Draft copy for Pilot study

PLIOT STUDY ON SULTAN WARD MALCERIA (GWMH)

PAIN ASSESSMENT AND RATIONALE FOR ANALGESIA

Name of Patient: D.O.B.

Hospital Number:

Signature of Assessor: Date of Assessment:

THE ANALGESIC LADDER (ADAPTED FROM W.H.O. ANALGESIC LADDER)

STEP 3 SEVERE PAIN

- **■** Strong opioid
- +/- Non opioid
- # +/- Adjuvant
- Oral morphine/oramorph 2.5-5mgs 4 hourly, if not on regular mild or moderate analgesia.

Note: A mild analgesia e.g. 1g Paracetamol = 5mg of Oramorph: See BNF guidelines page 13, 2003.

- To calculate Opiaté dose, if pain occurs before 4 hrs, give an extra 4 hourly dose form prn column. Review and reassess daily. Add any PRN doses to regular prescription. Divide 24 hr total by 6 to give 4-hrly dose.
- When stable, convert to Morphine Sulphate sustained release 12 hrly (Zomorph MST).
- Other strong opioids: Oxycodone, Methadone and Fentanyl (Fentanyl patches only in palliative care,
- If patient is dysphagic, vomiting, or unconscious give sc Diamorphine via syringe driver at 1/3 of 24hr total Morphine dose

STEP 2 MODERATE PAIN

- Weak opioid
- # +/- Non opioid
- # +/- Adjuvant

1. Codeine 30mg with paracetamol 500mg (co-codamol 30/500) 1-2 qds.

- Dextropropoxyphene 32.5mg with Paracetamol 325mg (coproxamol) 1-2 gds.
- Other drugs in this group include Dihydrocodeine and Tamadol (in secondary care Tramadol can only be prescribed by a consultant).

STEP 1 MILD PAIN

■ Non-opioid■ +- adjuvant

Paracetamol oral/pr (500mg-1g qds) maximum 4g per day.

NSAIDs Diclofenac tabs 50mgs tds/ SR capsules 75mgs bd, supps 100-150mgs daily.

Selective COX-2 inhibitors are now available (following NICE guidelines).

IS THE PAIN NEW

U YES

New and unexplained?

Ψ

For medical assessment/diagnosis

Old and diagnosed?

J NO

Continue with assessment process

Continue with assessment process overleaf

ASSESSMENT

LI	IST ANY CURRENT ANAL	GESIA /
		:
	L	

Using prompts below if necessary and if patient is able; HOW DOES THE PATIENT DESCRIBE: -

A) THE PAIN?

Throbbing 1 Shooting 4 Stabbing Wrenching 2 Burning 5 Dull Cramping 3 Exhausting 6	7 Crushing 9 Sharp 11 Gnawing 8 Stinging 10 Radiating 12 Tight	13 14
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B) HOW CONSTANT THE PAIN IS?

	Continuous 1	Intermittent	 Rhythmic 3	Brief 4	Other 5		
•		i	 	1	1	1 1	

C) WHAT INCREASES THE PAIN?

Movement Medication	1 2	Stillness Insomnia	3 4	Heat Anxiety	5	Cold	7	Eating	9	Not Eating	10
				runicly		Outer	81			_	1

D) WHAT RELIEVES THE PAIN?

Movement 1 Medication 2	Stillness Massage	3 Heat 4 Divers	5 Cold	•	Eating	9 Not Eating 10
				"'9 U	1 -	f)

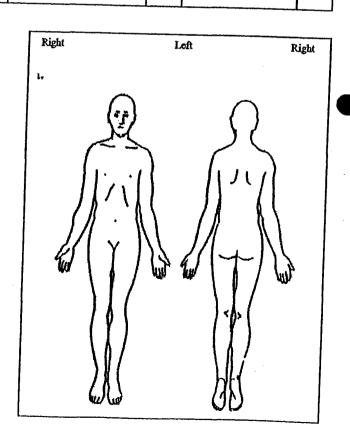
E) WHAT NUMBER BEST DESCRIBES THE PAIN?

			T	· .			*	
	No pain at all	1	A little pain	2	Quite a lot of pain	3	A very bad pain 4	1
ı		L					11 vory batt pain	4

INDICATE SITES OF PAIN ON THE BODY CHART OPPOSITE USING LETTERS A-E

Example o following c	f how t hart:	his	WOI	ıld i	be r	'eco	rded on
DATE	site	A	В	C	D	E	SIGN
14.00 10/4/89	A	2	4	1	2	3	·

Example shows Site 'A', is graded as (A 2 Wrenching) (B 4 Brief) (C 1 On movement) (D2 Medication) (E 3 Quite a lot of pain)
Use the following chart to record pain assessment (As illustrated here)



TIME	SITE	A	В	С	D	E	SIGN	DATE	SITE	A	В	С	Ħ	E	SIGN
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If the patient is anxious or distressed: -

- Encourage verbalisation of feelings. Try and establish cause of distress/anxiety.
- Listen to concerns/worries and try to give reassurance and explanations if required.
- If anxiety/distress is not relieved give prescribed anxiolytics
- Monitor effect and titrate as required.

If patient is or becomes unconscious or is unable to swallow: -

- Consider administration of rectal/transdermal patches or subcutaneous medication via a syringe driver
- Monitor for non-verbal signs of pain/distress e.g. grimacing, moaning or guarding.
- Titrate syringe driver as required.

REVIEW EFFECTIVENESS

Re-evaluate after ½ hour; tick one of the boxes to indicate how the pain has changed. NB: Person responsible for doing this may vary with primary care setting i.e. hospital/home.	☐ No pain ☐ Some pain ☐ No change
IF Some or No Change in level of pain	Review Medication i.e. Is it an appropriate choice? Is it an appropriate dose? Re-assess; Review Prescription.
Reassess pain after 3hrs; tick one of the boxes to indicate how the pain has changed. NB: This may vary with care setting and patient circumstances	No pain Some pain No Change
IF not pain free after 3 hours	Reassess and review medication

If stable continue with prescribed medication, but continue to assess pain level and review effectiveness of analgesia.

NOTE: There may be more than one type or area of pain and REMEMBER chronic pain must also be fully assessed.

NOTE: A record of any relevant changes in management of patients pain should be recorded in medical and nursing notes: Please use the comments box below to bullet point and date any relevant changes made and where further more-in-depth notes on those changes have been recorded.

	Carlongo	Where recorded	Signature
Date	Brief reason for change		
			,

 Explanation and rationale give medication i.e. analgesia and/o 	en to patient and/or relatives as regards the use of or sedation prescribed.
Sign/Date when informed	
 Explanation and rationale give 	ven to patient and/or relatives as to the use of syringe
driver/s.	

Sign/Date when informed