Site educators will need to add slides concerning the drugs that are approved to give under standing orders at their site
Learning Outcomes

The aim of this presentation is to:

• Provide an understanding of pain assessment and the physiological and behavioural indicators related to pain and pain assessment

• Emphasise the importance of providing early assessment of pain and appropriate pain relief strategies

• Provide the emergency nurse with an overview of commonly used pharmacological agents used in the treatment of pain and other presenting problems.
Advise the participants of the local requirements.

**Assessment Methods**

To obtain authorisation to initiate pharmacological standing orders the participant must complete the following educational components:

- Complete the self directed learning package
- Complete all the learning activities in the student guide
- Complete the multiple choice / short answer exam and obtain an 80% pass mark
- Meet the `Local” requirements set out by the ED managers and Drug Committee
Background

- Pain is the most common symptom reported by patients who present to the ED, more than 60% of patients report pain on arrival to the ED.
- Many of these patients will also self-medicate for pain before arriving.
- Early assessment of pain and timely access to analgesia should be one of the major objectives to good emergency care.
- A primary goal for the emergency nurse should aim to reduce the time patients wait in pain through the provision of early analgesia and reassurance.
Definition of Pain

• “An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.
• The experience of pain is subjective and personalised for each individual.
• Poorly recognised, poorly assessed and inappropriately treated.
• Pain is whatever the experiencing person says it is and it is as severe as the patient reports.
• Often cannot be fully communicated to others.
• Inability to communicate verbally does not negate the possibility that the person is in pain and requires suitable pain relieving treatment.
Pain Assessment

- The assessment and measurement of pain are fundamental to the process of assisting in the:
  - diagnosis of the cause of a patient’s pain
  - selecting an appropriate analgesic therapy
  - evaluating then modifying that therapy

- The assessment of acute pain should include:
  - thorough general medical history
  - physical examination
  - specific ‘pain history’

- Historically, patients attending emergency departments have had a poor assessment of their pain needs and suffered delayed administration of appropriate analgesia.
## Pain History

<table>
<thead>
<tr>
<th>P</th>
<th>Provoked</th>
<th>What provoked the pain and what makes it worse? Did the pain occur during exercise or at rest (unprovoked)? Does anything change the intensity of the pain i.e deep inspiration or movement?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q</td>
<td>Quality</td>
<td>How does the patient describe the pain? i.e sharp, dull, crushing, burning, shooting, cramping.</td>
</tr>
<tr>
<td>R</td>
<td>Region, Radiation, Relief</td>
<td>Ask the patient to describe the region affected by the pain and what makes it better or worse? i.e body posture, prescription or over the counter medications.</td>
</tr>
<tr>
<td>S</td>
<td>Severity</td>
<td>Ask patient to rate their pain on a validated pain scale</td>
</tr>
<tr>
<td>T</td>
<td>Time of Onset &amp; Duration</td>
<td>Ask the patient when the pain commenced and how long it has been there for? Is the pain constant or coming and going? Patients may also have self administered analgesics or received analgesia from paramedics. Drug, dose and time of last administration are important.</td>
</tr>
</tbody>
</table>
Pain Measurement

- Pain is an individual and subjective experience modulated by physiological, psychological and environmental factors such as previous events, culture, prognosis, coping strategies, fear and anxiety.

- Most measures of pain are based on self-report, in some instances it may not always be possible to obtain reliable self-reports of pain. Examples of patients in whom this may occur include:
  - Impaired consciousness
  - Cognitive impairment
  - Young children and the elderly
  - Language difficulties
  - Inability to understand the measures
  - Unwillingness to cooperate
  - Severe anxiety
Pain Measurement

• When assessing a patient’s pain it is not up to the patient to ‘prove’ they have pain before it is considered real to the treating nurse.

• In assessing a child’s pain, a measuring tool must take into account a child’s age, cognitive level, type of pain, and the situation in which the pain is occurring.

• No single measure is useful for all children with all types of pain, whether it be acute, chronic, or recurrent.

• All patients (where possible) presenting in acute pain should have an allocated pain score.

  o Mild Pain    < 5
  o Moderate Pain 5-7
  o Severe Pain  > 5
### Pain Scales

**Children > 8 yrs & Adults**
- Numerical Rating Scale (NRS)
- Visual Analogue Scale (VAS)
- Verbal Numerical Rating Scales (VNRS)

**Elderly or Confused Patient**
- Abbey Pain Scale (APS)

**Paediatrics 3-8 Yrs**
- Wong-Baker FACES Rating Scale
- Faces Pain Scale-Revised

**Neonates & Paediatrics < 2 yrs**
- FLACC Behavioural Pain Scale
Numerical Pain Scales

- Numerical rating scales have both written and verbal forms.
- Patients rate their pain intensity on the scale of 0 to 10 where 0 represents ‘no pain’ and 10 represents ‘worst pain imaginable’, or their degree of pain relief from 0 representing ‘no relief’ to 10 representing ‘complete relief’.
Visual Analogue Scales

- Visual Analogue Scales (VAS) consists of a 100 mm horizontal line with verbal anchors at both ends and no tick marks.

- The patient is asked to mark the line and the ‘score’ is the distance in millimeters from the left side of the scale to the mark.

- VAS ratings of greater than 70mm are indicative of ‘severe pain’ and 0-5mm ‘no pain’, 5–44 mm ‘mild pain’ and 45–74 ‘moderate pain’

| No pain (0) | (from 0 to 100) | Unbearable pain (100) |
Wong & Baker Pain Scale

- The Wong-Baker Faces Pain Scale is recommended for children as young as 3-8 years and consists of six cartoon faces ranging from a smiling face for ‘no pain’ to a tearful face for ‘worst pain’.

0: NO HURT
1: HURTS A LITTLE BIT
2: HURTS A LITTLE MORE
3: HURTS EVEN MORE
4: HURTS A WHOLE LOT
5: HURTS WORST
Faces Pain Scale – Revised

• The Faces Pain Scale - Revised (FPS-R) was adapted from the Faces Pain Scale in order to make it possible to score on the widely accepted 0-to-10 metric.

• It shows a close linear relationship with visual analogue pain scales across the age range 4 through 12 years.

• It is easy to administer the absence of smiles and tears in this faces scale may be advantageous in such cultures where these expressions are less acceptable or honorable.
FLACC Behavioural Pain Scale

- When children cannot speak or comprehend and use self-report pain measurement tools, behaviour is the primary means by which they communicate their pain.

- Distress behaviours such as crying, facial grimaces, body posture, rigidity, changes in sleep, and consolability have been associated with pain in young children.

- The FLACC Behavioural Pain Scale is a simple and consistent tool to identify, document, and evaluate pain in infants and young children who have difficulty verbalising the presence or intensity of pain.

- This pain scale used in pre verbal children up to 2 years.
Discuss the differences between self rating and behavioural scales. Research shows that clinicians commonly underscore patients on behavioural scales. For young children it is best to use the behavioural scale in combination with the parents impression.

### FLACC Behavioural Pain Scale

<table>
<thead>
<tr>
<th>Categories</th>
<th>Scoring*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face</td>
<td>No particular expression or smile</td>
</tr>
<tr>
<td></td>
<td>Occasional grimace or frozen, withdrawn, distressed</td>
</tr>
<tr>
<td></td>
<td>Frequent to constant frozen, quivering chin, clenched jaw</td>
</tr>
<tr>
<td>Legs</td>
<td>Normal position or relaxed</td>
</tr>
<tr>
<td></td>
<td>Uneasy, restless, tense</td>
</tr>
<tr>
<td></td>
<td>Squirming, shifting back and forth, tense</td>
</tr>
<tr>
<td></td>
<td>Kicking or legs drawn up</td>
</tr>
<tr>
<td>Activity</td>
<td>Lying quietly, normal position, moves easily</td>
</tr>
<tr>
<td></td>
<td>Moans or whimpers; occasional complaint</td>
</tr>
<tr>
<td></td>
<td>Crying steadily, screams or sobs, frequent complaints</td>
</tr>
<tr>
<td>Cry</td>
<td>No cry (awake or asleep)</td>
</tr>
<tr>
<td></td>
<td>Reassured by occasional touching, hugging, or being talked to; distractible</td>
</tr>
<tr>
<td></td>
<td>Difficult to console or comfort</td>
</tr>
<tr>
<td>Consolability</td>
<td>Content, relaxed</td>
</tr>
</tbody>
</table>

**Note:** Each of the five categories (Face, Legs, Activity, Cry, and Consolability) is scored from 0-2, which results in a total score between 0 and 10.

The Abbey is based on behavioural changes, which can make it difficult to use in ED. If possible ask relatives carers to assist you in using it, as they know the baseline behaviours.

Remember this cohort of patients frequently have poorly managed pain.
Principles of Pain Management

• Pain is best treated early and effectively because once established it is more difficult to treat.

• Appropriate early, aggressive management of acute pain may minimise the transition to chronic pain.

• An integrated multidisciplinary approach to pain management is often required for both acute and chronic pain.

• Adverse physiological and psychological effects may result from unrelieved severe pain.

• Untreated severe pain can increase a patient’s fears and anxiety leading to aggressive behaviour and a detrimental effect on the patient’s physiological parameters.
Oligoanalgesia

• The nurse’s own knowledge, attitudes, and perception influence the manner in which the pain experience is evaluated and treated.

• Patients who are at particular risk for deficient analgesia (oligoanalgesia) are:
  o infants, children and the elderly
  o patients with emotional and mental illnesses
  o patients with chronic pain
  o substance abusers
  o Culturally and linguistically diverse patients
  o more seriously injured
Misconceptions

- Traditionally medical training and practice (last century) was that analgesia should be withheld until a diagnosis has been reached.
- Analgesia will mask significant clinical signs and symptoms leading to a delayed diagnosis and treatment.
- Strong fears of ‘narcotics’ to cause ‘addiction’.
- Unwarranted and counterproductive leads to under-prescribing.
- Misunderstanding of the terms addiction, tolerance and physical dependence.
- Overestimation of the actual incidence of patients receiving opioids for pain management.
- In a large study involving almost 12,000 patients receiving opioids, addiction was described in just four patients (0.03%) e.
Non-Pharmacological Pain Relief

- Non-pharmacological pain relief is any method used to relieve pain that does not involve taking medications.
- While there are medications that can control pain, there are also alternative pain relief methods that can be used alone or in conjunction with medication.
- Alternative techniques to consider for pain relief include:
  - Therapeutic touch
  - Heat or cold compresses
  - Acupressure
  - Play therapy / distraction therapy
  - Positioning
  - General comfort measures
  - Guided imagery
  - RICE - Rest, Ice, Compression, Elevation
  - Relaxation
  - Keeping patient informed and reassured
Pharmacological Pain Management

Nurse Initiated Medications

• Paracetamol 500mg is commonly recognised as a NIM, not requiring a medical standing order

Approved Standing Orders for Nurse Initiated Analgesia

• Site Dependant – need to check local protocols
Inclusion & Exclusion Criteria

Check local protocols
Adherence to these are a medico-legal requirement
Example of Paediatric Drugs / Flowchart

- Refer to local protocols and flow charts

[Flowchart image]
Example of Adult Drugs / Flowchart

- * Refer to local protocols and flow charts
Patient Preparation includes:

- Initial nursing assessment
  - Brief History
  - Physical examination
  - GCS > 14
  - Full set of vitals signs (HR, RR, SpO², BP)
  - Pain Score (Numerical or Visual)
- Check for indications & contraindications to drug
- Check for allergies / hypersensitivities
- Current medications / analgesia prior to presentation
- Designated bed available i.e morphine
  - Basic monitoring (BP, HR & intermittent SpO²)
  - Oxygen
  - Suction
Drug Administration

Check the 5 R’s of medication administration

- Right Drug
- Right Dose
- Right Route
- Right Time
- Right Person

Beware of other medications already administered including over-the-counter medications which contain paracetamol and/or codeine
Documentation

Drugs must be checked and prepared according to

hospital policy & the nurse initiating

administration must document:

- All drugs administered will be recorded on the Statim Medication Section NSW Health Medication Charts
- Controlled Drug Ward Register – S4 & S8 drugs
- Prescribing Dr’s will be the medical officer that signed the Standing orders (check locally)
- The dosage and time given
- The order must be signed by the nurse followed by a printed surname
Documentation

It is the responsibility of the nurse initiating treatment and/or the designated nurse caring for the patient to ensure that the treating medical officer co-signs the standing order as soon as possible.
Ongoing Monitoring

• Assess effectiveness of analgesia
• Record ongoing observations at specified intervals
• Observe for adverse drug reaction
• Pain score, pain *prior* to administration
• Pain score, pain *post* administration
• Time when and if the patient became pain free

• Not responding to analgesia or If further analgesia is required – escalate care
Questions
Acknowledgement

- Developed with thanks
- Leanne Horvath: ED CNC South Eastern Sydney LHN
References


