CGP113

POLICY AND PROCEDURE FOR PAIN MANAGEMENT

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1. POLICY INTRODUCTION

The Policy and Procedure for pain management in emergency medical services has been developed to ensure and maintain safe and quality care and achieve optimum outcomes and to support National Ambulance staff providing the care and transportation of patients.

National Ambulance strives to deliver clinical services in accordance with international evidence based best practices, and with the appropriate sections in the NA Patient Care Protocols (CGP 134). Pain is one of the most common symptoms in patients who call for an ambulance. Pain management is essential for not only humanitarian purposes but also to allow for better patient assessment as well as prevent patient deterioration.

This policy is related to Clinical Quality Assurance and is subject to Clinical Audit. Therefore it is important that all staff adhere to the requirements of this policy.

2. SCOPE

Care and management of a patient requiring pain management is only to be performed by National Ambulance Clinical personnel as trained within their scope of practice and privileging.

This policy and procedure includes all elements of patient assessment and management for pain management in the Pre-Hospital Emergency Medical Services (EMS) environment to ensure best possible outcomes; it also includes requirements for documentation to ensure that comprehensive and accurate recording of all patient related activity takes place.

3. ROLES AND RESPONSIBILITIES

1. Chief Operations Officer

The Chief Operations Officer is responsible for the implementation and monitoring of this Policy and Procedure.

2. Medical Director/Delegate

The Medical Director/Delegate is responsible for development of this Policy and Procedure, this includes the review and revision of any Performance Indicators or training to support this Policy and Procedure.

3. All Managers

All Managers are responsible for ensuring that staff have induction in alignment with this Policy and Procedure, for monitoring the applicability and ongoing implementation as well as raising any issues with the MD / Delegate and reporting any incidents or near misses through the QHSE system. Reporting of the suspected or confirmed communicable disease must be completed in accordance with the DOH regulations and in accordance with the steps that are included in the policy and procedure.

4. Staff

All staff that provide care for patients are responsible for acting according to this policy and procedure in accordance with their scope of practice. They are also responsible for ensuring that they attend or pursue any relevant training recommended by their Manager (i.e. eLearning and face to face training).

4. POLICY STATEMENT

National Ambulance clinical staff must act in the best interests of the patient, any relatives or guardians accompanying the patients and within their specified scope of practice and must use relevant qualifications, training, skills and experience to provide optimal clinical care including Pain assessment and management .
National Ambulance clinical staff must be fully aware of the consent considerations required for all patients and ensure they have knowledge and understanding of:

- CGP 134 NA Patient Care Protocols
- CGP 105 Patient Consent Policy and Procedure
- CGP 103 Patient Rights and Responsibilities Policy and Charter
- CGP115 Patient Transportation Policy & Procedure and
- CGP119 Patient Care Record and Patient Care Documentation and Reporting Policy & Procedure.

Pain screening, assessment and management in the emergency services field should be initiated as soon as possible. To facilitate this National Ambulance will ensure that:

- All clinical staff have adequate resources to enable them to provide optimum care such as equipment and Vehicles, medical gases and drugs.
- All clinical staff have access to suitable ongoing training to ensure they have the most relevant and up to date information and that they have access to ongoing support in the workplace.
- Other relevant policies, procedures and guidelines are in place and available to support this policy and procedure.
- They key points of this policy and procedures are detailed in Appendix 2.

4.1. WHY THIS IS IMPORTANT FOR YOU?

As a clinician you have a responsibility:

- To ensure that you have the knowledge, training and skills to give the best quality and safest patient care.

This Policy and procedure gives you some of the tools to achieve this and is designed to support the decision-making process in patient care;

- The stepwise process to assess and re-assess and manage all patients is contained in this Policy and Procedure;
- To provide pain relief to any patient in need, using non-pharmacological and/or medication likely to be the most effective and to monitor and record the outcomes of the interventions;
- To only make use of drugs and other analgesic options that are available to you and are within your individual scope of practice and level of privilege that you have attained at National Ambulance.
- To adhere to the indications, contraindications and dosing schedules and resource allocation for the analgesics that you can prescribe/administer;
- To protect the patient from any undue harm as well as protecting yourself by abiding to NA Policy & Protocol and also by completing learning and development programs put out by NA.
- This Policy and Procedures is intended to complement good clinical judgment; it is not always possible to write a policy, procedure and guidelines for every condition that a patient may have and your clinical judgement is critical in pain management processes.
- Please use CGP 134 NA Patient Care Protocol to guide your treatment in pain management.
- Consent is required and needs to be annotated in the patient care records.
- The most senior qualified clinician is to assume the leadership role.
- You must act in the best interests of the patient and perform within your scope of practice.
- Assessments must be carried out before, during and after any pain management intervention. Continuous monitoring of the patient would be best practice and also highlights immediate changes in patient response that can be acknowledged or dealt with earlier than later.
- It's imperative that you work as a team and provide a consistent standard of care to the patients in the pre-hospital field.
- When you have carried out the assessment you must document comprehensively and accurately all your findings and all relevant information required on the Patient Care Record.

For example:

A patient with a compound fracture of tibia and fibula could benefit from the following modes of analgesic care and treatment:

- Psychological communication including distraction and reassurance
- Pharmacological, non-narcotic – inhaled nitrous oxide (given prior to splinting)
- Pharmacological non-narcotic – intravenous Paracetamol
- Non Pharmacological – Splinting
- Pharmacological, narcotic – intravenous morphine

4.2. Pain Assessment and scoring

The level of pain experienced by a patient is very unique and differs from individual to individual and from culture to culture; In addition patient perception of pain may differ. Clinical staff should look for and accept what the patient is saying regarding their level of pain and treat accordingly.

All patients should be screened for pain and the result documented to indicate the need for further more detailed assessment and management.

For the purposes of pain assessment you can use the mnemonic **SOCRATES**:

- S – Site
- O – Onset
- C – Character
- R – Radiates
- A – Associated symptoms
- T – Time/duration
- E – Exacerbating or relieving factors
- S – Severity

The clinician should ask the patient to rate their pain from 0-10 with 10 being the worst pain they have ever felt (or use of an appropriate pain scoring tool). This pain score needs to be reassessed after each intervention; this is important as it will determine the type of analgesia necessary to treat the patient and to provide the best pain relief.

If a patient is cognitively impaired, the ambulance staff will have to rely on behavioral patterns, use of the correct scoring tool as well as history from family members. For children, specific evidence based scoring tools must be used e.g. FLACC and Wong and Baker. See specific pain section in JRCALC and NA Arabic communication book (and illustrations below).

It is imperative to document a pain score before and after analgesia administration or after an intervention such as splinting is performed, this should be in accordance with the table at **Appendix 1**.

Specifically, as a minimum at least 2 pain scores must be recorded for every patient; tracking and trending patients' pain is essential in continuity of clinical care.

Pain scoring should also be performed and re-performed to assess outcome of treatment for all patients. The timing of the re assessment should be dependent on the type of pain relief given to the patient and the route used as a guide in Appendix 1.

4.3. MANAGEMENT

As with all patient treatment, pain relief procedures must be explained to the patient, explanation of the patient's condition as well as what methods were used to provide the pain relief. The clinician's general bedside manner can go a long way in alleviating pain. Consent should be sought in accordance with the National Ambulance Consent Policy and Procedure.

There are two types of management for pain relief: pharmacological interventions and non-pharmacological interventions:

- Pharmacological interventions include the use of specific drugs to achieve pain relief. Clinicians should refer to their protocols regarding the use of these drugs;

- Non-pharmacological interventions can include as examples reassurance, explanation, distraction, splinting, dressing or cooling.

Non-pharmacological interventions are simple but extremely effective. Applying burn dressings to a burn will go a long way to alleviate the patient's pain. For example, splinting an injured limb provides much emotional comfort to the patient as well as helps with pain relief. Splinting is imperative to prevent further soft tissue damage, bleeding and other serious complications at the injury site. If at all possible, try and treat the underlying cause of the pain.

Pain assessment helps determine the pain severity; this should dictate whether pain relief is provided in the fashion of an *analgesic ladder* or more commonly in the pre-hospital setting as an immediate bolus. Assessment and reassessment will determine whether analgesia is required in incremental intervals or if the patient requires analgesia in a more immediate way and with the use of more potent medication.

Entonox should be started immediately until the other analgesia takes effect. It's important to titrate the analgesia to effect as this minimizes the amount of potent analgesia administered.
For those patients who suffer with chronic pain they may need require large doses of analgesia. Please liaise with the NA Medical Director (via the ACC team lead) if treatment is required beyond the NA Protocols.

Be aware of Respiratory Depression and/or Other side effects that may warrant your immediate attention and intervention. Always be prepared to manage a patient's airway and/or take over or assist ventilations if required.

Other interventions may also be required if there is a drop in Blood Pressure or adverse reactions. Therefore, monitoring the patient closely after pain interventions is essential. Familiarity, with medications and their pharmacological actions including adverse effects will help to alert you to possible supportive actions required.

Following any type of pain management, it is imperative that you assess the effect using the Appendix 1 to inform the timing of this reassessment.

4.4. Analgesic Types

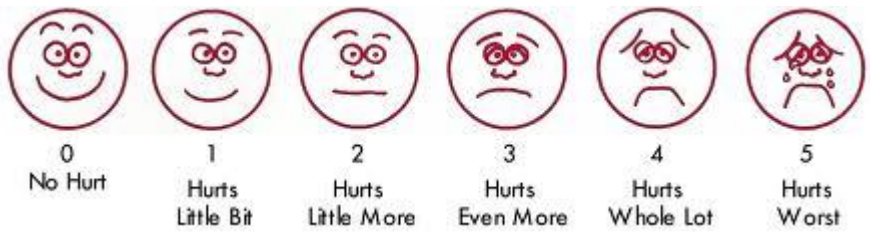
National Ambulance uses the following types of Analgesics

- Inhaled Analgesics – Entonox, Penthrox
- Non- opiate analgesics – Paracetamol, Ibuprofen
- Opiate Analgesics – Morphine
- Specific analgesics - Ketamine

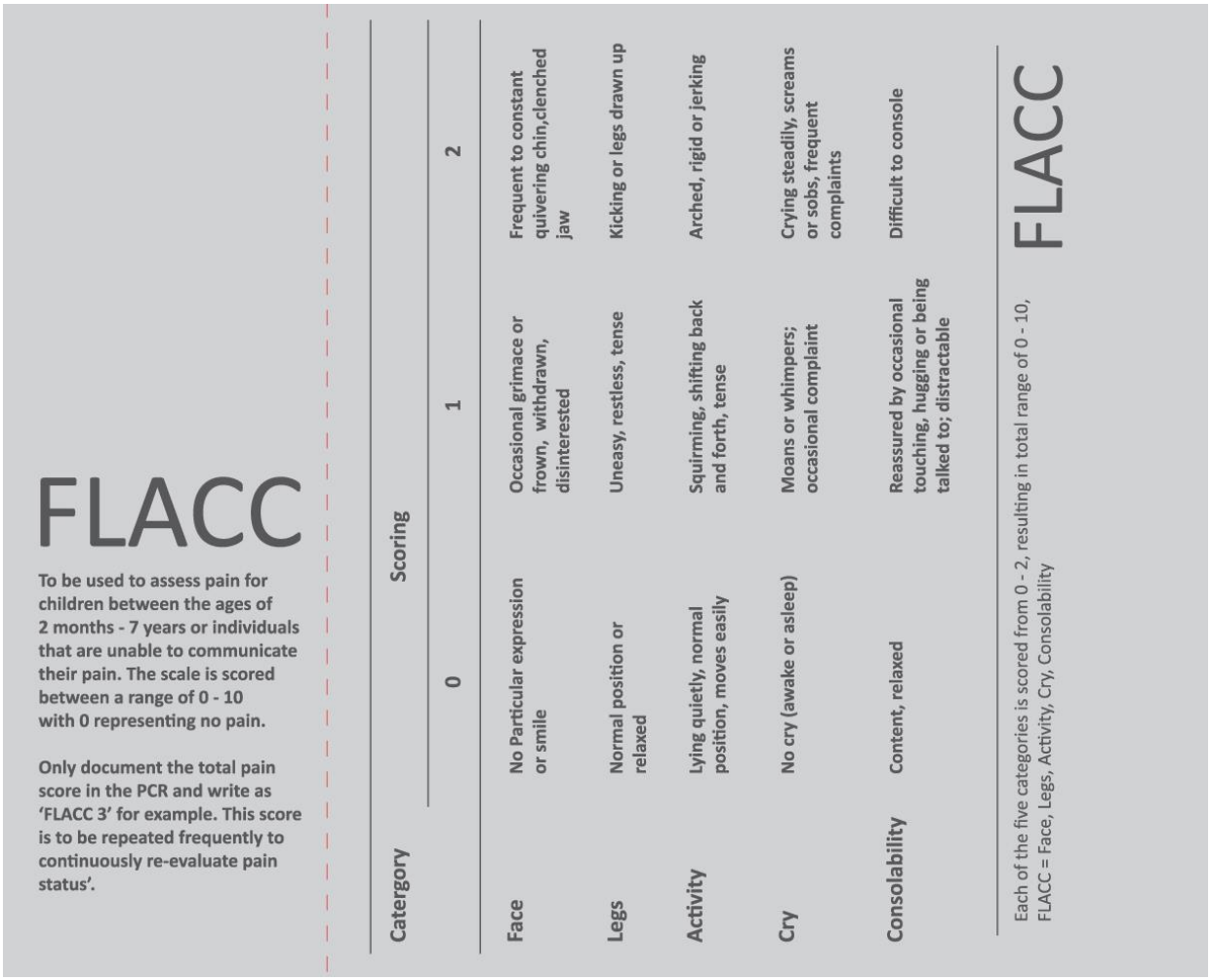
4.5. Pain Management in children

All children who are in pain require analgesia and it should be administered as soon as clinically possible. There is no reason to delay pain relief and if unsure, it's vital that clinical staff seek medical expertise to provide that pain relief. As with adults, all children need to have their pain assessed. Children may not be able to express the severity of their pain appropriately so two methods are currently used to assess the patient's pain score using the Wong and Baker faces and the FLACC scale as detailed below.

- **Wong and Baker** – the patient is shown the faces and is asked to point to the face that describes how he/she is feeling.



- **The FLACC scale**: **F**ace, **L**egs, **A**ctivity, **C**ry, **C**onsolability scale – is a measurement tool to assess pain in children who are unable to communicate their pain or up to 7 years of age.



FLACC

To be used to assess pain for children between the ages of 2 months - 7 years or individuals that are unable to communicate their pain. The scale is scored between a range of 0 - 10 with 0 representing no pain.

Only document the total pain score in the PCR and write as 'FLACC 3' for example. This score is to be repeated frequently to continuously re-evaluate pain status'.

Catergory	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	Difficult to console

Each of the five categories is scored from 0 - 2, resulting in total range of 0 - 10,
FLACC = Face, Legs, Activity, Cry, Consolability

FLACC

The child's condition and the resultant score will determine the amount of analgesia required.

4.6. SUMMARY

Pain is one of the commonest conditions that require interventions by Pre hospital clinicians. There are multiple options to reduce pain. This document gives an overview of the tools that you can use, the steps to take and the modalities of pain management.

5. RELEVANT LEGISLATION

International, federal or local legislation and circulars relevant to this Policy. Full detail on this legislation can be found in QHP109 Legal Register.

Code, Name of Legislation	Jurisdiction
Continuum of Care Standards – Pain Management – HRC.39 & 40	DOH
Assessment of Patient (AOP) – AOP.6 (ME1, 2, 3 & 4)	JCI

6. RELATED POLICIES AND FORMS

List related policies and procedures to the created/updated policy.

Policy & Procedure /Form
CGP 134 NA Patient Care Protocols
CGP 105 Patient Consent Policy and Procedure
CGP 103 Patient Rights and Responsibilities Policy and Charter
CGP115 Patient Transportation Policy & Procedure
CGP119 Patient Care Record and Patient Care Documentation and Reporting Policy & Procedure

7. FEEDBACK

Any feedback or suggestions for improvement to this Policy, Processes or Procedures can be submitted to qhse@nationalambulance.ae

8. DOCUMENT CONTROL AND OWNERSHIP

A review and update of this document will take place as necessary, when changes occur that identify the need to revise this Policy such as changes in roles and responsibilities, release of new legislative or technical guidance, or identification of a new policy area.

This document ownership for editing is identified as:

- Medical Director

This controlled document is managed / overseen by [Procurement and Tendering Committee and/or Audit and Risk Management Committee and/or HR and Compensation Committee].

Change Brief

Version No.	Date	Change
1	09 December 2013	First Draft
2	22 April 2014	Converted to Policy and Procedure
3	22 September 2014	Revised to ensure specific detail on screening for pain for Appendix 1 added to follow for reassessment of pain at intervals aligned with the type and route of pain relief given. Key points summarised in Appendix 2.
4	20 September 2016	Policy Revision
5	April 2019	Terminology (Medical Director, DOH) Delete CSD and replace with ACC Delete Diclofenac from analgesic type and Appendix 1
6	May 2021	Due for Review Delete word “Supervisors”

Medical Director

CEO Approval

Board Member Verification

Appendix 1 - Pain scoring re-assessment times for pharmacological interventions

Drug	Route	Time to Onset	Time to maximum effect	Pain Reassessment time
Entonox	IN	3 - 5 mins	5 - 10 mins	Every 3 - 5 mins
Penthrox	IN	2 - 5 mins	5 - 10 mins	Every 3 - 5 mins
Paracetamol	IV	<15 mins	30 - 60 mins	Every 15 mins
Paracetamol	PO	30 - 60 mins	1 - 3 hours	Every 20 - 30 mins
Ibuprofen	PO	30 - 60 mins	2 hours	Every 20 - 30 mins
Morphine	IV/IO	5 - 10 mins	10 - 20 mins	Every 5 mins
Fentanyl	IV/IO	immediate	3 - 15 mins	Every 1 - 5 mins
Ketamine	IV	30 seconds	5 mins	Every 1 - 5 mins
Ketamine	IM	5 - 10 mins	10 - 20 mins	Every 5 mins

References - www.clinicalpharmacology.com

Pain scoring re-assessment times for non-pharmacological interventions

Intervention	Pain Reassessment time
Psychological e.g. distraction	Every 5 mins
Dressings	Every 5 mins
Splintage	Every 5 mins

Appendix 2

KEY POINTS

- Treat pain with drug and non-drug interventions at the soonest opportunity
- Screen all patients for pain as part of your assessment
- Document pain scores frequently and always pre and post intervention
- Use appropriate methods and tools to assess pain e.g. Socrates, Wong Baker and FLACC.
- Ensure that you have the relevant qualifications, training and skills for the patient care that you administer.
- Be aware of side effects & complications that need to be managed.
- If pain is worsening, despite interventions try another intervention; transport patient promptly to a facility where pain can be managed further.
- CGP 134 - Patient Care Protocols must be used to guide all patient care.