Pain

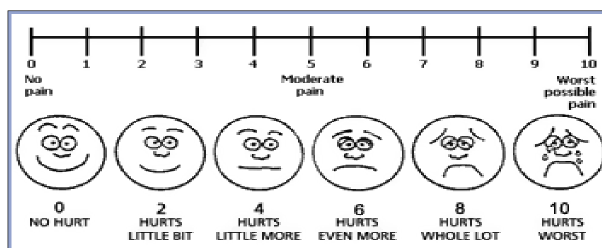
Definition

Pain is; "an unpleasant sensory or emotional experience associated with actual or potential tissue damage, or described in terms of such damage" (International Association for the Study of Pain, 2008).

Assessment tools

Person able to communicate

1. **Use preferred tool for your organisation**
   e.g., Wong-Baker FACES™ Pain Rating Scale.



2. **Describe type of pain**

Type of pain	Descriptor
Somatic	Aching, throbbing, gnawing, localised
Visceral	Deep aching, cramping, dull pressure
Neuropathic	Burning, shooting, pins and needs, tingling
Bone	Constant, deep

3. **Document clearly:** Consider the following, assessing their pain using the PQRST format:

P	Palliating factors Provoking factors	"What makes it better?" "What makes it worse?"
Q	Quality	"What is your pain like? Give some words that tell me about it."
R	Radiation	"Does that pain go anywhere else?"
S	Severity	"How severe is it?" Measured on numbered scale
T	Time	"Do you feel it all the time?" "Does it come and go?"
U	Understanding	"What does this symptom mean to/for you?" "How does this symptom affect your daily life?" "What do you believe is causing this pain?"

Acknowledgement to Ministry of Health for sharing Resources Te Ara Whakapiri
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Person unable to communicate

Use the preferred tool for your organisation if available. If no tool is available, the **Abbey Pain Scale** can be used to assess pain in those unable to communicate. The Pain Scale is an instrument designed to assist in the assessment of pain in a person who is unable to clearly articulate their needs.
The Abbey pain scale does not differentiate between distress and pain, therefore measuring the effectiveness of pain-relieving interventions is essential.
The pain scale should be used as a movement-based assessment, therefore observe the person while they are being moved, during pressure area care, during wound care, while showering etc. A second evaluation should be conducted 20 minutes after any intervention (non-pharmacological and/or medication). If, at this assessment, the score on the pain scale is the same, or worse, consider further intervention and act as appropriate.

Complete the scale at least **twice a shift and especially when person is showing signs of distress.** Use 1 page per day – extra columns for distressing behaviour.

Date: ___________	Time	Time	Time	Time	Time	Time	Time	Time
Score: Absent 0 Mild 1 Moderate 2 Severe 3								
E.g. Behavioural – 2 or 3 if person is verbally or physical aggressive								
Vocalisation e.g. Whimpering, groaning, crying, verbalising								
Facial Expression e.g. Looking tense, frowning, grimacing, looking frightened								
Change in Body language e.g. fidgeting, rocking, guarding part of the body, withdrawn								
Behavioural change. e.g. increased confusion, refusing to eat, alteration in usual patterns.								
Physiological Change e.g. Temperature, pulse or BP outside normal limits, perspiring, flushing or pallor **0 if not indicated/done**								
Physical changes e.g. skin tears, pressure areas, arthritis, contractures, previous injuries								
Total Score								
0 – 2 No Pain **3 – 7 Mild pain**	**6 – 13 Moderate Pain**			**14 + Severe Pain**				
Name of person assessing								

https://www.apsoc.org.au/PDF/Publications/Abbey_Pain_Scale.pdf

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Pain

Holistic considerations

Reflect on: Te Whare Tapa Wha principles (Durie 1994)

Emotional considerations:	Fear and anxiety can be both cause and consequence.
Spiritual considerations:	What impact does pain have on the person's sense of self and their mana/wellbeing? Are there any cultural considerations, e.g., Māori/Asian/Pacific peoples?
Social considerations:	How does the pain affect the person's family/whānau life? And how is this, in turn, affecting the family/whānau's relationship with their partner/friends?
Physical considerations:	Are there activities or positions that are particularly painful for the person?

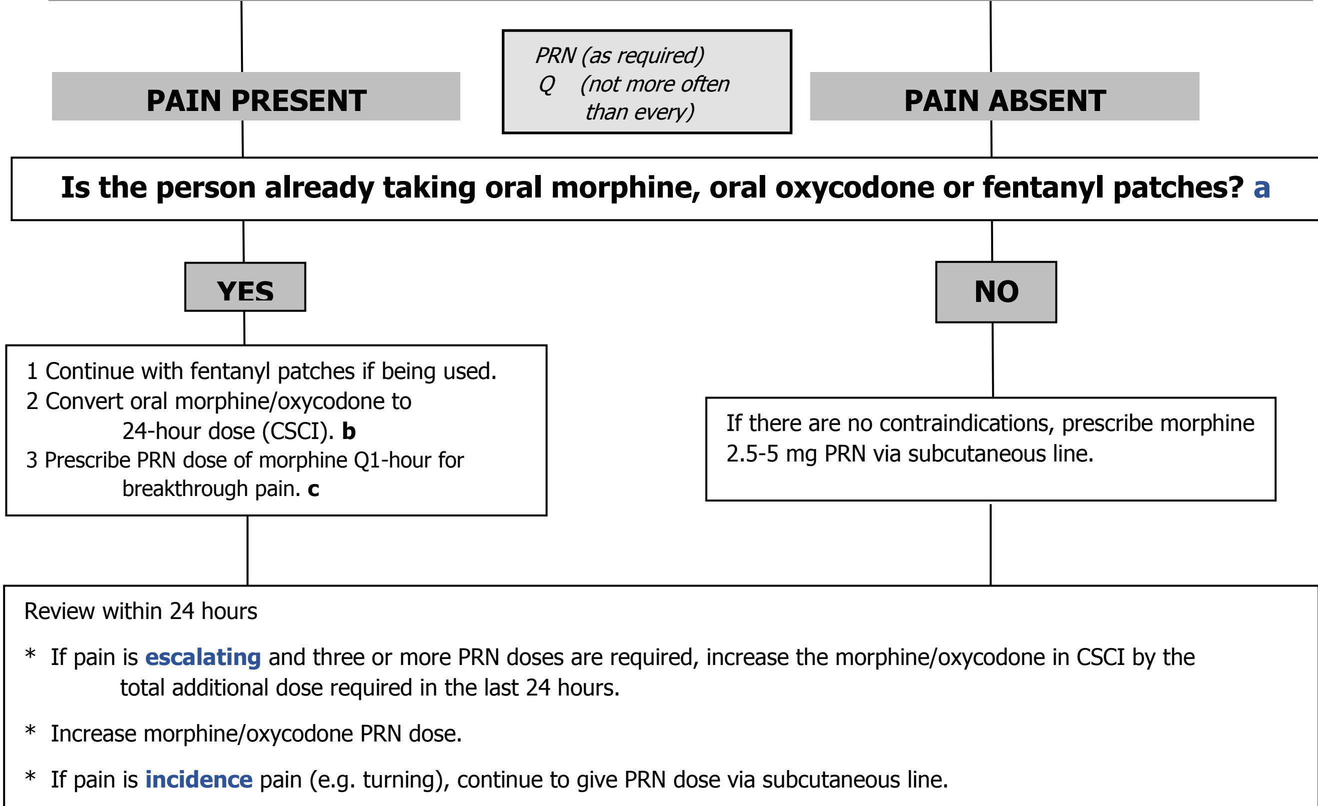
1. Involve the person's family/whānau if the person is happy for them to be involved.
2. Being with the person and believing that their pain exists can help reduce their pain.
3. Helping to position the person to make them as comfortable as possible and helping to reposition them regularly can help reduce stiffness and muscular aches and provide pressure relief. Provide pressure relieving aids.
4. Guided imagery and distraction is a technique that teaches the person to mentally remove themselves from the present and imagine that they are in another place, e.g., a favourite vacation spot. It can help reduce some types of pain by helping the person to relax or distract them from unpleasant thoughts. Distraction therapy comes in many forms, e.g., guided audio, TV, music, reminiscing, etc.
5. Heat and/or coolness can often help ease pain, e.g., by applying heated or chilled wheat packs. Care should be taken to ensure the temperature is suitable and the person will not be burned.
6. Massage or touch can be beneficial. Those giving massage should have an understanding of what is beneficial and what may cause harm. It is important to be aware that some people may not be comfortable with massage or touch.
7. Prayer and mindfulness meditation can be beneficial in reducing pain or existential suffering, depending on the person's spiritual or cultural perspectives.

Pain

PAIN

* Morphine is the first-line opioid if eGFR > 45ml/min (unless contraindicated).
* Use morphine with caution when eGFR 30-45ml/min.
* Use oxycodone with caution when eGFR 15-30ml/min

If the person is in renal failure eGFR<30ml/min consider an alternative opioid to morphine/oxycodone, e.g. fentanyl. (see pain management flow chart for a person with severe renal impairment.)



If symptoms persist, contact the Specialist Palliative Care team for

a. If methadone is being used, please contact your Specialist Palliative Care Team for advice.

MORPHINE/OXYCODONE CALCULATIONS

b. To **CONVERT** from oral morphine/oxycodone to 24-hour CSCI morphine/oxycodone, halve **the total 24-hour dose** of oral morphine (24-hour total oral morphine = 60 mg then prescribe 30 mg subcutaneous morphine).

c. PRN doses of morphine/oxycodone: **divide** 24-hour dose by six and give up to Q1 hour.

Anticipatory prescribing in this manner will ensure that in the last hours and days of life there is no delay responding to a symptom if it occurs.

If you require further advice 24hrs each day 7 days a week please contact the Specialist Palliative Care Service at Mercy Hospice PH 3615966

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Pain – Renal impairment

* Morphine and oxycodone have a risk of toxicity in renal impairment (myoclonic jerks, delirium, drowsiness and respiratory depression).
* Fentanyl is the safest first-line opioid when eGFR <30ml/min
* Methadone is an alternative but can be complex to use and should be started only with advice from a Palliative Medicine Specialist.
* If person is on fentanyl patch, leave in situ and dos PRN fentanyl accordingly. **a**

PAIN PRESENT

PAIN ABSENT

Is the person already taking oral morphine, oral oxycodone or fentanyl patches? a

YES

* Give a stat dose of fentanyl **a** 10-20 mcg via subcutaneous line
* Consider starting fentanyl 100-300 mcg via CSCI over 24 hours.

NO

If there are no contraindications, prescribe morphine 2.5-5 mg PRN via subcutaneous line.

If no contraindications, prescribe fentanyl 10-20 mcg PRN hourly via subcutaneous line.

If already on fentanyl, this does will need to be higher. **a**

Review within 24 hours

* If pain is **escalating** and three or more PRN doses are required, increase the fentanyl in CSCI by the total additional dose required in the last 24 hours.
* Increase fentanyl PRN dose.
* If pain is **incidence** pain (e.g. turning), continue to give PRN dose via subcutaneous line.

If symptoms persist, contact the Specialist Palliative Care team for

PRN (as required)
Q (not more often than every)

If pain uncontrolled or conversion from standard opioid to fentanyl unclear, contact Specialist Palliative Care Team for advice.

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