Pain Assessment and Management Policy

Purpose

Effective pain management has important implications for improving independence, quality of life and quality of care. SOS Homecare Ltd recognises that the majority of clients experiencing pain can get acceptable pain relief using standard pain killing treatments. Where this is not the case, pain can generally be controlled using a variety of methods. This policy seeks to inform carers how to identify when a client is in pain and how this can be managed whilst maintaining the client's privacy and dignity.

Pain management needs will be assessed as part of the care planning process and pain levels will be regularly monitored using recognised pain management tools. The effectiveness of analgesia will be monitored and staff will liaise with relevant health care professionals to ensure the most positive outcome(s) for clients.

Duties

The Branch Manager will be responsible for:

- ensuring that staff are familiar with this policy and that clients' pain is effectively assessed, monitored and managed in line with best practice.
- monitoring the application of this policy.
- ensuring that clients' pain management requirements are met and that the effectiveness of pain relief is monitored and appropriately communicated to the GP or other relevant health care professional.

Principles

Encourage the client to talk specifically about any pains or discomfort they have. Research has found that pain assessment tools which use an observational approach or methodology are considered the gold standard for identifying pain in non-communicative, cognitively-impaired clients (see Appendix 2 – The Abbey Pain Scale). This obviously does not remove the need to verbally support non-communicative clients who are in pain and to treat them with dignity and respect, but it should be borne in mind that there are ways other than verbal in which pain can be communicated or assessed.

Be careful not to discount clients who frequently say they are in pain. Investigate and take appropriate action as prescribed. Remember constant low levels of pain can lead to depression and inhibit quality of life.

Observe any sudden changes in behaviour and restlessness. Check facial expressions, loss of appetite, sleeplessness or restriction in mobility.

Investigate and record the time of regular discomfort or pain. This may help distinguish between different causes. A client with a long standing heart condition, particularly angina, may also suffer severe and acute pain from indigestion that can be more easily addressed, but require different treatment.

Encourage accurate feedback from all staff who interact with the client. Many people pass pain off in a jovial fashion. Never underestimate pain or complaints caused by psychosomatic disorders or indeed a client who fakes pain to draw attention to their emotional state. Remember emotional pain can be much more dramatic and stressful than physical pain, depression can hurt deep inside.

Always check that the resident has actually swallowed any medication given to them. Any client with extreme pain, particularly in the event of having a terminal illness, may be helped by the use of a syringe driver (see section 6.3 “Pain control at the end of life”). SOS Homecare Ltd staff will only be responsible for the administration of oral medication or patches. Where a client requires injections, or the use of a syringe driver, this medication will be administered by District Nurses or other medical professionals.

Clients in discomfort or great pain may want to be alone and to be quiet or equally they may want to be in the thick of things to take their mind off their sufferings. Always ascertain their wishes and select the environment that is most appropriate to their needs.

Develop techniques and stimulating interventions and activities that distract the client’s focus from their discomfort or pain. This may be a simple chat, pet therapy, being involved in some activity involving concentration, such as board games or quizzes. Exercise may bring relief, as indeed may relaxing music.

Much pain and discomfort occurs during the night and can cause sleeplessness and weariness. Ensure that causes are fully investigated and that painkillers are used where appropriate, instead of sedation, although in the end both may be necessary. Investigate why a person regularly wakes up in pain, check the sleeping environment.

Severe pain often causes fear. Fear that the pain cannot be controlled; fear that something terrible inside must be happening and eventually a fear of death itself. Staff both day and night must make themselves available to comfort the client and of course act promptly to alleviate such pain. Understanding causes of pain can help with the acceptance of it. Often one person can be great assistance to another; do not underestimate the support clients can give one another. Sitting with the individual, simply holding a hand is probably the most tested and powerful, effective relief with the least side effects.

Procedure

In order to assess and subsequently manage a client’s pain the following procedure must be followed:

- Establish at the initial assessment stage (and whenever the Care Plan is reviewed) whether the client experiences any pain and if so, at what times, what type of pain and what alleviates the pain.
- Where pain is reported, conduct a pain assessment. If the client can communicate and verbalise their pain, use the Pain Assessment Tool (Appendix 1).
- Where the client has difficulty with communicating apply the Abbey Pain Scale (Appendix 2)

The assessment of pain will identify the following:

- Location
- Intensity/depth
- Times when pain is experienced
- The length of time the pain lasts
- How the client is able to express their pain
- Current methods of pain relief
- Factors which may increase pain
- The effect the pain has on the client’s daily life.

Once the assessment has taken place, the timescales for monitoring the client's pain levels i.e. twice daily, daily, weekly etc will be detailed in their care plan.

Monitoring of the client's pain will be recorded on a pain assessment chart (see Appendix 3 – Pain rating scale – Review). Whilst this chart is designed for weekly review's this can be changed to suit the individual pain review timescales required for each resident. Best practice is for both the pain assessment chart and the review chart to be kept in with the client's MAR chart so that correlation is evident between the frequency of administration of analgesia and pain assessment.

If the client is prescribed PRN analgesia; it is vital that the effectiveness of the medication is also captured in the log book to feed into medication and pain management reviews

If further medication is required before the next available prescribed medication, the pain should be reassessed.

Breakthrough pain must be reported to the GP for further guidance.

Pain control at the end of life

Managing symptoms, including pain, is an important part of end of life care. Each person will have different symptoms, depending on their condition and the kind of treatment they may be having. Symptoms can include nausea and vomiting, constipation, loss of appetite, and pain. Whilst not everyone nearing the end of their life will experience pain, staff should be aware of the possibility and pain should be assessed regularly in all client's with a terminal illness, including those with cognitive impairment.

SOS Homecare Ltd staff will work in liaison with the client's GP and other health care specialists (i.e. local palliative care team, McMillan nurses etc.) to access relevant analgesia medication and to ensure local protocols are being followed.

Typically in managing pain; the doctor will prescribe the weakest painkiller available that keeps the client free from pain. In order of strength (starting with the weakest) there are non-opioid painkillers, such as paracetamol; then mild opioids, such as codeine; and strong opioids, such as morphine.

Medication will be given in the least invasive way possible. This means they will be given in a way that causes the least amount of discomfort, pain or distress.

The first step is to take medication by mouth (orally). If this is not possible – for example, if the resident is vomiting or cannot swallow – painkillers can be given:

- Through a patch on the skin
- Through an injection under the skin (subcutaneous)
- Through an injection into the muscle (intramuscular)
- Directly into a vein (intravenous)

Sometimes a small, battery-operated pump called a syringe driver is used to give medication continuously under the skin for a period of time. SOS Homecare Ltd staff will only be responsible for the administration of oral medication or patches. Where a client requires injections, or the use of a syringe driver, this medication will be administered by District Nurses or other medical professionals.

Sometimes supplementary (adjuvant) painkillers are used alongside non-opioid and opioid painkillers. Adjuvants include medicines that are designed for other conditions, such as epilepsy, but work well with certain types of pain.

Some drugs can have side effects, such as making the client feel drowsy or sick. Staff must monitor the client for any signs of side effects and notify the GP/specialist nurse immediately if any occur.

SOS Homecare Ltd staff will assess and monitor pain as defined within this policy; making use of the Abbey Pain Scale if the client cannot verbalise or is not cognitively aware.

Training

SOS Homecare Ltd will ensure, through training, monitoring of process and staff supervision that the highest standards of pain management are applied at all times and that recognised pain assessment tools are used to support positive outcomes for residents.

Equality and Diversity Statement

SOS Homecare Ltd is committed to the fair treatment of all regardless of age, colour, disability, ethnicity, gender, nationality, race, religious or spiritual beliefs, and responsibility for dependants, sexual orientation, or any other personal characteristic. The company will ensure that this policy is implemented consistently regardless of any such factors, and all clients will be treated with dignity and respect.

Policy Review

This policy will be reviewed every two years.

APPENDIX 1

PAIN ASSESSMENT TOOL

Name of Client	
Date of review	
Staff Name	

Please mark the scale below to show how intense your pain is. A zero (0) means no pain, and ten (10) means extreme pain.

How intense is your pain now?

0 1 2 3 4 5 6 7 8 9 10

How intense was your pain on average last week?

0 1 2 3 4 5 6 7 8 9 10

Now please use the same method to describe how distressing your pain is. A zero (0) means not at all distressing, and ten (10) means extremely distressing.

How distressing is your pain now?

0 1 2 3 4 5 6 7 8 9 10

How distressing was your pain on average last week?

0 1 2 3 4 5 6 7 8 9 10

Now please use the same method to describe how much your pain interferes with your normal everyday activities. A zero (0) means does not interfere, and ten (10) means extreme interference.

0 1 2 3 4 5 6 7 8 9 10

If you have had treatment for your pain, how much has this relieved the pain? A zero (0) means not at all, and ten (10) means completely

0 1 2 3 4 5 6 7 8 9 10

APPENDIX 2

Use of the Abbey Pain Scale

The Abbey Pain Scale is best used as part of an overall pain management plan. It is an instrument designed to assist in the assessment of pain in clients who are unable to clearly articulate their needs.

Ongoing assessment

The Scale does not differentiate between distress and pain, so measuring the effectiveness of pain-relieving interventions is essential. It is most effective when used as a movement-based assessment. The staff recording the scale should therefore observe the resident while they are being moved, e.g. during pressure area care, while showering etc.

Complete the scale immediately following the procedure and record the results in the client's notes. Include the time of completion of the scale, the score, staff member's signature and action (if any) taken in response to results of the assessment, e.g. pain medication or other therapies.

A second evaluation should be conducted one hour after any intervention taken in response to the first assessment, to determine the effectiveness of any pain-relieving intervention.

If, at this assessment, the score on the pain scale is the same, or worse, consider further intervention and act as appropriate. Complete the pain scale hourly, until the client appears comfortable, then four-hourly for 24 hours, treating pain if it recurs. Record all the pain-relieving interventions undertaken. If pain/distress persists, undertake a comprehensive assessment of all facets of client's care and monitor closely over a 24- hour period, including any further interventions undertaken. If there is no improvement during that time, notify the medical practitioner of the pain scores and the action/s taken.

The Abbey Pain Scale

For measurement of pain in people who cannot verbalise

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

Name of Client	
Date	
Time	
Name of Staff	
Latest pain relief	*[medication]*
Given at	*[time]*

		Absent (0)	Mild (1)	Moderate (2)	Severe (3)
Q1	**Vocalisation** *e.g. whimpering, groaning, crying*				
Q2	**Facial expression** *e.g. looking tense, frowning, grimacing, looking frightened*				
Q3	**Change in body language** *e.g. fidgeting, rocking, guarding part of body, withdrawn*				
Q4	**Behavioural change** *e.g. increased confusion, refusing to eat, alteration in usual patterns*				
Q5	**Physiological change** *e.g. temperature, pulse outside normal limits, perspiring, flushing or pallor*				
Q6	**Physical changes** e.g. skin tears, pressure areas, arthritis, contractures, previous injuries				
	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 pain	8-13 Moderate pain	14+ Severe pain

Finally, tick the box that matches the type of pain

CHRONIC	ACUTE	ACUTE AND CHRONIC

References: Abbey J, DeBellis A, Piller N, Esterman A, Giles L, Parker D, Lowcay B. The Abbey Pain Scale. Funded by the JH & JD Gunn Medic al Research Foundation 1998–2002. (This document may be reproduced with this reference retained.)