CLN/P3

PORTSMOUTH HEALTHCARE NHS TRUST
CORPORATE POLICY

POLICY FOR ASSESSMENT AND MANAGEMENT OF PAIN

BACKGROUND

Despite dramatic advances in pain control over the past 20 years, many patients in both hospital and community continue to suffer unrelieved pain and up to three-quarters of patients experience moderate to severe pain whilst in hospital. Pain control in hospital has long been documented as ineffective and problematic. Effective problem - solving skills and interventions which reflect the multidimensional nature of pain are required for effective pain management and there needs to be a logical link between the assessment of the problem and the desired outcome.

1. PURPOSE

This policy identifies mechanisms to ensure that all patients/clients have early and effective management of their pain and or distress .

2. SCOPE

This policy provides a framework for all staff working within the Trust who are involved in direct and indirect care. All individual guidelines, protocols and procedures to support the policy must have been approved by the appropriate professional group.

3. RESPONSIBILITY

It is the responsibility of all professionals and support staff involved directly and indirectly in care to ensure that patients/clients

- have their pain and distress, initially assessed and ongoing care planned effectively with timely review dates.
- are informed through discussion of the proposed ongoing care and any need for mechanical intervention

3.1 All professionals are responsible for:

- assessment
- planning
- implementation of action plans
- evaluation
- clear documentation
- liaison with the multiprofessional team

Nurses are also specifically responsible for the:

- administration of the prescribed medication

Medical and Dental staff are also specifically responsible for:

- appropriate prescribing of medication
- clear unambiguous completion of prescription sheet

PAM's are specifically responsible for:

- prescription of therapies
- providing appropriate aids

Service lead groups are responsible for:

- ensuring that the pain management standards are implemented in every clinical setting
- ensuring that the necessary resources and equipment is available
- ensuring that systems are in place to determine and access appropriate training and that qualified nurses can evidence their competencies
- ensuring that standards are being maintained by regular audit and monitoring

4. REQUIREMENTS

4.1 Pain Assessment

All patients/clients who complain of or appear to be in pain must have an initial assessment to establish the type/ types of pain their experiencing.

4.1.1 Systems must be in place to ensure that:-

- all qualified nursing and medical staff have the required skill to undertake pain assessments and manage pain effectively.
- a local 'agreed' pain assessment method is implemented.
- a local 'agreed' documentation method is implemented
- all staff have the required training to implement and monitor the 'pain standards'

4.1.2 All professional staff are required to:-

- exercise professional judgement, knowledge and skill
- be guided by verbal and non verbal indicators from the patient/client/ re intensity of pain
- be guided by carer/relatives if appropriate
- document site and character of the pain
- share information with the care team to enable a multiprofessional approach to the management of the patient/client
- plan on going care where possible with the patient , documenting clear evaluation dates and times
- ensure documented evidence supports the continuity of patient care and clinical practice

4.2 Prescribing

A clear unambiguous prescription must be written by medical staff following diagnosis of the type/types of pain.

- The prescription must be appropriate given the current circumstances of the patient/client
- If the prescription states that the medication is to be administered by continuous infusion (syringe driver) the rationale for this decision must be clearly documented
  N.B (**The continuous infusion route is not more effective than the oral route)**
- All prescriptions for drugs administered via a syringe driver must by written on a prescription sheet designed for this purpose
- Systems must be in place to ensure staff have the access to appropriate medication guidance and the analgesic ladder.
- Systems must be in place to ensure staff have the skill to implement the above

5. AUDIT/CLINICAL GOVERNANCE

The systems in place to support this policy should be subject to an annual audit based on the requirements of this policy and should feature in annual clinical governance plans and reports

This policy is supported by the following documents

- **Syringe driver variable dose prescription chart**
- **Syringe driver check list**
- **Pain management cycle**
- **Pain management standards**

POLICY PRODUCED BY: Wendy Inkster
POLICY PRODUCED: April 2001
APPROVED BY TRUST BOARD:
REVIEW DATE: May 2003

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SYRINGE DRIVER VARIABLE DOSE PRESECRIPTION

Name	Date of Birth	Ward / Address	Hospital No

Allergies and Drug Sensitivities

DRUG 1 (approved name)

Dose per 24 hours	Route	Max. dose per 24hr not to exceed.
To be diluted in	**Start date**	**Pharm**

Signature of Prescriber Date

DRUG 2 (approved name) Pharm

Dose per 24 hours	Route	Start date

Signature of Prescriber Date

DRUG 3 (approved name) Pharm

Dose per 24 hours	Route	Start date

Signature of Prescriber Date

Special Instructions for analgesics
(to include strategy for dose increases, and additional PRN doses, changes in patient condition)

- If breakthrough pain occurs, a PRN dose of ....mg can be given every .....hours
- If PRN dose does not control pain, increase subsequent PRN dose(s) to .....mg every .....hours to the maximum dose written on this prescription
- If pain is controlled with **Drug 1** as prescribed and no additional PRN doses have been required, repeat the **same** daily dose on the following day.
- If pain has only been controlled with the addition of PRN doses, add total PRN doses given in previous 24 hours to the dose given in syringe driver in the previous 24hours, rounded up to the nearest 5mg but only up to maximum dose written on this prescription.
- PRN doses may only continue to be administered as prescribed if dose does not exceed the maximum variable- dose prescription
- If the patient/clients pain or anxiety is not controlled within the above parameters or there are concerns about sedation level or overdose, a medical review must be requested and or specialist medical advice be sought

Signature of Prescriber
Date

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PORTSMOUTH HEALTHCARE NHS TRUST - SYRINGE DRIVER RECORD CHART.

NURSES: This chart must be completed on setting up the syringe driver and at least every shift change.

PATIENT NAME **NHS/HOSP NO.** **WARD/ADD RESS** **DATE**

PATIENT																							
Pain level																							
Sedation level																							
Respiratory rate																							
Infusion site																							
*PRN doses administered (mg)																							
SYRINGE DRIVER	**SYRINGE DRIVER MODEL =** **SERIAL NUMBER =**																						
Light flashing Yes or No																							
Rate set @ (state mm/24hr or 1hr)																							
millimetres of fluid remaining																							
Syringe secure Yes or No																							
Connections secure Yes or No																							
Clarity of fluid in syringe																							

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Signature of checking nurse																						

Pain level		
No pain		1
Acceptable pain		2
Unacceptable pain		3
if 3 take & record action		

Sedation level	
Awake	1
Dozing intermitently	2
Difficult to awaken	3
if 3 take & record action	

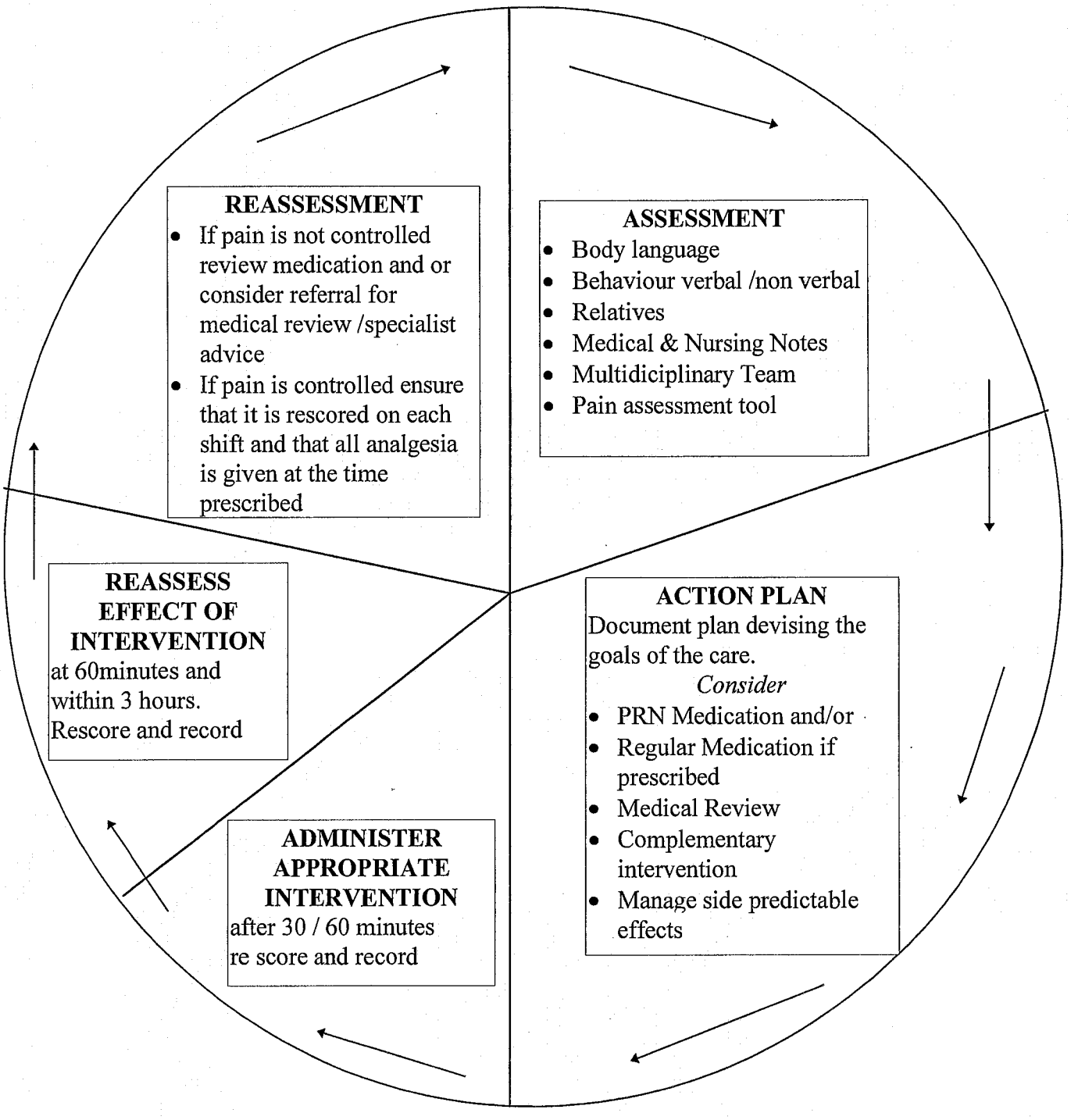
Respiratory rate		
9 - 24 / min		1
Less than 9 / min		2
More than 25 /min		3
if 2 or 3 enter on sheet		

All PRN doses given must

be recorded and signed for

Enter all concerns and action taken in progress sheet.

PAIN MANAGEMENT CYCLE



Nursing Standard: 1
Topic: Pain Management
Sub topic: Assessment

Standard Statement: The patient/client has an initial assessment of their pain

S1 A registered nurse or competent support worker in learning disabilities is identified as responsible for the patient/client on each shift	The identified nurse / competent support worker: Follows the pain assessment process of the pain management cycle and gathers information	O1 *The patients/client pain has been identified*
S2 Pain assessment method is agreed	P1 *Asks the patient/client about: Where the pain is: What it feels like; What increases it: What relieves it Observes for non verbal indicators Psychological and social state should be considered including anxiety, depression and patients/clients beliefs about pain*	*O2 Factors which influence the pain have been recognised*
S3 Documentation method is agreed	*P2 Record the results of the pain assessment on the agreed documentation*	*O3 The patient / client has*
	P3 Action plans as per pain management cycle Identifying the need for	*a) been given the prescribed PRN medication*
S4 Documentation is available : i.e. Medical, psychological and socio-economic histories	*a) prescribed PRN medication or*	*b) been referred to the relevant medical team*
	b) referral to the medical team or	
	c) alternate complementary intervention	

Audit form 1
Audit objective: to establish if the patient client has had an initial assessment made of the pain
Time frame: to be determined locally

Sample: representative number of both nurse and patients / clients
Auditors: to be determined locally
Date:

Target group	Code	Method	Audit Criteria
Nurse	*S1*	*Ask & check records*	*Is there a registered nurse / competent support worker (learning disabilities) identified as responsible for the patient/ client on each shift?*
	S2	*Ask & check records*	*Is there an agreed pain assessment method?*
	S3	*Ask & check records*	*Is there an agreed pain documentation method?*
Nurse	*P1*	*Ask & check records*	*Is the pain management cycle chart available?*
			If appropriate:
			a) have non verbal indicators been considered
			b) have psychological and social state been considered
			c) have relatives involvement been considered
	P2	*Check records*	*Is the pain assessment recorded on the agreed documentation?*
	O2	*Ask & check records*	*Is there evidence that factors influencing pain have been recognised?*
	O3	*Check records*	*a) Have any prescribed medication or complementary alternative been given?*
			b) Have any medical referrals been timely?

Nursing Standard: 2
Topic: Pain Management
Sub topic Action Plan

Standard Statement: An action plan is devised, using the information gained from the assessment which reflects effective management of the pain.

Structure	Process	Outcome
S1 A registered nurse will administer the patients /clients prescribed medication. In learning disabilities a registered nurse will authorise a competent support worker to administer the patients /clients prescribed medication the	*The identified nurse:* Follows The Pain Management Cycle Chart *P1 Monitors the effects of the prescribed medication 30 /60 minutes post administration. If good effect reassess at 60 minutes and within 3 hours*	*O1 The patient / client would communicate and / or show non verbal indications of a reduction in their pain* *O2 The patient / client would communicate and / or show non verbal indications of no reduction in their pain*
S2 Information regarding the WHO Analgesic Ladder is available *S3 Patients / clients start at the step of the WHO Analgesic Ladder appropriate for their severity of pain*	*P2 Ask patient / client about the effect observe for non verbal indicators*	
	P2 Record the medication effect after each reassessment in the patients / clients documentation *P3 Ensure that all prescribed analgesia is administered at the correct time* *P3 Identifies the patient / client who needs further medical review*	*O3 Records would show the effects of the prescribed and administered medication* *O4 The patient / client has been refereed to the relevant medical team for further review*

Audit form 4
Audit objective: to establish if the clinical team work ensuring that the organisation of staff is responsive to and meets the individual requirements of the patient / client in order to effective manage their pain
Time frame: to be determined locally
Sample: representative number of both nurse and patients / clients
Auditors: to be determined locally
Date:

Target group	Code	Method	Audit Criteria
All staff	*S1*	*Ask*	*Can each members of the multidisciplinary team explain their responsibility in relation to pain management?*
	S2	*Ask & observe*	*Are policies available for the administration of medicines, IV Therapy and assessment and management of pain?*
	S3 *P2* *O2*	*As, observe & check records*	*Is there a system in place to ensure staff have the required skill to undertake a pain assessment and ongoing pain management?*
	S4	*Ask, observe & check records*	*Is there a system in place to ensure staff implement the agreed pain assessment and documentation methods?*
	S5 *P4*	*Ask*	*Is there an established communication system for consultation / advice with specialist departments?* *Do staff know who to contact and how to implement the system?*
Nurse	*P1* *O1*	*Ask & check records*	*Is there evidence of regular review of the agreed pain assessment and documentation methods?*

Audit form 2
Audit objective: to establish if the patient / client has had an action plan devised
Time frame: to be determined locally
Sample: representative number of both nurse and patients / clients
Auditors: to be determined locally
Date:

Target group	Code	Method	Audit Criteria
Nurse	*S1*	*Ask & check records*	*Has a registered nurse or in learning disabilities competent support worker administered the patients / clients prescribed medication?*
	S2	*Ask & observe*	*Is there an WHO Analgesic Ladder available?*
	S3	*Ask & check records*	*Do patients / clients commence on the step of the Analgesic Ladder appropriate for their severity of pain?*
Nurse	*P1*	*Ask & check records*	*Is there evidence that the effects of the prescribed medication has been assessed 30 / 60 minutes and again within 3 hours post administration?*
	O3	*Check records*	*Has the effects of the prescribed medication been recorded on the agreed documentation?*
	O3	*Check records*	*Have referrals to relevant medical teams been timely?*

Nursing Standard 4
Topic: Pain Management
Sub topic Organisational Issues

Standard Statement: The clinical teams work towards ensuring that the organisation of staff is responsive to, and meets the individual requirements of, the patient / client in order to effective manage their pain.

Structure	Process	Outcome
S1 All staff understand their responsibilities in accordance to the policy for assessment and management of pain	*P1 The Clinical Area / House Manager meets with the clinical team initially to agree the local pain assessment and documentation methods then meets on a regular review basis*	*O1 Recorded agreed local Pain Assessment and Pain Documentation methods.*
S2 Policies are available for the administration of medicines and for IV Therapy	*P2 The Clinical Area / House Manager and individual practitioners should ensure they have the required skills to undertake a pain assessment and for the effective ongoing management.*	*O2 Evidenced competence of all appropriate team members*
S3 Systems are in place to ensure that nursing staff have the required skill to undertake a pain assessment and for effective ongoing pain management.	*P3 The clinical team follow the pain management cycle chart and are guided by using the WHO Analgesic Ladder*	
S4 Systems are in place to ensure a local agreed pain assessment method and documentation method is implemented.	*P4 The clinical team have a working knowledge of the communication systems established with other specialist departments*	
S5 Communication systems are established for consultation with other specialist departments.		

Nursing Standard 3
Topic: Pain Management
Sub Topic: Care Issues

Standard Statement: A plan of care is devised which meets the individual requirements of the patient /client in order to effective manage their pain.

Structure	Process	Outcome
S1 Information is available about *a) the patients / clients health status* *b) the pain assessment (NB Standard 1)* *c) the action plan (NB Standard 2)* *S2 The patient / client where ever possible should be given information about the pain management and be encouraged to take an active role in their pain management* *S3 Communication systems with family and friends are in place where relevant*	*P1 The registered nurse with the patient / client or relevant others devise a plan of care which:* *P2 Incorporates information from the initial assessment* *P3 Incorporates information from other members of the multidisciplinary team* *P4 Defines the goals of the care* *P5 Patients / clients receiving an opioid should have possible side effects managed effectively.* *a) Constipation:* *access to regular prophylactic laxatives* *b) Nausea & vomiting:* *assess need for a short term antiemetic.* *c) Sedation:* *d) Dry Mouth :* *Good oral hygiene*	*O1 The patient /client receives the planned care.* *O2 The care plan is evaluated regularly as specified within it.* *O3 Evidence where possible of patient / client participation in their pain management*

Audit form 3
Audit objective: to establish if a plan of care is devised which meets the individuals requirements of the patient / client
Time frame: to be determined locally
Sample: representative number of both nurse and patients / clients
Auditors: to be determined locally
Date:

Target group	Code	Method	Audit Criteria
Nurse	*S1*	*Ask & observe*	*Is information available about:* *a) health status* *b) pain assessment* *c) an action plan*
	S2	*Ask & observe*	*Where ever possible has the patient / client been encouraged to take an active role in their pain management?*
	S3	*Ask & observe*	*Is there an established system for communicating with family and friends of the patient / client?*
	P1	*Ask, observe & check records*	*a) Is there a plan of care for the patient / client?* *b) Has it been devised by the nurse with the patient / client or relevant others?* *Does it: Incorporate information from the initial assessment?*
	P2		*Incorporate information from members of the multidisciplinary team?*
	P3		*Defines the goals of the care?*
	P4		*If the patient / client is receiving an opioid have predictable side effects*
	P5		*been considered and managed accordingly?*
Nurse / Patient /Client	*O1*	*Ask & check records*	*Has the patients / clients received the planned care and participated in their pain management?*