Addressograph

Daily Pain Assessment Chart

NHS Lanarkshire

CHI No .... Hospital No .... Ward ....

Name .... Consultant .... ❑ Hairmyres ❑ Monklands ❑ Wishaw

Once daily - ask your patient: “Overall, how would you rate your level of pain during the last 24 hours - none, mild, moderate, severe or very severe?

	Date														
	Time														
	Signature														
4 very severe	4														
3 severe	3														
2 moderate	2														
1 mild	1														
0 none	0														
Please tick appropriate box if signs of opioid toxicity are present.		❑ drowsiness ❑ confusion ❑ hallucinations ❑ jerking	❑ drowsiness ❑ confusion ❑ hallucinations ❑ jerking	❑ drowsiness ❑ confusion ❑ hallucinations ❑ jerking	❑ drowsiness ❑ confusion ❑ hallucinations ❑ jerking	❑ drowsiness ❑ confusion ❑ hallucinations ❑ jerking	❑ drowsiness ❑ confusion ❑ hallucinations ❑ jerking	❑ drowsiness ❑ confusion ❑ hallucinations ❑ jerking	❑ drowsiness ❑ confusion ❑ hallucinations ❑ jerking	❑ drowsiness ❑ confusion ❑ hallucinations ❑ jerking	❑ drowsiness ❑ confusion ❑ hallucinations ❑ jerking	❑ drowsiness ❑ confusion ❑ hallucinations ❑ jerking	❑ drowsiness ❑ confusion ❑ hallucinations ❑ jerking	❑ drowsiness ❑ confusion ❑ hallucinations ❑ jerking	❑ drowsiness ❑ confusion ❑ hallucinations ❑ jerking

- every cancer patient should be asked about their pain on admission and should have a daily score recorded unless on post-op protocol
- when commencing the chart, please enter all dates along the top row

- if pain ≥ 2, an urgent reassessment of pain and review of analgesia is needed (see overleaf for guidelines)
- if pain ≥ 3 for 24 hours, or side effects of medication are apparent, consider contacting the Specialist Palliative Care Team
- reduction of pain to a level acceptable to the patient should usually be achieved within 48 hours

FRM.DPASSC.40862.W

Pain Management Guideline

Step 1: Mild Pain

Paracetamol and/or NSAID +/- Adjuvant

1g, 4 times/day *(if not contra-indicated)*

Pain should be fully assessed before treatment with analgesics is started (see Pain Assessment Guide)

Continue to ask the patient about their pain regularly.

Step 2: Mild to Moderate Pain

Opioid + Paracetamol and/or NSAID +/- Adjuvant

e.g. codeine 30-60mg, 4 times/day or dihydrocodeine 30-60mg, 4 times/day *(if not contraindicated)*

Best given as a combined preparation e.g. co-codamol 30/500, 2 tablets, 4 times/day

Prescribe a regular laxative when opioids are being taken regularly (see step 3).

Discuss and resolve any concerns about taking opioids e.g. addiction, tolerance, opioids only for advanced disease, etc.

Step 3: Moderate to Severe Pain

Opioid + Paracetamol and/or NSAID +/- Adjuvant

(if not contraindicated)

Stop step 2 opioid (full daily dose of codeine (240mgs) is approx equivalent to 24mgs oral morphine/day)	
*Whenever possible titration should be with **normal release oral morphine***	
*If starting with **normal release** oral morphine, (e.g. oramorph)* *5-10mg, 4 hourly and as required for **breakthough pain**.* *(A 2.5mg dose may be enough in the elderly or those with renal impairment)*	*If starting with **controlled release** oral morphine, (e.g. MST Continus)* *10-15mg 12 hourly **and** normal release morphine 5mg as required for **breakthrough pain**.*

Regular laxative	***Prophylactic antiemetic***
Movicol *Senna + Docusate* *Co-danthramer* *(if prognosis limited)*	*Prescribed as required, for 7-10 days* *metoclopramide 10mg 3 times/day* *or* *haloperidol 1.5mg nocte*
Seek advice:	
❖ *Severe pain* ❖ *Movement related pain*	❖ *Dose of opioid increasing rapidly* ❖ *Pain not responding to treatment*

Breakthrough Pain

- Prescribe normal release morphine at 1/6th of regular 24hour dose.
- Subcutaneous morphine should be prescribed at half the oral breakthrough dose if oral route is problematic
- Ranges of doses should be avoided
- Please always assess response to breakthrough analgesia 30-60 mins after administration, and record in nursing notes
- If alternative opioids being used seek advice.

Adjuvant Therapies

- **ANTICONVULSANT -**
  nerve pain, e.g. Gabapentin100-300mg daily initially and titrate gradually to 3 times daily regime.
- **AMITRIPTYLINE -**
  nerve pain – 10-25mg nocte and titrate (can cause sedation, confusion, dry mouth)
- **STEROIDS -**
  e.g. dexamethasone – raised intracranial pressure (8-16mg/day), nerve pain (8-16mg/day), liver pain (4-6mg/day). Give before mid-afternoon, reduce to lowest effective dose (monitor blood glucose levels).
- **TENS, NERVE BLOCK, RADIOTHERAPY, BISPHOSPHONATES**

Dose Titration in Step 3

- Consider increasing regular oral opioid dose each day in steps of about 1/3 (or according to breakthrough doses used in previous 24 hours) or until pain is controlled or side effects develop.

Subcutaneous (SC) Analgesia

When converting to a s/c opioid:

- Calculate the total 24hour dose of oral morphine and divide by 2
- This is the 24hour s/c dose which is usually given in a syringe pump
- Prescribe 1/6th of the 24hour dose s/c as required for breakthrough pain.

Opioid Toxicity (seek advice)

- Increasing drowsiness
- Vivid dreams/hallucinations
- Muscle twitching/myoclonus/jerking
- Abnormal skin sensitivity to touch
  → Reduce opioid dose by 1/3 and ensure patient adequately hydrated, using SC/IV fluids if necessary
  → Consider adjuvant therapies and/or alternative opioids

Adapted from SIGN Guideline, ‘Control of Pain in Patients with Cancer’ www.sign.ac.uk