3 | The British Pain Society publications – pain scales in multiple languages | www.britishpainsociety.org |
| 4 | “This is Me” Royal College of Nursing and The Alzheimer’s society (Hard Copies available on the Wards) | <https://www.alzheimers.org.uk/> |
| 5 | The British Pain Society, Concise guidance to good practice; A series of evidence based guidelines for clinical management. No 8 The assessment of pain in older people; October 2007. | https://www.britishpainsociety.org |
| 6 | World Health Organisation 3 Step pain ladder (1986) | http://www.who.int/cancer/palliative/painladder/en/ |
| 7 | NHS Wiltshire, NHS BaNES and NHS  Swindon CCGs Pain Management Documents | Intranet – 3Ts Formulary pages |

## Consultation Process

The following is a list of consultees in formulating this document and the date that they approved the document:

| **Job Title / Department** | **Date Consultee Agreed Document Contents** |
| --- | --- |
| Pain Management Specialist Nurse | 20/3/16 |
| Senior Formulary Pharmacist | 6/4/16 |
| Clinical lead for Dementia | 7/3/16 |
| Divisional Director of Nursing | 7/3/16 |

# Appendix A – Equality Impact Assessment

**Equality Impact Assessment**

**Our Vision**

Great Western Hospitals NHS Foundation Trust wants its services and opportunities to be as accessible as possible, to as many people as possible, at the first attempt.

**Are we Treating Everyone Equally?**

Define the document. What is the document about? What outcomes are expected?

Consider if your document/proposal affects any persons (Patients, Employees, Carers, Visitors, Volunteers and Members) with protected characteristics? Back up your considerations by local or national data, service information, audits, complaints and compliments, Friends & Family Test results, Staff Survey, etc.

If an adverse impact is identified what can be done to change this? Are there any barriers? Focus on outcomes and improvements. Plan and create actions that will mitigate against any identified inequalities.

If the document upon assessment is identified as having a positive impact, how can this be shared to maximise the benefits universally?

# Appendix B – Quality Impact Assessment Tool

|  |  |  |
| --- | --- | --- |
| **Purpose**  To assess the impact of individual policies and procedural documents on the quality of care provided to patients by the Trust both in acute settings and in the community. | | |
| **Process**  The impact assessment is to be completed by the document author. In the case of clinical policies and documents, this should be in consultation with Clinical Leads and other relevant clinician representatives.  Risks identified from the quality impact assessment must be specified on this form and the reasons for acceptance of those risks or mitigation measures explained. | | |
| **Monitoring the Level of Risk**  The mitigating actions and level of risk should be monitored by the author of the policy or procedural document or such other specified person.  High Risks must be reported to the relevant Executive Lead. | | |
| **Impact Assessment**  Please explain or describe as applicable. | | |
| 1. | Consider the impact that your document will have on our ability to deliver high quality care. | *This document provides a framework for consistent pain assessment* |
| 2. | The impact might be positive (an improvement) or negative (a risk to our ability to deliver high quality care). | *Positive* |
| 3. | Consider the overall service - for example: compromise in one area may be mitigated by higher standard of care overall. | *NA* |
| 4. | Where you identify a risk, you must include identify the mitigating actions you will put in place. Specify who the lead for this risk is. | *NA* |
| **Impact on Clinical Effectiveness & Patient Safety** | | |
| 5. | Describe the impact of the document on clinical effectiveness. Consider issues such as our ability to deliver safe care; our ability to deliver effective care; and our ability to prevent avoidable harm. | *Aim to prevent the avoidable harmful effects of unresolved pain and associated distress* |
| **Impact on Patient & Carer Experience** | | |
| 6. | Describe the impact of the policy or procedural document on patient / carer experience. Consider issues such as our ability to treat patients with dignity and respect; our ability to deliver an efficient service; our ability to deliver personalised care; and our ability to care for patients in an appropriate physical environment. | *Will provide consistency in pain assessment for patients and ensure patients who are unable to verbalise their pain have these needs met.* |
| **Impact on Inequalities** | | |
| 7. | Describe the impact of the document on inequalities in our community. Consider whether the document will have a differential impact on certain groups of patients (such as those with a hearing impairment or those where English is not their first language). | *NA* |