Pain Management Level 1
(Pain Assessment)

Patients have rated
Liverpool Heart and Chest Hospital
the **top** performing hospital
in the country for
Overall Patient Care

No.1
in England for
Overall Patient Care

Includes the following elements

- ➢ **Patients previous history**

- ➢ **Physical assessment**

- ➢ **Psychological assessment**

- ➢ **Social circumstance**

- ➢ **Current analgesia**

- ➢ **Intensity of Pain**

- ➢ **Potential new problem**

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- ➢ Site of pain
- ➢ Duration
- ➢ Initial precipitating event
- ➢ Radiation
- ➢ Character / description
- ➢ Pattern
- ➢ Rest / movement
- ➢ Sleep disturbance
- ➢ Exacerbation and relieving factors
- ➢ Previous and current medication
- ➢ Patients understanding
- ➢ Physical
- ➢ Psychological / social issues

- **Numerical Rating Scale**

0   1   2   3   4   5   6   7   8   9   10

No pain   **Worst pain imaginable**

Patient to indicate score
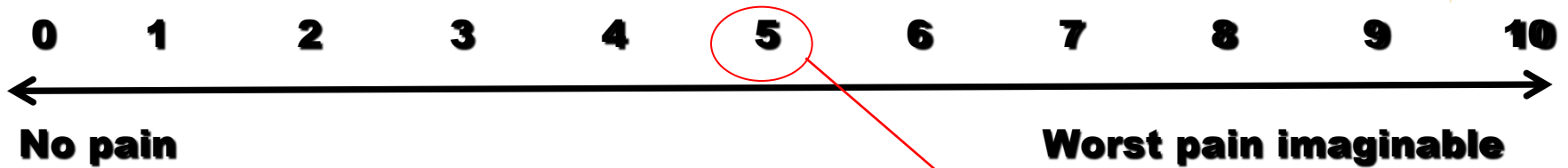
- **Visual Analogue Scale**

X

X **Extreme Pain**
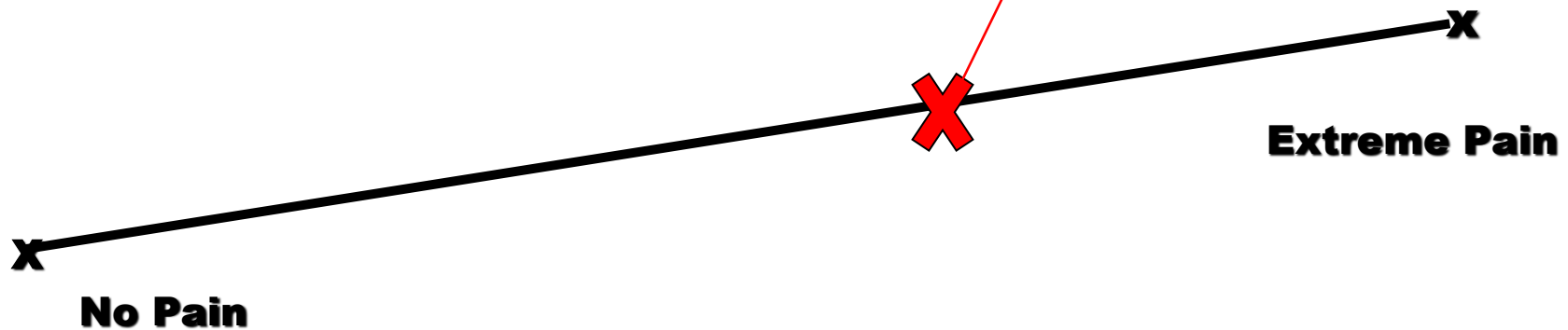
No Pain

Visual analogue is usually used for research; based on 0-100 measured on 100mm line. (measurement not visible to patient)

Categorical Rating Scale:-

0 - No pain

1 - No pain at rest, mild pain on movement.

2 - Intermediate pain at rest, moderate pain on movement.

3 - Continuous pain at rest, severe pain on movement

MODERATE

UNIVERSAL PAIN ASSESSMENT TOOL

This pain assessment tool is intended to help patient care providers assess pain according to individual patient needs. Explain and use 0-10 Scale for patient self-assessment. Use the faces or behavioral observations to interpret expressed pain when patient cannot communicate his/her pain intensity.

	0	1	2	3	4	5	6	7	8	9	10
Verbal Descriptor Scale	NO PAIN		MILD PAIN		MODERATE PAIN		MODERATE PAIN		SEVERE PAIN		WORST PAIN POSSIBLE
WONG-BAKER FACIAL GRIMACE SCALE	Alert Smiling		No humor serious flat		Furrowed brow pursed lips breath holding		Wrinkled nose raised upper lips rapid breathing		Slow blink open mouth		Eyes closed moaning crying
ACTIVITY TOLERANCE SCALE	NO PAIN		CAN BE IGNORED		INTERFERES WITH TASKS		INTERFERES WITH CONCENTRATION		INTERFERES WITH BASIC NEEDS		BEDREST REQUIRED
SPANISH	NADA DE DOLOR		UNPOQUITO DE DOLOR		UN DOLOR LEVE		DOLOR FUERTE		DOLOR DEMASIADO FUERTE		UN DOLOR INSOPORTABLE
TAGALOG	Walang Sakit		Konting Sakit		Katamtamang Sakit		Matinding Sakit		Pinaka-Matinding Sakit		Pinaka-Malalang Sakit
CHINESE	不痛		輕微		中度		嚴重		非常嚴重		最嚴重
KOREAN	통증 없음		약한 통증		보통 통증		심한 통증		아주 심한 통증		최악의 통증
PERSIAN (FARSI)	بدون درد		درد ملایم		درد معتدل		درد شدید		درد بسیار شدید		بدترین درد ممکن
VIETNAMESE	Không Đau		Đau Nhẹ		Đau Vừa Phải		Đau Nặng		Đau Thật Nặng		Đau Đớn Tận Cùng
JAPANESE	痛みがない		少し痛い		いくらか痛い		かなり痛い		ひどく痛い		ものすごく痛い

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	SCORE AT REST / ON MOVEMENT
0	no pain at rest
	no pain on movement
1	mild pain at rest
	mild pain on movement
2	intermittent pain at rest
	moderate pain on movement
3	continuous pain at rest
	severe pain on movement

EPR Flow sheet assessment tool

In patients that are able to verbalise their pain score this is the preferred assessment tool to use in our trust.

For measurement of pain in patients who cannot verbalise

How to use scale: While observing the patient, score questions 1 to 6.

Name of patient:..

Name and designation of person completing the scale:.................................

Date: .... Time:.......................................

Latest pain relief given was .... at ....hrs.

Q1. Vocalisation
eg whimpering, groaning, crying
Absent 0 Mild 1 Moderate 2 Severe 3 ☐

Q2. Facial expression
eg looking tense, frowning, grimacing, looking frightened
Absent 0 Mild 1 Moderate 2 Severe 3 ☐

Q3. Change in body language
eg fidgeting, rocking, guarding part of body, withdrawn
Absent 0 Mild 1 Moderate 2 Severe 3 ☐

Q4. Behavioural change
eg increased confusion, refusing to eat, alteration in usual patterns
Absent 0 Mild 1 Moderate 2 Severe 3 ☐

Q5. Physiological change
eg temperature, pulse or blood pressure outside normal limits,perspiring,flushing or pallor
Absent 0 Mild 1 Moderate 2 Severe 3 ☐

Q6. Physical changes
eg skin tears, pressure areas, arthritis, contractures, previous injuries
Absent 0 Mild 1 Moderate 2 Severe 3 ☐

Add scores for Q1 to Q6 and record here Total pain score ☐

Now tick the box that matches the total pain score	0-2 no pain	3-7 mild	8-13 moderate	14+ severe

Finally, tick the box which matches the type of pain	chronic	acute	acute on chronic

Abbey pain scale to be used for patients who cannot verbalise or are unable to use a visual pain tool.
for example;
 Dementia
 Confusion
 Intubated patients

+ Adjuvant

NSAIDs (non-steriodal anti-inflammatory drugs)

Ketorolac IV (in theatre)

Ibuprofen oral

Local anaesthetic

lidocaine patch

single shot paravertebral injection

Wound infiltration

Intercostal blocks

Neuropathic agents

Gabapentin

Ketamine

IV Infusion on POCCU/THDU only

Oral surgical wards

Paracetamol

Epidural (Fentanyl & Levobupivacaine)

OR

PCA/IV Morphine

+ or -paravertebral infusion

OR Oxycodone

+ Paracetamol

Dihydrocodeine

Codeine Phosphate

+ Paracetamol

Mild

1

Moderate

2

Severe

3

PAIN

Multimodal or "Balanced" Analgesia

> This approach simultaneously administers two or more analgesic agents with different modes of action.

➢ This will act more efficiently leading to a reduction in pain

➢ Can reduce side effects for example; Codeine causes constipation and nausea

> Combining paracetamol and codeine can reduce the amount of codeine required and therefore should reduce the side effects experienced.

> Examples of a multimodal regime

> Arthritic pain- paracetamol, codeine and ibuprofen

> Post operative pain- Paracetamol, PCA morphine and gabapentin

Analgesic Groups

Paracetamol (oral, IV or PR)

Opioids

Morphine (Mst and oramorph)

Codeine

Dihydrocodeine

Tramadol

Diamorphine

Oxycodone (oxycodone MR and oxycodone immediate release)

NSAIDs (non-steriodal anti-inflammatory drugs)

Ketorolac IV (in theatre)

Ibuprofen

Diclofenac

Naproxen

Local anaesthetic

lidocaine patch

Paravertebral Infusion

Single shot paravertebral injection

Wound infiltration

Intercostal blocks

Neuropathic agents

Gabapentin

Pregabalin

Amitriptyline

Ketamine (anaesthetic in small doses produces analgesic effect)

Points to Remember

➢ Assess pain regularly

➢ Use the right pain assessment tool

➢ Reassess effectiveness of analgesia

➢ Give regular analgesics

➢ Use a multimodal approach

➢ As a rule you would only use one drug from each group

➢ Seek advise of medical or Acute pain team