ST VINCENT'S HOSPITAL SYDNEY
A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

Policies & Protocols

Clinical Practice Manual
- Pain Assessment and Management for Elderly Patients with Traumatic Injuries Protocol

Protocol:

Objective:

To ensure elderly patients with traumatic injuries are provided with safe and effective best practice pre-operative pain assessment and management.

Principles of Action:

The principles of action to minimise pain and associated risks for elderly patients with traumatic injuries includes the following:

- Conducting regular and ongoing pain assessments using validated and appropriate tools for elderly patients
- Initiating best practice pain management as soon as possible with consideration to:
  - Ensuring pain management strategies are implemented in response to assessment outcomes
  - Age-related changes in drug sensitivity, efficacy, metabolism and side effects
  - Caution in prescription of non steroidal inhibitors
  - Ensuring symptoms other than pain, such as constipation, insomnia and depression are treated as part of the patient's pain management plan
  - Referral to a pain specialist and / or multidisciplinary pain service if troublesome pain persists
- Ensuring continual documentation of pain assessment, management strategies and outcomes
- Ensuring patients / carers are provided patient education on traumatic pain and pain management strategies.

Definitions:

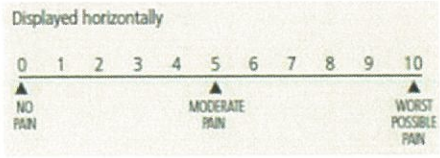
Traumatic Injury	Traumatic injury is an injury to the body that occurs when a physical force contacts the body.
Elderly	Older than 75 years of age

Process:

Pain Assessment:

1. Each patient's pain is to be individually assessed.
2. Staff are to assess every patient for pain as follows:
   - On admission
   - As prescribed, e.g. according to the Nurse Care Plan and Clinical Pathways
   - Post administration of pain relief treatment to assess for effectiveness
   - Pain should be assessed more frequently if it is poorly controlled, or if the pain stimulus or treatment interventions are changed.
3. Assessment of the patient's pain is to include the following aspects:
   - Pain assessment both on rest and during physical activity e.g. coughing, deep breathing or movement
   - Consider the patient's medical condition and treatment, e.g. operations/procedures.
4. Ask the patient whether they have pain.
5. If the patient has pain, ask the patient to indicate the site/s of the pain.
6. Use the Verbal Numerical Rating Scale (VNRS) to assess the patient's level of pain (Refer to the VNRS/VAS Procedure).

Numerical Rating Scale



7. For non-English speaking patients refer to the culturally and linguistically diverse (CALD) VNRS tools available at http://intranet.stvincents.com.au/svPageDocBase/uploads/11920SVMHSSQL01-Doc.pdf
   and
   http://intranet.stvincents.com.au/intra/page?sid=14261375SVMHSSQL12&ent=SVH26&page=394SVMHSSQL01&ity_key=
   or the
   Wong- Baker Faces Pain Rating Scale

Wong-Baker FACES Pain Rating Scale

8. Patients with dementia or delirium may be unable to answer questions relating to pain. The Abbey Pain Scale is to be implemented for these patients.
9. Attend additional patient assessment as per PCA, Continuous Epidural Analgesia and Administration of Intermittent Doses of S4D and S8 Medications policies.
10. Attend physical assessment, if applicable: e.g. vital signs.
11. Assess sedation using the Best Eye Response in the Glasgow Coma Scale (see below) (Refer to the Neurological Assessment Procedure).

Best Eye Response in the Glasgow Coma Scale	Score
Open eyes spontaneously	4
Opens eyes in response to speech	3
Open eyes in response to painful stimulation (e.g. sternal rub or trapezium pinch)	2
Does not open eyes in response to any stimulation	1

12. At an appropriate interval after the implementation of an intervention/s to manage the pain, e.g. analgesia administration, clinical staff will reassess the intervention's effectiveness.

Abbey Pain Scale

Pain Management Strategies

Patient Education:

Patients and carers/significant family members should receive adequate education on the pain assessment and management, this should include:

- Prevention strategies
- Management aims, treatment options and possible complications.

The SVH Fascia Iliaca Block Patient / Carer Information Brochure is available on EDIS or to assist in patient education.

Documentation:

- Assessment of the patient's pain is to be documented in the Patient's Healthcare Record.
- The VNRS, Wong-Baker or Abbey Pain Score is to be documented on the Nursing Care Plan or Clinical Pathway or, where applicable, the Patient Controlled Analgesia Chart (P433) and Observation Chart / Patient Observations Chart.
- Identify when the Abbey Pain Scale is used by including (APS) after the result. For example 11/18 (APS).
- The administration of analgesia is to be documented in the patient's medical record where prescribed, e.g.:
  - MedChart
  - 24 Hour Fluid Record and Intravenous Order Chart
  - Patient Controlled Analgesia Chart.
- Pain management interventions used and the evaluation of their effectiveness are to be documented in the patient's healthcare record.

Compliance:

Compliance will be monitored biannually by auditing the patient's healthcare record, MedChart and Nursing Care Plan. This will be a randomly selected group of elderly patients with a traumatic injury.

The audit will be conducted by Chronic Pain Service and outcomes will be monitored and actioned by the SVH Geriatric Ambulatory Medicine Program Committee biannually. The audit will assess patient and practice outcomes.

The practice audit will cover the following key principles:

1. **Patient Outcome**

- Patient satisfaction
- Decreased LOS, Delirium & Readmission rates

1. **Practice Outcome**

The practice audit will cover the following key principles:

Preoperative	Postoperative
1. Pain assessment documented 2. Time to initial analgesia is less than 30 minutes 3. Paracetamol charted and given every 6 hours 4. Additional opioids charted 5. Response to analgesics documented 6. Evidence that fascia iliaca nerve blocks were inserted for patients with fractured NOF	1. Pain assessment documented 2. Paracetamol charted and given every 6 hours 3. Additional opioids charted regularly and PRN 4. Response to analgesia documented 5. Geriatric Referral

Standard:

National Standards:

NSQHS Standard 4: Medication Safety

References:

Supporting Evidence:

- The Australian Pain Society (2005). Pain in residential Aged Care Facilities – Management Strategies (2005). Retrieved on 01/03/2013 from
- 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 (2010), *Acute Pain Management: Scientific Evidence* (3rd edition), ANZCA & FPM, Melbourne.

Focus Area(s):

- Acute and High Dependency
- Patient Care - Assesment/Management
- Patient Care - General

Linked PP:

- Falls Management - Patients who have had a Fall in the Inpatient Setting Protocol
- Neurological Assessment Protocol
- Pain Assessment and Management Policy
- Pain Assessment Using the VNS or VAS Protocol
- Patient Controlled Analgesia Protocol

Departments:

- Clinical Organisation Wide

Revision History:

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