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 multi-professional 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

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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 resource 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 multi-professional 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
- Complete the pain and controlled drugs monitoring chart (mandatory for in-patients, optional use in a primary care setting)
- Complete the syringe driver record chart (where a syringe driver is being used in a hospital setting) (appendix A) and/or ask the patient to complete a personal pain diary (patient in the community). N.B. It would also be good practice to encourage use of a personal pain diary in a hospital setting, (where the patient is capable of completing it).

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

- There must be a record of prescribing/authorisation to administer all drugs (in secondary care, this is the prescription chart; in primary care settings this is the "record of administration of drugs prescribed by a doctor"
- If the prescription state)s 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 be 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.
- Pain and controlled drugs monitoring chart (mandatory in hospital, optional for primary care setting).

This policy is supported by the following documents

- **Syringe driver record chart/good practice information**
- **Record of authorisation for nurses to administer prescription only drugs prescribed by a doctor or nurse prescriber (primary care setting only)**
- **Record of authorisation for nurses to administer drugs (including controlled drugs) via a syringe driver (primary care setting only)**
- **Personal pain diary**
- **MS26 syringe driver in palliative care**
- **Pain assessment, rationale for analgesia and pain monitoring chart**

Distribution:

Policies to be distributed to all PCT Premises and Corporate Policy Holders

Policy produced by: Joint PCTs Medicines and Prescribing Committee District PCTs

Accountable Director:

Approval Process:

Date Approved:

Adopted by Trust Board:

Date of Next Review: April 2004

Good Practice Information

This information relates to the use of Syringe Drivers and accompanying Record Chart

Please keep these guidelines with the, "Medicines Policy" and the "Policy for Assessment and Management of Pain".
Any nurse who sets up a syringe driver should do so in accordance with the Nursing and Midwifery Council's (NMC), 'Code of professional conduct'. Particular attention should be paid to sections 3/4/6/8.

- Section 3...you must obtain consent before you give any treatment or care.
- Section 4...you must co-operate with others in the team.
- Section 6...you must maintain your professional knowledge and competence.
- Section 8...you must act to identify and minimize the risk to patients and clients.

NMC June 2002

Relating to the Syringe Driver

1. Consider whether the use of a syringe driver is the best option. (See "Guidelines for use of Medication for Symptom Control in Palliative Care").

2. Ensure there is communication with patient and/or carers, depending on individual need and choice, giving an explanation of why a syringe driver is recommended and what drugs will be administered. The conversation should be recorded in the patient's care plan in their records.

3. Ensure the prescription is valid, legible, signed and dated.

4. Gain consent of the patient if they are able to make an informed decision and document in the care plan in the patient's records.

5. Ensure each syringe is labeled stating the medication it contains

6. Check diluents and compatibility (if in doubt, contact pharmacist)

7. It is preferable to use a luer lock syringe with a driver.

Relating to Record Chart

8. Use one record chart per syringe driver.

9. Use record chart in conjunction with an agreed care plan.

10. The nurse should review the patient on a regular basis with regard to pain control and sedation levels until agreed goals have been achieved. Thereafter, review as to the needs of the patient but at least at every drug round.

11. If concerns are registered on the chart, action must be taken according to the patient's individual needs and documented in nursing care plan in the patient's records.

12. On completion, the record should be filed with the prescription chart in the patient's records.

Please use this chart in conjunction with guidelines. **SYRINGE DRIVER CLINICAL RECORD CHART**
Nurses review Patient until agreed goals have been achieved. Thereafter as per needs of patient or at least on every drug round

NAME | **HOSP NO** | **WARD** | **DATE**

START TIME																		
PATIENT																		
Pain level																		
Sedation level																		
Respiratory rate																		
Infusion site																		
PRN dose administered (mg)																		
SYRINGE DRIVER	**SYRINGE DRIVER MODEL**								**SERIAL NUMBER**									
Light flashing Yes/No																		
Rate set @ (state mm/24hr)																		
Millilitres of fluid remaining																		
Syringe secure Yes or No																		
Connections secure Yes or No																		
Is fluid clear Yes or No																		
Signature of checking Nurse																		

NAME OF DRUGS	

PAIN LEVEL	
No Pain	1
Acceptable Pain	2
Unacceptable Pain	3
If 3 record action	

SEDATION LEVEL	
Awake	1
Dozing Intermittently	2
Difficult to waken	3
If 3 record action	

RESPIRATORY RATE	
9 to 24 a min	1
Less than 9 a min	2
More than 25 a min	3
If 2 / 3 record action	

Enter all concerns and action taken in nursing notes

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Record of Authorisation for Nurses to administer Prescription Only Drugs prescribed by A Doctor or Nurse Prescriber (Primary Care Setting Only)

Patients Name .....

Address .....

.....

Doctor .....

Sister .....

Centre .....

Date Prescribed	Drug	Route	Dose	Frequency	Prescribers Signature

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Record of Authorisation for Nurses to administer Drugs (including controlled drugs) via a Syringe Driver (Primary Care Setting Only)

Patients Name ..... **Doctor** .....

Address ..... **Sister** .....

..... **Centre** .....

Date Prescribed	Drug	Initial Prescribed Dose over 24 hours	Stat. Dose which may be given s/c if breakthrough pain occurs*	Amount by which dose in syringe driver may be increased at each review by nurse before referral to prescriber**	Maximum total dose (daily and stat doses)	Prescribers Signature
30/08/03	Diamorphine	20mg	5mg	5mg	40mg	

* A pain assessment should be undertaken and documented prior to administration of stat doses of analgesics

**The dose of analgesic given via a syringe driver should only be increased after careful documented pain assessment taking into account the administration of stat doses in the preceding 24 hours.

CYCLIZINE	Nausea / vomiting caused by: Mechanical bowel obstruction Raised intracranial pressure Motion sickness	100 - 150 mg / 24 hr	Possible drowsiness Dry mouth Constipation Blurred vision Often causes site irritation
METOCLOPRAMIDE	Nausea / vomiting caused by: Gastric irritation Gastric stasis Functional bowel obstruction (no colic present)	30 - 100 mg / 24 hr	Occasional drowsiness / restlessness Diarrhoea Colic Extra Pyramidal effects may occur at higher doses
LEVOMEPROMAZINE	Broad spectrum antiemetic, if first line antiemetics listed above are inadequate Terminal agitation	6.25 - 12.5 mg / 24 hr 50 - 75 mg / 24 hr (max 300 mg / 24 hr)	Sedating Dose dependant postural hypotension Skin irritation
HALOPERIDOL	Chemical causes of vomiting, e.g. Morphine, hypercalcaemia, renal failure Terminal delerium	5 - 10 mg / 24 hr (maybe start at 2.5 mg for elderly) 20 - 30 mg / 24 hr	Drowsiness Dry mouth Constipation Blurred vision
MIDAZOLAM	Anxiety Agitation Myoclonic jerks Anticonvulsant Need for sedation	10 - 60 mg / 24 hr	Drowsiness
HYOSCINE BUTYLBROMIDE (BUSCOPAN)	Bowel colic Need to reduce gut secretions Death rattle	60 - 120 mg / 24 hr 20 - 40 mg / 24 hr	Dry mouth
HYOSCINE HYDROBROMIDE	As above Also nausea and vomiting	0.8 - 2.4 mg / 24 hr	May cause agitation or confusion (e.g. in Elderly) More sedating than butylbromide
GLYCOPYRRONIUM	Respiratory secretions when sedation not required Cheaper than hyoscine	200 - 600 mcg / 24 hr	Precipitates with dexamethasone
DRUGS TO USE FOLLOWING SPECIALIST ADVICE	NSAID's Voltorol Ketamine Octreotide		

SOME DRUGS, e.g. CHLORPROMAZINE, PROCHLORPERAZINE AND DIAZEPAM ARE IRRITANTS AND SHOULD NOT BE GIVEN SUBCUTANEOUSLY.

DILUENTS

Use water for injection or normal saline to make up volume. The drugs in this leaflet have been shown to be compatible and remain active in solution over several days.

SITES

Upper chest
Upper back
Upper arm
Abdomen
Thighs

Areas to avoid

Lympoedematous limb
Broken skin
Near a joint
Upper arm if patient in bed and requires turning
Site over boney prominence
Previously irritated skin
In the abdomen if ascites present

ROUTINE OBSERVATIONS

A nurse or carer should examine the syringe driver daily to check that it is working satisfactorily.

The injection site should also be inspected. Discomfort, redness or swelling indicate a local reaction and irritation, in which case the needle should be re-sited and the drugs used reviewed. Skin reactions may more often occur when using cyclizine or levomepromazine.

Local reactions vary - in different patients a site may be used for 1 - 10 days.

BATTERY LIFE

A new battery should deliver fifty full syringes. The indicator light will stop flashing if the battery needs changing, but the pump will continue to operate for 24 hours.

ALARM SYSTEM

The audible alarm system will sound if the pump stops for any reason. This may mean that the syringe plunger has come to the end of its travel, or has jammed.

THE SYRINGE DRIVER
EQUIPMENT USED

A GRASEBY MEDICAL SYRINGE DRIVER type MS26, butterfly needle infusion set - 25 90 cm microbore; syringe 20, 30, or 50 ml and transparent dressing.

SETTING UP THE SYRINGE DRIVER

1. Insert battery - longlife, 9v, alkaline duracell.

   An alarm will sound for a few seconds to show that there is battery power. It can be silenced by pressing the start / test button.

   Press button again to start motor - the pump is then on and the indicator light will start flashing.

2. Select a syringe of a suitable size - usually 20ml, or 30ml - 20ml used normally.

   Draw up the quantity of drugs prescribed - dilute with water for injection to a useful length of liquid in the barrel of the syringe (e.g. 48 mm).

3. Set the rate to give the required amount per day to use the known length in the time specified.

   The pump acts by delivering a set length of liquid in pulses at a regular rate. So it is the LENGTH of fluid in the syringe not the volume that is the important measurement. There is a measuring scale on the machine.

   MS26 measures rate in DAYS

   $$\text{RATE} = \frac{\text{Length of Liquid (MS26)}}{\text{Time in days}}$$

4. Check measurement of fluid EVERY time syringe is changed (as syringe barrel sizes may vary), adjust rate accordingly.

YOUR DIARY

Date	What sort of day have you had? How much extra pain relief did you need? Did you have any side effects? Questions to ask the doctor or nurse	Pain rating score for the day 0 - 10

You have a right to have your pain believed and relieved

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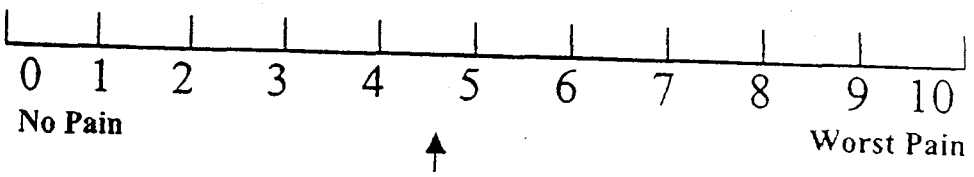
YOUR DIARY



Use this scale to help you describe your pain each day

Date	What sort of day have you had? How much extra pain relief did you need? Did you have any side effects? Questions to ask the doctor or nurse	Pain rating score for the day 0 - 10
e.g. 3/5/00	Severe pain when I woke up. Took 1 extra	7/10

The syringe driver is useful for symptom control when other methods of administration are inappropriate:-

Oral route inappropriate:
- Dysphagia
- Severe nausea to vomiting
- Severe oral tumours, sores, or infection
- Poor absorption of oral medication
- Profoundly weak, unconscious, or heavily sedated patients
- When taking oral medication becomes too difficult

Rectal route inappropriate:
- Diarrhoea
- Constipation
- Rectal tumour disease
- Patient preference

N.B. A syringe driver should not be used simply to increase analgesia - only use when above applies.

DRUGS USEFUL IN THE SYRINGE DRIVER
ANALGESIC

DIAMORPHINE - This is the best analgesic. It is much more soluble than Morphine.

The dose of diamorphine to be given by subcutaneous infusion via the syringe driver in 24 hours is calculated as follows:

If the patient is on oral morphine, use ONE THIRD OF TOTAL oral dose given in previous 24 hours (slow release + breakthrough doses).

E.g. Total daily dose of morphine = 120 mg
Total daily syringe driver dose of diamorphine = 40 mg

N.B. If fentabyl patch in situ, analgesia may well not be required in the syringe driver.

If pain not controlled seek specialist advice.
Failure to deliver the infusion may result from kinked tubing, a dirty screw lead, or a deficient injection site.

START BOOST BUTTON

This present on type MS26. When pressed it delivers a minute amount of infusion fluid (0.23 mm) and is therefore not going to achieve any *significant effect in symptom* control. Research is now showing this practice to cause pain at the needle site, so should not be done.

REFERENCES

Evans. N, Palmer. A. **Controlling breakthrough pain in palliative care,** (1998) *Nursing Standard*, 13,7,53-54

Wilson. V, Guidelines for the use of MS26 daily rate syringe driver in the community *British Journal Community Nursing* 2000. Vol5, No.4. 162-168

Full instructions are given in a leaflet supplied by GRASEBY MEDICAL LTD, Colonial Way, Watford, WD2 4LC. Tel: 01923-246434.

Cautionary Note: Some of the drug usage recommended is outside product licence, either by way of indication, dose, or route of administration. However, the approaches described are recognised as reasonable practice within Palliative Medicine in the UK.

Named Resource Nurse

For specialist advice contact:

In hospital	Hospital Palliative Care Team 023 9228 6904
In community	Community Palliative Care Team 023 9225 0001

Office hours Monday – Friday
9.00 a.m. – 5.00 p.m.

Out of office hours/weekends

The Rowans
Purbrook Heath Road
Purbrook, Waterlooville
Hants. PO7 5RU

023 9225 0001

NHS

THE MS26 SYRINGE DRIVER IN PALLIATIVE CARE

If you are unsure that this leaflet relates to the syringe driver you are planning to use please contact your Senior Nurse/Nurse Manager

Produced by
The Palliative Care Team

QUESTIONS ABOUT YOUR PAIN

Maybe some of the words listed below describe your pain.

Circle as many as you need:

Dull Ache	Tingling	Crushing
Nagging	Shooting	Pulsing
Stabbing	Sharp	Gnawing
Burning	Stinging	Cramping

These words might help explain the kind of pain you are having. Sometimes, this helps in choosing the best treatment.

YOUR DIARY

Date	Time	Drug	Dose of Medication taken for breakthrough pain

YOUR DIARY

Date	Time	Drug	Dose of Medication taken for breakthrough pain

You have a right to have your pain believed and relieved

QUESTIONS ABOUT YOUR PAIN

What makes your pain better? ☑

Cold	☐	Heat	☐	Exercise	☐
Resting	☐	Massage	☐	Painkillers	☐
Exercise	☐	Eating	☐	Alcohol	☐
Complementary Therapies			☐	Music	☐
Rubbing sore area			☐	TV	☐
Moving about			☐		

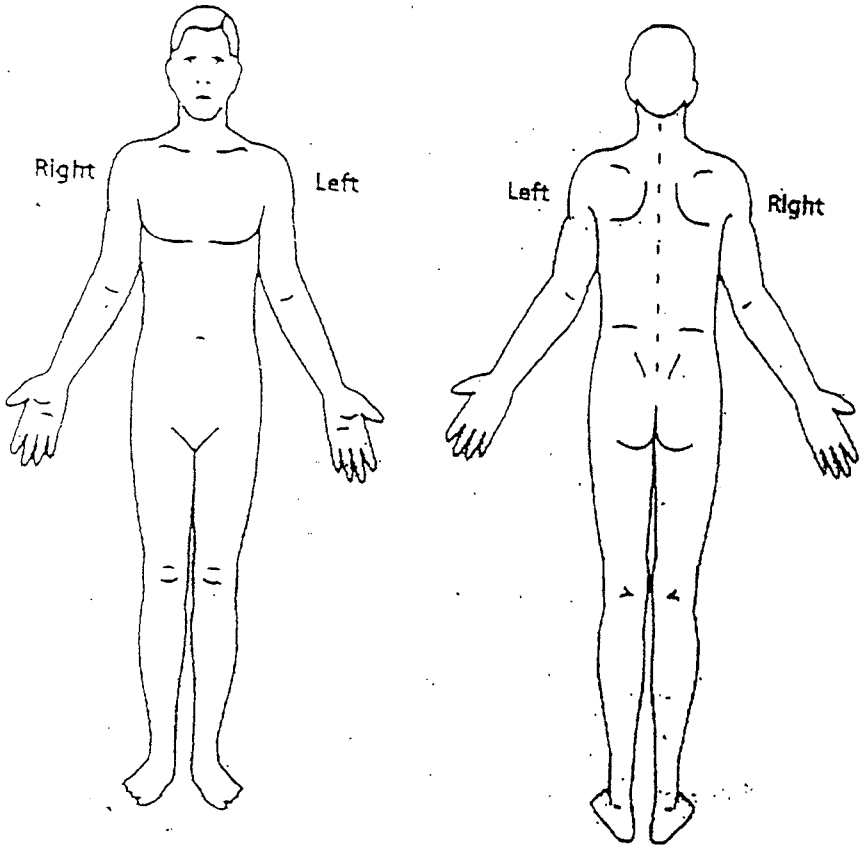
Think about how your pain makes you feel, when you fill in the diary.

- Does the pain disturb your sleep?
- How is your appetite?
- What other problems are troubling you? (e.g. nausea, constipation).
- When do you have pain? (e.g. at rest or just when you move?)
- What does your pain feel like? (sharp, aching, numb)
- What does your pain stop you from doing?
- Why do you think you have the pain?
- What makes your pain worst?

QUESTIONS ABOUT YOUR PAIN

Where does it hurt?

✏ Draw on the picture to show where your worst pain is:



YOUR DIARY

Date	Time	Drug	Dose of Medication taken for breakthrough pain

You have a right to have your pain believed and relieved

Personal Pain Diary

Your Name:

.....

Name of your Clinical Nurse Specialist:

.....

Draft copy for Pilot study

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 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).

STEP 2
MODERATE PAIN

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

1. Codeine 30mg with paracetamol 500mg (co-codamol 30/500) 1-2 qds.
2. Dextropropoxyphene 32.5mg with Paracetamol 325mg (coproxamol) 1-2 qds.
3. Other drugs in this group include Dihydrocodeine and Tamadol (in secondary care Tramadol can only be prescribed by a consultant).

STEP 3
SEVERE PAIN

- Strong opioid
- +/- Non opioid
- +/- Adjuvant

1. Oral morphine/oramorph 2.5-5mgs 4 hourly, if not on regular mild or moderate analgesia. (Note: see pain guidelines)
2. To calculate Opiate dose, if pain occurs before 4 hrs, give an extra 4 hourly dose form pm column. Review and reassess daily. Add any PRN doses to regular prescription. Divide 24 hr total by 6 to give 4 hrly dose.
3. When stable, convert to Morphine Sulphate sustained release 12 hrly (Zomorph MST).
4. Other strong opioids: Oxycodone, Methadone and Fentanyl (Fentanyl patches only in palliative care,
5. If patient is dysphagic, vomiting, or unconscious give sc Diamorphine via syringe driver at 1/3 of 24hr total Morphine dose

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 the 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.

If the patient is cognitively impaired:

- Consider involving close relatives for their views
- Look for non-verbal signs of distress i.e. grimacing, moaning, rigidity, guarding and resisting nursing intervention.

Care Assessment and Monitoring (Date of Assessment.....)

Description of Pain: i.e. throbbing: stabbing: constant, gnawing?

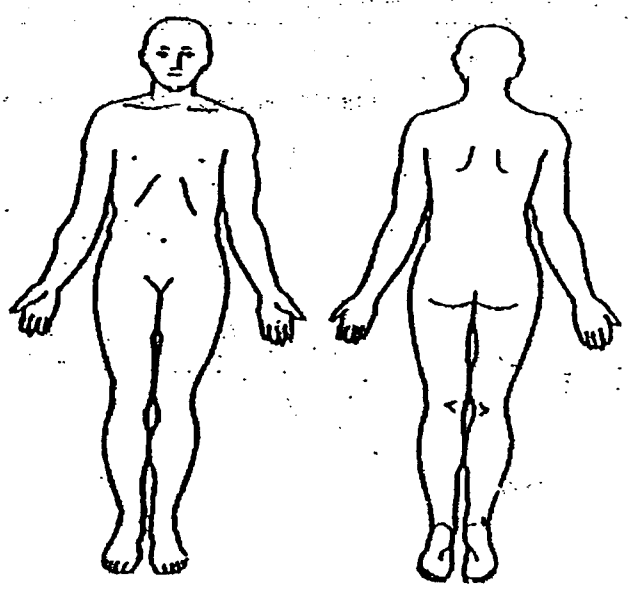
What appears to make the pain better or worse i.e. position, heat/cold etc?

Add history of any previous analgesia/pain management intervention (if none please state none).

What number best describes the severity of the pain (record this on pain monitoring chart)

No pain at all	1	A little pain	2	Quite a lot of pain	3	A very bad pain	4

Indicate sites of pain on chart opposite using letters A, B, C, D etc depending on number of pain sites.



Example of how this would be recorded on the pain monitoring chart:

TIME / DATE	site	severity Code	Signature
14.00 10/4/89	A	4	
14.00 10/4/03	B	2	

Action taken to relieve pain (Date.....)

Pain Monitoring Chart

Date / Time	Site	Severity Code	Signature	Comments on plan of care and any changes made to analgesia/treatment of pain

Please Note: Any new change in medication should be assessed ½ hourly until patients pain is at a satisfactory level.

Pain Monitoring Chart: continuation

Date / Time	Site	Severity Code	Signature	Comments on plan of care and any changes made to analgesia/treatment of pain

Note: A record of any relevant conversations with patient or relatives regarding management of pain should be recorded in either the medical or nursing notes. Please use the comments box below to bullet point who conducted the conversation and where recorded.

Date	Give brief account of when conversation took place and by whom:	where recorded	Sign