



CLINICAL GUIDELINE

Assessment & Monitoring (adult/ surgical), Queen Elizabeth University Hospital

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.


Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Lead Author:	Kenneth Pollock
Approval Group:	South Sector Clinical Governance Forum

Important Note:

The Intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

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		Effective From	January 2023
	Acute Pain Service Guidelines (Adult / Surgical) Assessment & Monitoring	Review Date	January 2025
		Version	2.1
Author(s) Stephanie Brockie, Jackie Bell, Kristin Smith Approved by: Dr Kenneth Pollock			

Assessment of pain

Assessment of pain is the essential prerequisite for successful pain management. It is unrealistic to expect that patients will be pain free. The aim of pain management is to optimise analgesia to enable functionality.

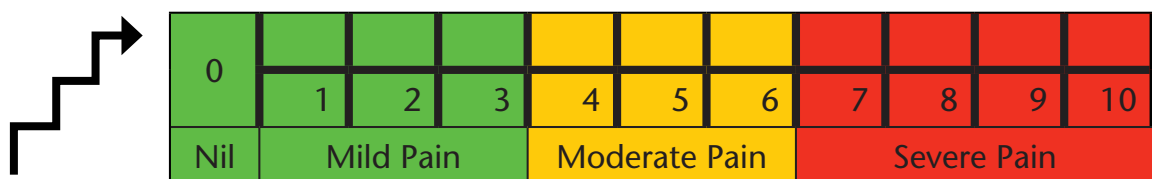
Basic elements of a pain assessment

Site of pain	Where? Localised or generalised? Is this an expected or new location? Does pain radiate elsewhere?
Description of the pain	Write down words used to describe pain e.g. sharp, dull, colicky, throbbing, aching, burning or shooting. This may help to determine the nature of pain and help decide the correct intervention.
Intensity of the pain	Score the intensity by using the pain scales below.
Function (see function score below)	Assess ability to perform a task appropriate to their painful injury or operation. For example: deep breathing, coughing, turning in bed or walking to the toilet.
Past history of pain	Obtain a baseline pain score to determine what pain score patient normally functions with. Does the patient normally take any analgesia?

Assessment Tools

There are several pain scoring tools available for use:

Numerical Rating Scale (NRS) and Verbal Descriptor Scale (VDS)



Pain scores in multiple languages are available from the Acute Pain Nurses or can be accessed at www.britishpainsociety.org/british-pain-society-publications/pain-scales-in-multiple-languages/

Abbey Pain Scale

Behavioural tools are advocated for those patients who are cognitively impaired and unable to report pain verbally. Often a carer, friend or staff member who knows the patient well can help with the pain assessment.

Abbey Pain Scale

Pain assessment for patients unable to self report pain.

Staff should perform the pain assessment while the patient is being moved e.g. during pressure area care, while showering etc. An evaluation should be conducted one hour after any intervention taken, to determine the effectiveness of any pain-relieving intervention or further action required.

Affix ID Label

What type is the pain? (Circle as appropriate)	Chronic	Acute	Acute on Chronic
Score: 0 = Absent; 1 = Mild; 2 = Moderate; 3 = Severe	Date _____ Time _____ Score _____	Date _____ Time _____ Score _____	Date _____ Time _____ Score _____
Vocalisation e.g. whimpering, groaning, crying			
Facial expression e.g. looking tense, frowning, grimacing, looking frightened			
Change in body language e.g. fidgeting, rocking, guarding part of body, withdrawn			
Behavioural change e.g. increased confusion, refusing to eat, alteration in usual patterns			
Physiological change e.g. temperature, pulse or blood pressure outside the normal limits, perspiring, flushing or pallor			
Physical changes e.g. skin tears, pressure areas, arthritis, contractures, previous injuries			
Pain Score Total			
Print name of assessor			
Remember: Consider if any Non Pharmacological interventions will support the pain management plan.			
Score 0 – 2 No Pain Continue to assess. Ensure analgesia prescribed PRN according to local analgesic guidelines.	Score 3 – 7 Mild Pain Administer prescribed analgesia according to local analgesic guidelines. Continue to assess.	Score 8 – 13 Moderate Pain Administer prescribed analgesia according to local analgesic guidelines. Continue to assess. Seek medical advice if pain is not responding to treatment.	Score 14+ Severe Pain Administer prescribed analgesia according to local analgesic guidelines. Continue to assess. Seek medical advice if pain is not responding to treatment.

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Function Score

Measurement of pain is only a part of the assessment of pain and efficacy of analgesia. The assessment of functional ability (for example the ability to deep breathe, cough and mobilise after surgery) gives a good indication of the effectiveness of analgesia.

A	No limitation, activity unrestricted by pain or settles quickly
B	Mild limitation, mild activity restriction
C	Moderate limitation, attempts activity but reluctant to continue because of pain SEEK ADVICE
D	Severe limitation, unable or refuses to perform activity because of pain URGENT REVIEW REQUIRED

Please document pain and function scores on NEWS2 or PCA/Epidural/IT chart when recording routine vital signs.

Assessment of adverse effects

To individualise treatment and maximise patient safety there needs to be ongoing assessment of any adverse effects of pain management therapies. These include signs of excessive opioid doses such as sedation, respiratory depression (respiratory rate of <8 breaths per minute), nausea and vomiting. Scoring tools for sedation and nausea and vomiting are shown below.

Sedation Scoring Tool


S	= Sleep	Normal sleep; easy to rouse
A	= Alert	Patient Alert
V	= Verbal	Occasionally drowsy; easy to rouse; responds to verbal stimuli
P	= Pain	Frequently drowsy; easy to rouse; responds to painful stimuli SEEK ADVICE
U	= Unconscious	Somnolent; difficult to rouse URGENT REVIEW REQUIRED

Postoperative Nausea and Vomiting Scoring Tool

0	= None	No treatment required.
1	= Mild Nausea	Not distressing; no retching / no vomiting CONSIDER TREATMENT
2	= Moderate Nausea	Troublesome; occasional retching / vomiting TREATMENT REQUIRED
3	= Severe	Distressing; frequent retching / vomiting URGENT REVIEW REQUIRED

Please document pain, function, sedation and nausea/vomiting scores on NEWS2 or PCA/Epidural/IT chart when recording routine vital signs.

References

1. Abbey J, Piller N, De Bellis A et al (2004) The Abbey pain scale: a 1 minute numerical indicator for people with end stage dementia. *Int J Palliat Nurse* 10(1): 6–13.
2. Macintyre PE, Schug SA, Scott DA, Visser EJ, Walker SM; APM:SE Working Group of the Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine (2015), *Acute Pain Management: Scientific Evidence* (3rd edition), ANZCA & FPM, Melbourne.
3. Macintyre PE, Schug, S (2015) *Acute Pain Management A practical guide* (4th Edition), CRC Press.
4. Royal College of Physicians, British Geriatric Society & British Pain Society (2018). *The assessment of pain in older people: UK national guidelines. Age and Ageing*, Volume 47.
5.  www.britishpainsociety.org/british-pain-society-publications/pain-scales-in-multiple-languages/