



## adult pain management guidelines

developed by the PAIN MANAGEMENT TASK GROUP of the  
HULL & EAST RIDING CLINICAL POLICY FORUM

SEPTEMBER 2006



### Pain Management Task Group Membership

<b>Dr Nassif Abd-Mariam</b>	General Practitioner, Morrill Street Health Centre, Morrill Street, Holderness Road, Hull, HU9 2LJ
<b>Dr Helen Bowden</b>	Macmillan GP Facilitator, Room SC45, Trust Headquarters Willerby Hill, Beverley Road, Willerby, HU10 6ED
<b>Dr Brian Culbert</b>	Consultant in Anaesthetics, Department of Anaesthetics, Castle Hill Hospital, Cottingham, East Yorkshire, HU16 5JQ
<b>Dr Ahmed Saleh</b>	Consultant in Anaesthetics, Department of Anaesthetics, Castle Hill Hospital, Cottingham, East Yorkshire, HU16 5JQ
<b>Dr Derek Haines</b>	Pain Management Specialist, Pain Clinic, Castle Hill Hospital, Cottingham, East Yorkshire, HU16 5JQ
<b>Dr Mark Hancocks</b>	General Practitioner & Medical Advisor, Eastern Hull Primary Care Trust, Netherhall, Wawne Rd, Hull, HU7 4YG
<b>Dr Tim Jackson</b>	Consultant in Accident & Emergency Medicine, Hull Royal Infirmary, Anlaby Rd, Hull, HU3 2JZ
<b>Mrs Jackie Matthews</b>	Pharmaceutical Adviser, East Yorkshire Primary Care Trust, Health House, Grange Park Lane, Willerby, HU10 6DT
<b>Dr Bruce Millar</b>	Consultant Clinical Psychologist, Humber Mental Health Trust, Victoria House, Park Street, Hull, HU2 8TD
<b>Dr Donald Sharp</b>	Honorary Consultant, Oncology Health Centres, Castle Hill Hospital, Cottingham, East Yorkshire, HU16 5JQ
<b>Ms Angela Orr Mr Stephen Morris</b>	Macmillan Clinical Nurse Specialists (Palliative Care) The Sutton Centre, The Princess Royal Hospital, Saltshouse Road, Hull, HU8 9HE.
<b>Dr Chris Woodyatt</b>	Pain Management Services, 53 Church Street, South Cave, Brough, East Yorkshire, HU15 2EP

### Additional Textual Contributions gratefully received from:

<b>Ms Wendy Allison</b>	Senior Pain Management Nurse, Hull Royal Infirmary Anlaby Rd, Hull, HU3 2JZ
<b>Ms Jane Clappison</b>	Senior Physiotherapist, East Riding & Hull Therapy Services Partnership, Highlands Health Centre, Lothian Way, Hull, HU7 5DD
<b>Ms Ann English</b>	Clinical Specialist, Physiotherapy, East Riding & Hull Therapy Services Partnership, Highlands Health Centre, Lothian Way, Hull, HU7 5DD
<b>Mr John Fielding</b>	Training & Development Officer, East Riding & Hull Therapy Services Partnership, Victoria House, Park Street, Hull, HU2 8TD

**Management, Administration & Editorial Support to the Pain Task Group:**

**Mrs Jenny Walker**

Clinical Policy Support Manager,  
Hull Public Health Directorate  
Victoria House, Park Street,  
Hull, HU2 8TD

Tel: 01482 617764

Email: [Jenny.Walker@whpct.nhs.uk](mailto:Jenny.Walker@whpct.nhs.uk)

**Input and feedback on the Guidelines from a patient perspective:**

**Ms Marguerite Makel**

Volunteer tutor from the Expert Patients Programme

**Ms Susan Raettig**

Chair of the Hull & East Yorkshire Cancer Patient Involvement  
Group



<b>CONTENTS</b>		<b>PAGE</b>
<b>SECTION A</b>	<b><a href="#">INTRODUCTION TO YOUR LOCAL PAIN MANAGEMENT GUIDELINES</a></b>	<b>10</b>
<b>A-1</b>	<b>Context and purpose</b>	<b>10</b>
<b>A-2</b>	<b>Key themes</b>	<b>10</b>
<b>A-3</b>	<b>Key tasks</b>	<b>11</b>
<b>SECTION B</b>	<b><a href="#">GUIDELINE DISSEMINATION &amp; EDUCATION</a></b>	<b>12</b>
<b>SECTION C</b>	<b><a href="#">PATIENT CENTRED CARE &amp; THE ASSESSMENT OF PAIN</a></b>	<b>13</b>
<b>C-1</b>	<b>Assessment &amp; the patients view of pain</b>	<b>15</b>
<b>C-2</b>	<b>The patient in context</b>	<b>16</b>
C-2-1	Understanding the whole person	16
C-2-2	Spirituality	17
C-2-3	Emotional Reactions to Pain	19
<b>C-3</b>	<b>Negotiating the management plan</b>	<b>19</b>
C-3-1	Finding common ground	19
C-3-2	Incorporating prevention and health promotion	22
C-3-3	Enhancing the Doctor - Patient relationship	22
C-3-4	Being realistic	22
<b>C-4</b>	<b>The importance of review</b>	<b>23</b>
<b>C-5</b>	<b>Caring for the carers</b>	<b>23</b>
<b>C-6</b>	<b>The initial assessment of pain</b>	<b>27</b>
C-6-1	What is pain?	27
C-6-2	Pain myths and barriers to pain assessment	27
C-6-3	Aims of the initial assessment	29
C-6-4	The assessment process	29
<b>C-7</b>	<b>The use of pain assessment tools</b>	<b>33</b>
C-7-1	Level 0 TPR	34
C-7-2	The Faces Pain Scale	35
C-7-3	Pre-consultation Patient Questionnaire	36
C-7-4	The LANSS Pain Scale	39
C-7-5	Brief Pain Inventory (short form)	41
C-7-6	Brief Pain Inventory (follow up form)	43
C-7-7	A Pain Assessment Chart (for Chronic Pain)	44
C-7-8	Short Form McGill Pain Questionnaire and Pain Diagram	45

<b>SECTION D</b>	<b><a href="#">MEDICINES MANAGEMENT</a></b>	<b>46</b>
<b>D-1</b>	<b>Professional codes of conduct</b>	<b>46</b>
D-1-1	Nurses and Midwives	46
D-1-2	Doctors	46
D-1-3	Key responsibilities of a Pharmacist	47
<b>D-2</b>	<b>Safe prescribing practice</b>	<b>47</b>
D-2-1	Principles in relation to prescribing	47
D-2-2	Principles for the administration of medicines	48
<b>D-3</b>	<b>The role of the pharmacist</b>	<b>49</b>
D-3-1	The new Community Pharmacy contract	49
<b>D-4</b>	<b>Records and documentation</b>	<b>50</b>
<b>D-5</b>	<b>Disposal of medicines</b>	<b>50</b>
<b>D-6</b>	<b>Controlled drugs</b>	<b>50</b>
D-6-1	Brand name prescribing	51
<b>D-7</b>	<b>Patient-held drug charts</b>	<b>51</b>
D-7-1	An example of a patient-held drug chart	52
<b>SECTION E</b>	<b>PAIN MANAGEMENT</b>	<b>53</b>
<b>E-1</b>	<b><a href="#">ACUTE PAIN MANAGEMENT</a></b>	<b>53</b>
<b>E-1-1</b>	<b>Self-help</b>	<b>53</b>
<b>E-1-2</b>	<b>Psychological approaches</b>	<b>53</b>
<b>E-1-3</b>	<b>Complementary and non-drug therapies</b>	<b>54</b>
<b>E-1-4</b>	<b>The WHO Analgesic ladder</b>	<b>54</b>
E-1-4.1	Diagram based on the 3-step WHO analgesic ladder	55
E-1-4.2	HEYHT Adult Analgesia Table	56
E-1-4.3	Flow Chart for Intermittent IV Opioid Administration (general hospital use)	57
E-1-4.4	Flow Chart for Intermittent IV Opioid Administration (A&E use)	58
<b>E-1-5</b>	<b>Medication options in A&amp;E</b>	<b>59</b>
<b>E-1-6</b>	<b>Inpatient pain management</b>	<b>59</b>
<b>E-1-7</b>	<b>Discharge medication</b>	<b>59</b>
Appendix 1	BAEM Guidelines for the Management of Pain in Adults	60
Appendix 2	Pain Relief while in Hospital (HEYHT patient leaflet)	63
<b>E-2</b>	<b><a href="#">CHRONIC PAIN MANAGEMENT</a></b>	<b>65</b>
<b>E-2-1</b>	<b>Chronic pain management and the biopsychosocial model</b>	<b>66</b>
<b>E-2-2</b>	<b>Definition and understanding of chronic pain</b>	<b>66</b>
<b>E-2-3</b>	<b>Chronic pain management techniques</b>	<b>66</b>

E-2-3.1	Behavioural approaches	66
E-2-3.2	Social approaches	68
E-2-3.3	Cognitive approaches	68
E-2-3.4	Psychodynamic approaches	71
E-2-3.5	Humanistic and integrative approaches	71
<b>E-2-4</b>	<b>The Expert Patients Programme and other Chronic Disease Management services</b>	<b>71</b>
<b>E-2-5</b>	<b>Chronic pain management options in Primary Care</b>	<b>72</b>
<b>E-2-6</b>	<b>Readiness to change</b>	<b>73</b>
E-2-6.1	Stages of readiness to change	73
E-2-6.2	Assessing readiness to change	73
E-2-6.3	Motivational interviewing	73
E-2-6.4	Principles of motivational interviewing	74
<b>E-2-7</b>	<b>Assessing factors associated with chronic pain</b>	<b>75</b>
E-2-7.1	Assessing coping measures	75
E-2-7.2	Assessing the affective component of pain	75
E-2-7.3	Health related questionnaires	76
E-2-7.4	Control and quality of life measures	76
<b>E-2-8</b>	<b>Roles of specialist and support services</b>	<b>76</b>
<b>E-2-9</b>	<b>Selected section references</b>	<b>77</b>
<b>E-3</b>	<b><u>CANCER PAIN MANAGEMENT (IN ADULTS)</u></b>	<b>78</b>
<b>E-3-1</b>	<b>Introduction to the management of cancer pain</b>	<b>79</b>
<b>E-3-2</b>	<b>Cancer pain assessment and management</b>	<b>79</b>
E-3-2.1	Factors influencing a patient's perception of pain	79
E-3-2.2	A pain assessment chart	81
E-3-2.3	Non-drug therapies for pain management	82
E-3-2.4	WHO analgesic ladder	82
<b>E-3-3</b>	<b>Drug therapies for cancer pain</b>	<b>84</b>
E-3-3.1	Strong opioids	84
E-3-3.2	Immediate release opioids	84
E-3-3.3	Titration chart	84
E-3-3.4	Converting from immediate release morphine to modified release morphine	84
E-3-3.5	Starting a patient on modified release oral morphine	85
E-3-3.6	Breakthrough pain	85
E-3-3.7	How to increase the modified release morphine dose	86
E-3-3.8	Patients unable to take oral opioids	87
E-3-3.9	Subcutaneous route	87
E-3-3.10	Other opioids	88

E-3-3.11	Guidelines for the use of transdermal Fentanyl	88
E-3-3.12	Starting transdermal Fentanyl	89
E-3-3.13	Calculating the appropriate breakthrough dose	90
E-3-3.14	Application of transdermal Fentanyl patches	90
E-3-3.15	Dealing with uncontrolled pain	91
<b>E-3-4</b>	<b>Anti-emetics, laxatives and adjuvant analgesics</b>	<b>91</b>
E-3-4.1	Anti-emetics	91
E-3-4.2	Laxatives	92
E-3-4.3	Adjuvants	92
E-3-4.4	Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	92
E-3-4.5	Corticosteroids	92
E-3-4.6	Bisphosphonates	93
E-3-4.7	Tricyclic anti-depressants	93
E-3-4.8	Anti-convulsants	93
E-3-4.9	Anti-spasmodics	94
<b>E-3-5</b>	<b>Palliative treatment options for bone pain</b>	<b>95</b>
<b>E-3-6</b>	<b>Advice &amp; contacts</b>	<b>95</b>
<b>E-3-7</b>	<b>Section references</b>	<b>96</b>
<b>SECTION F</b>	<b><a href="#">NON-DRUG THERAPIES FOR PAIN MANAGEMENT</a></b>	<b>98</b>
<b>F-1</b>	<b>Introduction</b>	<b>98</b>
<b>F-2</b>	<b>Complementary therapies for chronic and cancer pain</b>	<b>98</b>
F-2-1	Acupuncture	100
F-2-2	Therapeutic hypnosis	101
<b>F-3</b>	<b>Physiotherapy</b>	<b>103</b>
F-3-1	Physiotherapy and pain in palliative care	104
F-3-2	Physiotherapy and chronic pain	105
F-3-3	CSP standards for physiotherapists working in pain management programmes	107
<b>SECTION G</b>	<b><a href="#">SPECIFIC DRUG THERAPIES FOR PAIN MANAGEMENT</a></b>	<b>109</b>
<b>G-1</b>	<b>Drug usage and types of pain</b>	<b>109</b>
G-1-1	Non-opioid analgesics	109
G-1-2	Opioid analgesics	109
<b>G-2</b>	<b>Appropriate prescribing and current resource use</b>	<b>110</b>
G-2-1	Gabapentin	110
G-2-1.1	Pathway for the use of adjuvant analgesia in chronic neuropathic pain	111
G-2-2	Fentanyl	113
G-2-3	Paracetamol / codeine	113

<b>SECTION H</b>	<b><a href="#">PAIN MANAGEMENT IN SPECIAL GROUPS</a></b>	<b>114</b>
<b>H-1</b>	<b><a href="#">Elderly people with cognitive impairments</a></b>	<b>114</b>
H-1-1	Introduction	114
H-1-2	The challenge	115
H-1-3	Choice of pain assessment tools	115
H-1-4	Mild to moderate cognitive impairment	116
H-1-5	Severe cognitive impairment	117
H-1-6	Non-verbal signs of pain	117
H-1-7	Pain management	118
H-1-8	Summary	118
H-1-9	References	119
Appendix 1	The Abbey Pain Scale	120
<b>H-2</b>	<b><a href="#">Adults with learning disabilities</a></b>	<b>121</b>
H-2-1	Pain assessment & management	121
H-2-2	Behavioural indicators carers use to determine pain in non-verbal, cognitively impaired individuals	122
H-2-3	Use of pain assessment tools	122
H-2-4	References	122
<b>H-3</b>	<b><a href="#">Opiate dependent adults</a></b>	<b>123</b>
H-3-1	Pre and post operative pain relief	123
H-3-2	Patients prescribed high dose buprenorphine (Subutex)	123
<b>SECTION I</b>	<b><a href="#">CONTACTS &amp; FURTHER RESOURCES</a></b>	<b>124</b>
<b>I-1</b>	<b><a href="#">CONTACTS &amp; RESOURCES FOR STAFF</a></b>	<b>125</b>
I-1-1	Hospital & Hospice Services	125
I-1-2	Specialist pain management services	126
I-1-2.1	The Centre for Pain Medicine, Castle Hill Hospital	126
I-1-2.2	Primary Care Chronic Pain Management Service	128
I-1-3	Hospital Macmillan Specialist Palliative Care Nurses	128
I-1-4	Community Macmillan Nurses in Hull	129
I-1-5	Community Macmillan Nurses in the East Riding of Yorkshire	129
I-1-6	Oncology Health Centre	130
I-1-7	Community Pharmacies holding Palliative Care Drug Stocks	131
I-1-8	Out Of Hours (OOH) Palliative Care Contacts	131
I-1-9	District Nursing Contacts in Hull and East Riding	132
I-1-9.1	Hull district nursing contacts	133
I-1-9.2	East Riding district nursing contacts	133
I-1-10	Pain & Palliative Care Education	133




I-1-11	Translated resources	135
<b>I-2</b>	<b><a href="#">CONTACTS &amp; RESOURCES FOR PATIENTS</a></b>	<b>137</b>
I-2-1	Spiritual and religious support	137
I-2-2	Oncology health centres	138
I-2-3	The Expert Patients Programme	138
I-2-4	Dove House Hospice – Psychosocial help	140
I-2-5	Support groups	140
<b>I-3</b>	<b><a href="#">CONTACTS &amp; RESOURCES FOR CARERS</a></b>	<b>141</b>
I-3-1	Local resources	141
I-3-2	National resources	142
<b>I-4</b>	<b><a href="#">INFORMATION RESOURCES</a></b>	<b>143</b>
I-4-1	Books	143
I-4-2	Booklets & online resources	145

### TIPS ON USING THIS DOCUMENT




*This 'world wide web' icon appears in sections where it may be helpful to view more detailed information by referring to a specified website.*



*If you are viewing this document as an electronic PDF file, you can navigate around it by using the hyperlinks in the Contents Table or in the 'Bookmarks' pane. (Click on the  icon or on the Bookmarks tab on the left of the screen)*



*If you are viewing this document as an electronic word file, you can navigate around it by using the hyperlinks in the Contents Table or in the 'Document Map'. (click on the  icon or go to 'Document Map' on the 'View' drop down menu)*

## SECTION A INTRODUCTION TO YOUR LOCAL PAIN MANAGEMENT GUIDELINES

*(Principal authors = Dr Mark Hancocks, Dr Ahmed Saleh)*

### A-1 Context and purpose

### A-2 Key themes

### A-3 Key tasks

#### A-1 Context and Purpose

At the request of the Hull and East Riding Clinical Policy Forum (CPF) a small subgroup has been working over the past year to define and agree these Guidelines, which represent a local consensus view based where possible on available evidence and best practice in relation to pain management.

The request from the CPF arose against the backdrop of concerns about variations in practice across Primary and Secondary care, and a concern locally and nationally that the distressing symptom of pain was sometimes not adequately assessed and managed.

The CPF Pain Task Group membership is listed and represents input from the Hospitals Trust, Mental Health Teaching Trust and Primary Care representatives from the local PCTs.

Patient / user involvement has included comment and discussion from Expert Patients Programme representatives and the Hull and East Yorkshire Cancer Patient Involvement Group.

The purpose of these Adult Pain Management Guidelines is to provide clinical guidance for the assessment and management of

- Acute Pain
- Chronic Pain
- Cancer Pain

plus a directory to support access to further help and information about local service provision.

#### A-2 Key Themes

The group has focussed throughout on **key themes** in relation to pain management, which are:

- **A patient centred approach**
- A focus on an accurate **assessment** and understanding of the cause and meaning of pain through:
  - promoting the value of taking time and care to assess pain at the outset and agree realistic treatment goals
  - the use of a range of assessment tools
- **Evidence based management** of pain

### **A-3 Key Tasks**

The tasks that the group has focussed on are set out below and in more detail in each section of the Guideline:

- **Understanding the patient centred approach to pain assessment**
- **The use of assessment tools and understanding barriers to pain assessment**
- **Acute pain**  
Presenting the WHO pain ladder for the management of acute pain and agree a local consensus view on discharge medication and the use of analgesia in A&E.
- **Chronic pain**  
Presenting and understanding the bio-psycho-social approach to the assessment and management of chronic pain.  
Understanding the causes and maintaining factors for chronic pain.  
Approaches to chronic pain management including the use of talking therapies.  
A focus on coping rather than cure where appropriate.  
Specific drug and non-drug therapies for chronic pain management.
- **Cancer pain management**  
Guidance on the use of Opioids.  
Practical guidance, conversion charts and symptom control advice.  
Other non-drug therapies including the role of psychological support and treatment, complementary therapies and spirituality.
- **Specific drug therapies**  
Presenting a consensus view
- **Professional issues and guidance**  
Advice on medicines management, safe prescribing and professional responsibilities.
- **Optimal use of resources**
- **Directory**  
Local and national contacts and sources of further information and study.

We acknowledge, that like any other resource available for use by healthcare professionals, this tool can only ever be as effective as the person operating it. However, we hope that you find this resource of value. We would be pleased to hear from you if you feel that the resource can be improved in any way or if you feel there are significant omissions.

**Dr Mark Hancocks**

Chair, CPF Pain Management Task Group

**Dr Ahmed Saleh**

Vice-chair, CPF Pain Management Task Group

**SECTION B    GUIDELINE DISSEMINATION & EDUCATION**  
*(Dr Mark Hancocks)*

The Pain Management Task Group will make these Guidelines available to local healthcare professionals in electronic and/or printed format in full and/or summary form.

Documents will be placed on local NHS intranet/internet sites as appropriate.

To raise awareness of the Guidelines and to encourage their use and implementation across Hull and East Riding, the Task Group will engage the help of Prescribing Advisors and Pain Link Nurses to aid in dissemination.

We will seek sponsorship for a launch event and/or study days, where educational sessions will help reinforce and expand the knowledge to be derived from each of the main Guideline sections.

Future evaluation will be via prescribing audits, monitoring use of Fentanyl patches and surveys as appropriate.

**SECTION C     PATIENT CENTRED CARE & THE ASSESSMENT OF PAIN**

*(Principal authors = Dr Helen Bowden, Dr Nassif Abd-Mariam, Dr Derek Haines)*

**C-1            Assessment & the patients view of pain and the disease / illness experience**

**C-2            The patient in context**

C-2-1        Understanding the whole person

C-2-2        Spirituality

C-2-3        Emotional reactions to pain

**C-3            Negotiating the management plan**

C-3-1        Finding common ground

C-3-2        Incorporating prevention and health promotion

C-3-3        Enhancing the Doctor - Patient relationship

C-3-4        Being realistic

**C-4            The importance of review**

**C-5            Caring for the carers**

**C-6            The initial assessment of pain**

C-6-1        What is pain?

C-6-2        Pain myths and barriers to pain assessment

C-6-3        Aims of the initial assessment

C-6-4        The assessment process

**C-7            The use of pain assessment tools**

C-7-1        Level 0 TPR

C-7-2        The 'Faces' pain scale

C-7-3        Pre-consultation pain questionnaire

C-7-4        The LANSS pain scale

C-7-5        Brief Pain Inventory (short form)

C-7-6        Brief Pain Inventory (follow up form)

C-7-7        A Pain Assessment Chart (for chronic pain)

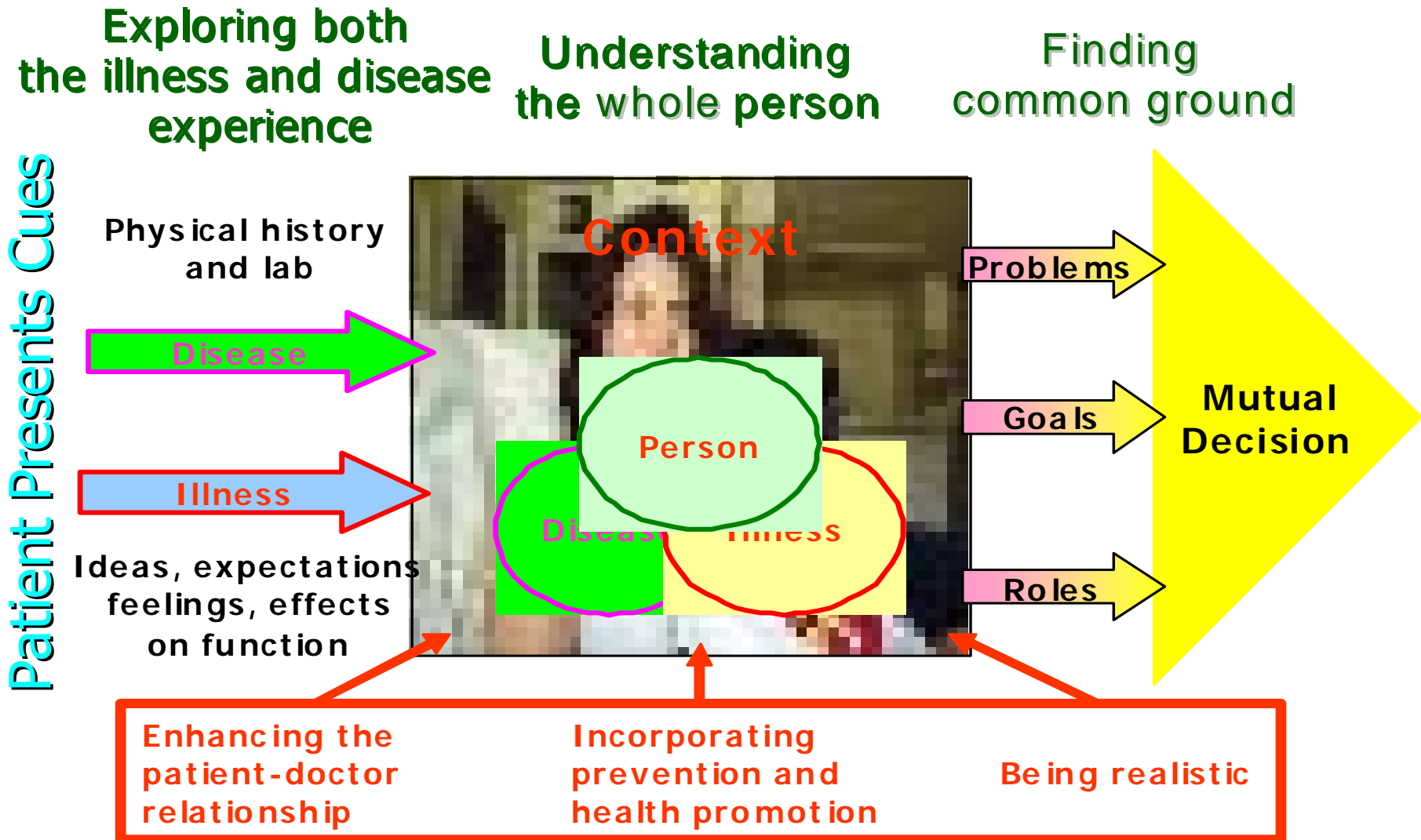
C-7-8        Short form McGill Pain Questionnaire and pain diagram

*NB. The Section on Patient Centred Care C1-C3 is broadly based on the Reference: Patient-Centred Medicine Transforming the Clinical Method by Stewart et al 1995.*



PATIENT CENTRED CARE

Stewart et al 1995



**C-1 Assessment & the patients view of pain and the disease / illness experience**

Two friends decide to try a horse-riding lesson. The next day they both ache all over. One spends the day joking with work colleagues about how unfit and 'old' they feel. The other, who had a lump removed for breast cancer 2 years earlier, is frightened that this pain represents spread of the cancer, can't face going to work, becomes tearful, and starts planning her funeral.

From the doctor's perspective the 'disease' process is the same, but the patient's experience of their 'illness' is quite different and has potentially profound influences on their health, self-esteem, mental state, ability to cope and finances.

<b>Disease Framework</b>	<b>Illness Experience</b>
Symptoms	Ideas
Signs	Concerns
Investigations	Expectations
Underlying pathology	Feelings
	Thoughts
	Effects on Life
	Unique Personal Story – Narrative

For someone with acute appendicitis the disease perspective perhaps more accurately reflects the patient's prime concern. However in more complex situations, such as chronic pain and cancer pain, unless we understand the illness experience, in particular the significance or meaning of the pain to the person, we are unlikely to deal effectively with the situation.

This section aims to help healthcare professionals explore all aspects of pain and to understand why they may be important. During a consultation the most important thing is to listen actively to the patient, showing empathy and a desire to fully understand the situation. The patient should be allowed to tell their story. Use of open questions and encouragement allows the patient to cover those aspects that they feel are important. Extra encouragement may be needed in areas that are not always considered in more straightforward consultations. A consultation that feels like a relaxed conversation will often result in more information than a list of questions. The suggested questions in the green boxes are not intended to be used as a list but are options when trying to steer the consultation in a particular direction or explore a particular aspect in more depth. The consultation should be seen very much as a partnership which aims to understand the issues and find mutual agreement about the best way to move forward.

Possible questions that may help explore the significance of the pain to the patient include:

**Questions might include:**

- What are your thoughts about this pain?
- Is there anything about this that is particularly worrying?
- Have you considered what this might be?
- What is the most difficult thing about this pain?

## C-2 The patient in context

### C-2-1 Understanding the whole person

Consideration of a person's pain gives us a very narrow perspective on them as a person. An attempt to understand the whole person can often improve our understanding and allow us to give more helpful suggestions for managing the pain. This includes their personality and usual coping mechanisms, the influence of past events on current behaviours in response to illness and care, the role of spirituality in their life, how family dynamics and social support affect their responses to pain. Other aspects affect pain less directly:

- ❖ Participation in leisure activities improves mood and widens a person's social support network.
- ❖ A person's education can influence how effective they are at accessing health services, information and help.
- ❖ Occupation can help give an insight into social status, skills, perspective on life – and much more.
- ❖ Financial concerns can have a profound influence on well-being and the ability to cope with pain or suggested treatment options.
- ❖ Mental health state eg. anxiety and depression
- ❖ Cultural or ethnic group:
  - The sense of belonging to a community (for example a neighbourhood, cultural or ethnic group, and age, religion, profession or leisure group) can have a positive effect on health regardless of actual interpersonal support.
  - Different groups can vary in their perceptions of illness causation, perspectives on treatment, attitudes and expectations of healthcare and resources, specific behaviours and responses to pain and illness sanctioned by the prevailing culture.
  - Cultural group can have a profound influence on self-treatment, informal support from family friends and colleagues and access to non-NHS treatments of all types (complementary therapies, healers, household aids to living).
  - The healthcare system itself can seem to alienate some groups more than others.
  - Specific needs such as language make it even more difficult to articulate needs and to receive support.

At the same time we need to be wary of applying stereotypes, perhaps checking out any assumptions that we might make with the individual.

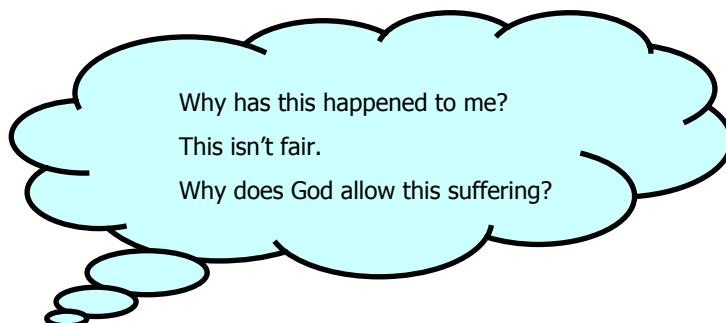
#### Questions might include:

Can you tell me something about you as a person?  
 Has anyone else you know had similar symptoms?  
 How did they cope?  
 What keeps you going?  
 Apart from medical help what helps you to cope?  
 How do these things help you cope?  
 How does your family react to your pain?  
 How do they affect your pain?

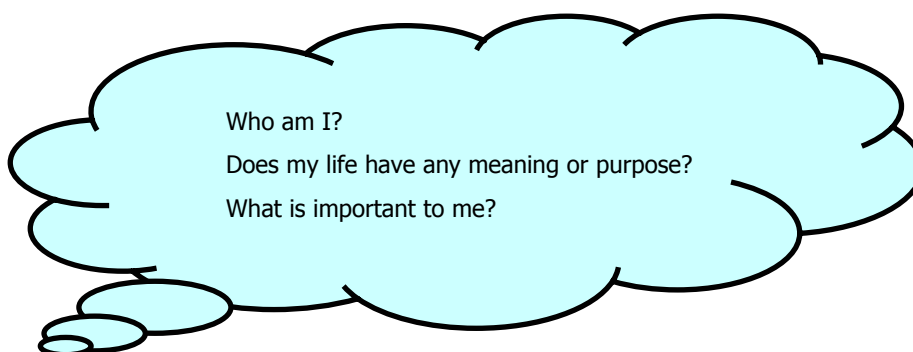
### C-2-2 Spirituality

Spirituality is about our views of the meaning of life; our purpose; our source of hope; our faith in the existence or not of an afterlife; the sense of a dimension beyond self. This may be expressed in terms of an outside influence, which is sometimes referred to as God. Spiritual well-being may be expressed in terms of a sense of reassurance, comfort, hope or peace. Spirituality is part of the holistic assessment of any patient and their situation, but may be most helpful in patients with chronic or life threatening conditions. It is important to avoid sounding judgemental throughout the consultation, but perhaps particularly when exploring spirituality. Many people feel very vulnerable when discussing their beliefs.

Illness often involves physical, emotional, intellectual and spiritual components, none more so than pain. Pain may prompt people to question the meaning of life or reflect on their lifestyle and values. They may seek to explain the situation by blaming something or someone outside themselves or harbour thoughts of guilt.



The illness or the possibility of surgery may imply to many people the threat of shortening of life. This may lead to a change in priorities, sometimes a desire to 'put things right'. Just having time lying in bed or restricted in activities by illness can lead people to reappraise their focus and values in life.



Pain and illness can affect an individual spiritually, perhaps strengthening reliance on their belief system to see them through or it can leave people angry and lost, as their belief system seems to have let them down. Conversely an individual's spirituality can affect how they manage the illness.

Illness may affect family and friends in different ways, some being supportive, caring and helpful, and others withdrawing at a time of need. Relationships with others may change dramatically as a result of the illness.

It can be particularly difficult if different family members come to terms with the situation in different ways and at different times. Carers and family members may also have spiritual needs.

Loss of health can lead to a bereavement type reaction, particularly when there does not seem to be a cure in sight. Disbelief, searching, anger, tearfulness, anxiety and depression, are all common as people struggle to come to terms with the situation. Spiritual questions often feature highly in this struggle and healthcare professionals may well be in a position to help their patients explore these concerns and when needed, refer on.

The cause of some pain seems to have a large spiritual component. Usually this is considered when pain is not controllable with drugs or physical therapies. The home situation may be complex and there may be deeper issues with 'unfinished business' - something which has not been resolved that is expressed in terms of physical pain. There may be unresolved anger, a sense of hopelessness, inability to trust, lack of inner peace, or a sense of disconnectedness or fragmentation. Spiritual pain is often expressed and felt by others in terms of suffering, anguish or torment rather than a focus on the physical aspects.

The threat of death perceived at the time of an accident, surgery, diagnosis or the real prospect of impending death may raise questions about dying and practicalities after death, but also questions about an afterlife, what does live on and what can be left behind for loved ones to cherish.

Spirituality includes but is not by any means restricted to religious beliefs and practices. Many people without a formal religion are comforted by prayers either said with them or just by knowing that others are praying for them. Unconventional beliefs may be particularly difficult to express but can be a source of distress. Chaplains are often willing to discuss such issues with patients who do not have a formal religious belief. The Chaplaincy team within the hospitals and hospice can be contacted by staff. It may be more difficult at home, though friends or the GP practice may be able to recommend sources of help.

Staff looking after patients with particularly distressing symptoms are often more aware of their own spirituality and may go through many of the same emotions. A situation may be particularly distressing because it is horrific or symptoms are uncontrollable or because the staff member identifies with the situation. If the patient has characteristics in common with the staff member or their relative, if there are interests in common, if they feel 'this could be me', the situation can cause a wide range of emotions. Staff also need support and should have mechanisms in place to find it.

#### *Options for referral or support:*

Macmillan nurses are often well placed to explore spiritual issues with patients and usually accept referrals to consider this aspect of patient care. The oncology health centres similarly would consider spirituality as part of their role. The Chaplaincy team in the hospital and the Social Work and Chaplaincy team at Dove House Hospice accept referrals for their own patients.

(See [Section I](#) for contact details)



*Taking a spiritual history*

Most healthcare professionals stick to a brief question about formal religion. However, many patients benefit from exploring their spirituality further. When it is clear that there is time to explore their deepest fears and hopes then, sometimes, the source of their greatest concern or comfort is uncovered. Sometimes reassurance that it is normal to have these fears is very comforting, but it is important not to 'normalise' the experience without first understanding the situation. This can give the impression that the history taker is not actually listening and belittles the individual's experience.

**Questions might include:**

Clearly you are in a lot of pain. What keeps you going?  
 This situation can be quite frightening. Is there anything in particular that worries you?  
 Who is important to you? What gives meaning to your life?  
 Do you believe in God? If so, how does that affect your life?  
 Has your faith helped in this situation or has it made you question your beliefs? Have you been able to speak to someone in your religious community about all this?

**C-2-3 Emotional Reactions to Pain**

Pain can cause a variety of emotions in the patient, family and their carers. These emotions can be a reaction to the situation, like a grief reaction for loss of health, or an emotional response to the pain itself which can be frightening, depressing and upsetting due to the severity, accompanied by a loss of hope if nothing seems to help. Most carers have limited experience of pain and find it difficult to extrapolate their experience of acute pain (pointing to a problem needing to be sorted out, or the positive outcome of labour pains) to the daily grind of chronic pain which has no apparent purpose or benefit. Pain cannot be seen but affects every dimension of the sufferer's life with inevitable consequences for their family and friends. Pain and disability often lead to isolation which exacerbates the emotional symptoms. The emotional symptoms themselves may be difficult for family and friends to cope with and lead to their withdrawal. Family and friends may also be wary of causing damage when they do something which seems to make the pain worse. There is huge scope for guilt. The patient also may feel guilty if they believe they are responsible for the situation. Anger is also common, at the situation, the sense of loss of control, the perceived cause(s) or apparent lack of help. The situation is complex. Exploring these emotions can help deal not only with the emotion itself but improve pain control.

**C-3 Negotiating the management plan****C-3-1 Finding common ground**

Finding common ground is the process through which the patient and doctor reach a mutual understanding and agreement in 3 key areas:

1. Defining the problem

2. Establishing the goals and priorities of treatment or management
3. Identifying the roles to be assumed by the patient and doctor.

The prime factor must always be that the patient is an individual and their wishes are of the utmost importance even if the professionals do not consider those wishes to be ideal.

People have usually thought about what might be causing their symptoms prior to speaking to a healthcare professional. This perspective may be very different to the traditional medical model. They may need considerable encouragement to share those thoughts but unless the patient is in agreement with the nature of the condition it is unlikely that they will follow any advice about treatment. The explanation and proposed treatment plan must at least be compatible with the patient's view. Using their own framework or words to define the problem and develop a management plan will help the patient feel that they have been heard.

With chronic pain particularly, the discussion of management is a meeting of experts, a mutual discussion of pros and cons, rather than the healthcare professional telling a passive patient what to do.

**Questions might include:**

Let us consider this pain together:

What are your thoughts on what is causing this?

Why do you think you are getting this pain now?

Did anyone else suggest to you what the problem might be?

Have you changed your mind about what you think is causing the pain since you first felt it?

If I were to suggest that this might be . . . . . what would you think?

What do you think that we might do about this pain?

I agree / disagree because ..... but, working together we can tackle the pain.

Always check that there is mutual understanding and aim for concordance:

So if I may just summarise what you have said, the pain is . . . and is worse when. .

. . . . and you are concerned that . . . . Is that right?

Is there anything else you would like to add?

So I see the options as . . . . .

Is that clear? Is there anything else I can tell you?

After hearing those options for treatment, what are your feelings?

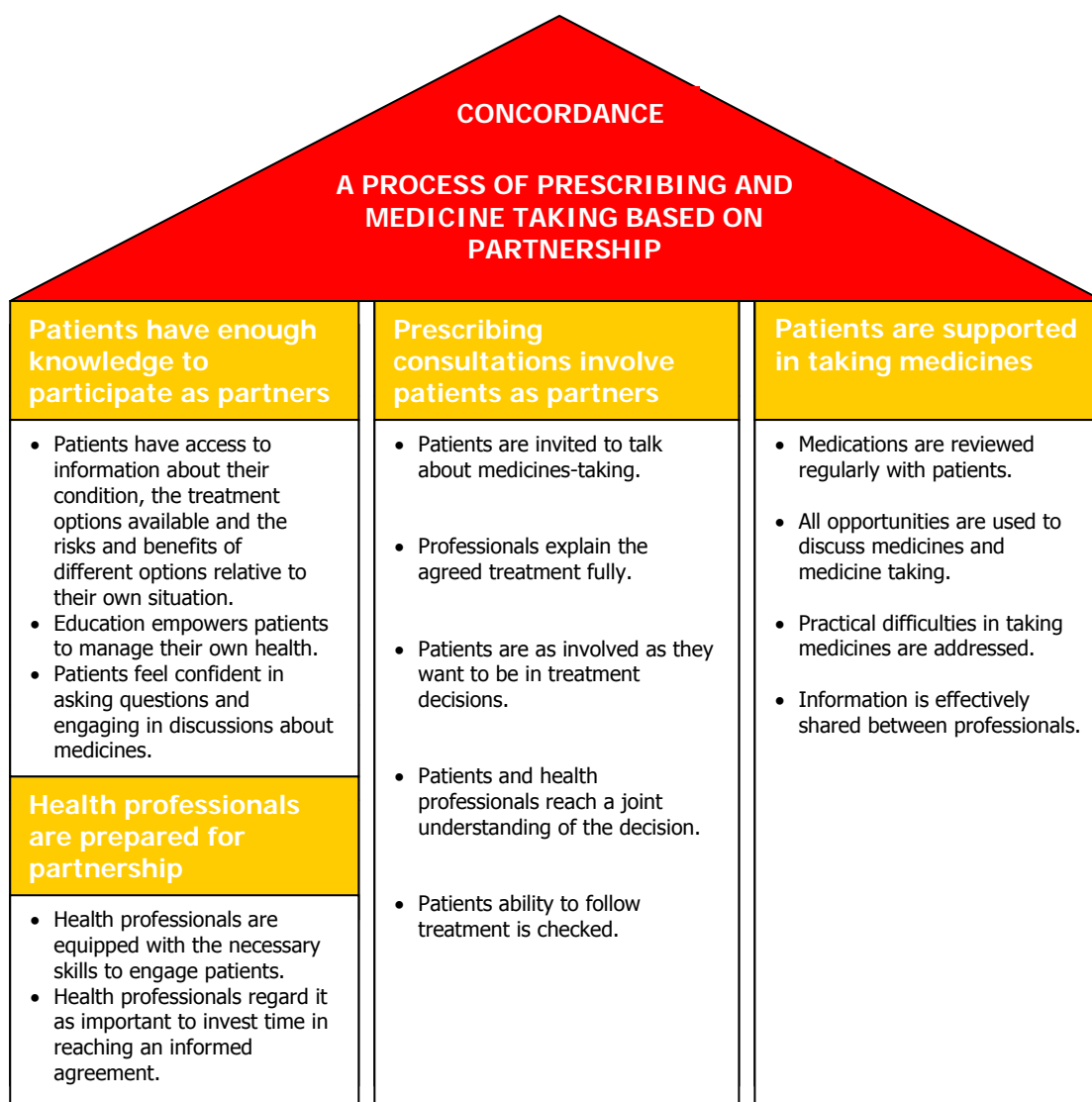
What would you like to do about this?

Can you think of any difficulties with this particular plan?

Is there anything we can do to make this treatment plan easier for you?

Finding common ground about the patient's role does not assume that the patient wants to play an active role. It may be that the patient wants the doctor to make the decision about the best treatment. Nevertheless the patient will usually appreciate the opportunity to take an active role and the explanation. At times a patient may be too poorly or a decision may be too complex for them to take a full and active role in the decision making process. Healthcare professionals need to be flexible and respond to the patient's desired level of involvement in finding common ground. Always bear in mind that it is the patient's wishes and choices that are of the utmost importance, even if they are not considered by others to be the ideal.

Concordance is an approach to the prescribing and taking of medicines that respects the wishes of the patient in determining when, whether and how medications are to be taken. Its aim is to come to some sort of agreement about a treatment plan, even if this involves an agreement to differ. (Contrast this with 'compliance', which is a measure of how far the patient is doing what the healthcare professional says).



(Source: <http://www.medicines-partnership.org/about-us/concordance>)

**C-3-2 Incorporating prevention and health promotion**

The World Health Organisation (WHO) has defined health promotion as the process of enabling people to take control over and to improve their health. Smoking, body mass index (BMI) and exercise/fitness levels all have some impact on pain. Alcohol, by affecting mood and increasing the risk of accidents, also has an impact on pain.

Complication reduction eg. the effects of reduced mobility and isolation can also be relevant areas to tackle. Reduction in unnecessary or ineffective medication (with reduction in side effects) is also part of this.

Promotion of self-help in various ways can have positive effects on pain. This includes self-help groups, exercise which will not exacerbate the pain eg. swimming and use of leisure activities, work or role within the family to promote self-esteem.

**C-3-3 Enhancing the Doctor - Patient relationship**

Clearly this refers not just to doctors but to all healthcare professionals. Balint described the concept of 'the doctor as drug'. Patients in pain appreciate the opportunity to share some of their suffering by talking or sharing moments of deep understanding. The healthcare professional may be able to stay beside them in their journey, offering empathy, compassion, respect and friendship even if there is no 'cure'. This is not easy, particularly if our training has led us to expect to help by 'doing something'. It is often extremely difficult to be with patients in pain. Like the patient and their carers we may be left feeling helpless and hopeless.

As healthcare professionals we have a role as the patient's advocate. Not only acquiring the knowledge and expertise required to refer them appropriately and help them navigate the NHS system, expediting appointments, prompting review, monitoring their medications etc. but also referring to claim any appropriate benefits and empowering them to take control of their lives.

**C-3-4 Being realistic**

It is very helpful to patients with acute pain to be given an idea of how long it may take to get better so that they can plan their lives with that in mind. For patients with chronic pain they may well be more aware than the healthcare professional of realistic goals for their pain and function.

It is important not to 'let patients down' by giving unrealistic expectations of what can be offered. Realistic information about healthcare resources, what the team can offer and when, what other agencies can do and how soon, helps patients to feel in control and less uncertain about what to expect or how soon to chase things up.

A discussion about the likelihood of side effects from medication can leave patients feeling more confident about what to do if new symptoms occur.

We also need to be realistic about what we as individuals can offer – time and resources. Also being realistic about how much the patient wants to share at this point in time or with this individual. Sometimes a relationship needs to continue for some time before a patient will venture their real fears. For others a different approach by a different healthcare professional may be needed. This should not be seen as a failure on anyone's behalf. The difficulty perhaps is knowing which situation you are in, or if indeed there is no one else or no other way forward that is more effective.

With pain, often the cause or diagnosis is not clear. Healthcare professionals need to be realistic about uncertainty and the need to make rational decisions based on incomplete knowledge. Nevertheless, however realistic we are being there is always room for hope and support.

#### **C-4        The importance of review**

With pain, when any medication is changed it is important to plan a review. This may be open ended, for example 'this should start to help within one week, if not we need to meet again' or more definite with a set review date. Regular review may be appropriate for patient support even if there is no planned intervention. There also needs to be a safety net (2005 Roger Neighbour, *The Inner Consultation*, Radcliffe Publishing 2nd edition) so that the patient knows what to expect and what to do if things are worse, if they have side effects or if something unexpected happens.

Some patients have more than one pain, for example cancer patients. It is important to review each type of pain. It may be that only one can be tackled at a time and changes in medication need to be frequently monitored. Patients with acute pain may need review to reduce and stop medication at the earliest appropriate time. Review should include re-assessment of the problem, concordance with medication or treatment plan, and negotiation of the future management plan.

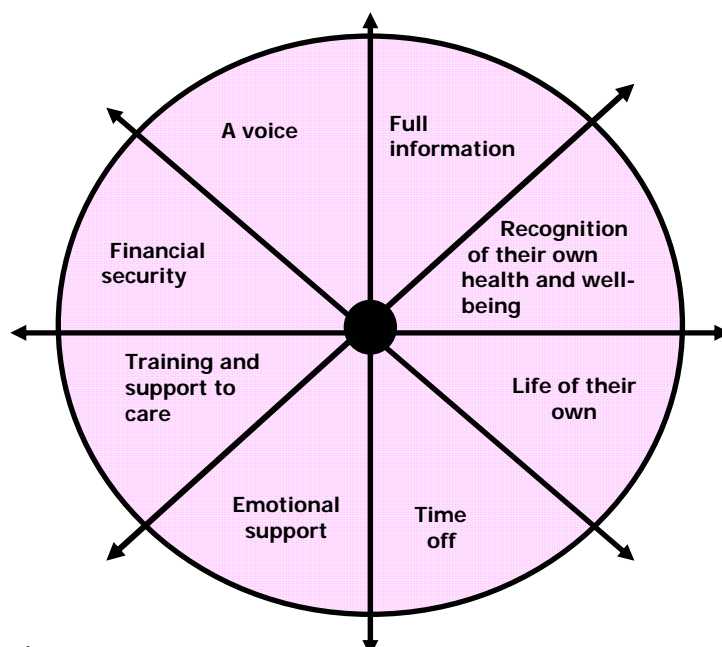
#### **C-5        Caring for the carers**

Carers provide an essential and usually large part of the patient's support and care. Treating them as part of the social and healthcare team, with the patient's permission, has potential to improve the patient's care and reduce unnecessary social and healthcare interventions. A good relationship with carers can be crucial in optimising care.

In particular, healthcare professionals must be aware that all carers (including carers of patients who may be in chronic pain) have needs of their own.

There have been many surveys and investigations of carers' needs. A growing body of research evidence suggests that there are certain categories of help, which enable carers to cope and to continue to care:





*(Source: Gold Standards Primary Care Handbook of Community Palliative Care for Pilot Practices, 2002. Dr Keri Thomas, Macmillan GP Facilitator, Calderdale and Kirklees Health Authority)*

### *Full Information*

The range of information required by carers is wide. For instance, carers often need comprehensive information on the health needs and treatment of the person they are caring for. This is particularly so when they are helping a person with their medication: they need to know how and when it should be taken, and be able to recognise any side effects from it. Many carers have this role – a survey of 1,300 carers found that 94% helped to ensure the person took their medication. Carers also need information to allow them to deal with the symptoms of some illnesses and recognise when they should ask for urgent professional help and where to get such help.

Patients and carers expect GPs and primary care team members to be well informed on local health and social care provisions, and benefits. While it is unrealistic to expect healthcare professionals to know everything it is helpful to be able to act as a signpost to direct carers to the appropriate person or place. Carers have said that they value this role.

Many patients and carers now access information themselves on the internet, in magazines and from other people. It is not unusual for them to have a deeper knowledge of specific aspects of their condition than the healthcare professionals. The professional's role may therefore include suggesting good resources (see [Section I](#)), checking understanding, clarifying complex concepts, explaining terminology and applying the information to the patient's specific situation.

### *Recognition of their own health and well-being*

Carers want to be seen, not just in terms of the services they provide to the person being cared for, but as a person in their own right with their own physical, social and emotional needs. Carers UK found that carers expressed a great deal of satisfaction with doctors who treated carer and patient together, and showed concern for the carer's physical and mental health. Representative surveys have confirmed that carers' own health suffers as a result of caring. Doctors and primary healthcare staff have a key role in helping to signpost carers to support so as to ensure that they get the financial benefits they need as well as physical support.

### *A life of their own and time off*

Time off from caring gives carers a chance to recharge their batteries or even carry out other chores.

### *Emotional support*

Having someone to talk to is greatly valued by carers, whether this person is a professional, a fellow carer or a friend. Not all carers will want to join a support group or will find it helpful, but research suggests that carers who have links with a support group are better able to continue to provide care.

### *Training and support to care*

In particular, carers have highlighted the following as important to them: help with bathing, house cleaning and maintenance, toileting and lifting.

Supporting carers can save both money and time with shorter appointment times, a reduced number of inappropriate queries, and potential reductions in GP prescription costs (eg. antidepressants).

### *Financial Security*

As a carer's income may be considerably cut, financial help may be important both to the carer and key in the well-being of patients. Healthcare professionals do not need to be able to give detailed advice, only to signpost the patient or family to relevant services (see [Section I-3](#)).

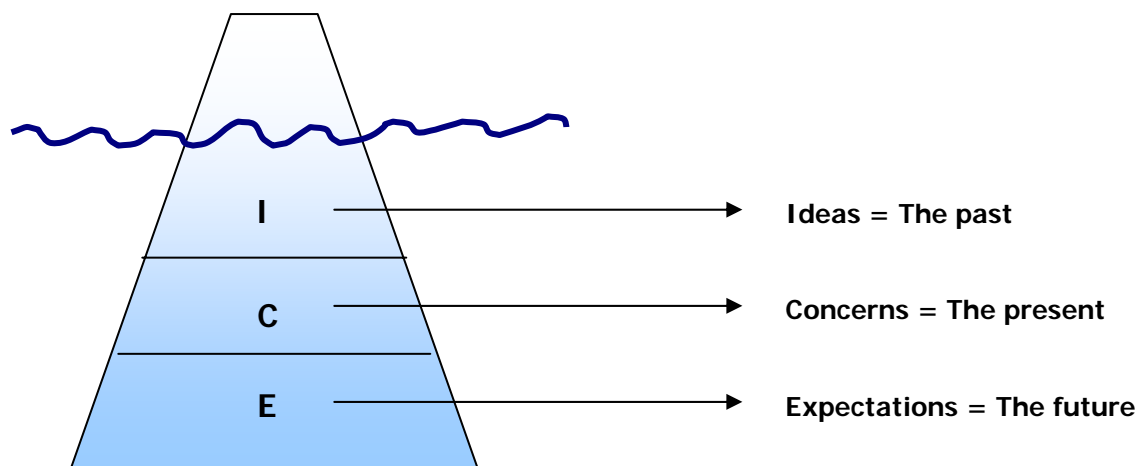
### *A voice*

The Audit Commission's investigations suggest that involving users and carers not only leads to greater satisfaction but can also lead to greater cost-effectiveness. A significant number of carers have expressed concern about the lack of recognition of their role by professionals in hospital. At the time of hospital discharge, it is important that carers are involved in the planning of future care of the patient, so that assumptions are not made about their ability and willingness to care.

Studies of carers' views of hospital discharge have highlighted the particular difficulties of failure to involve them in the timing of discharge and of providing little or no information about the future care of the patient. This may be dealt with by the new provisions under the Community Care (Delayed Discharges) Bill.

*(Source: Working with carers - Guidelines for good practice. © British Medical Association 2004. NB. Full references available on the web at <http://www.bma.org.uk/ap.nsf/Content/carers>)*

Sometimes however, it can be difficult to assess a carer's needs, as they tend to 'wear the same face' whether they are depressed or happy. They are focussed on the patient and may not feel they have been given permission to express their own needs, fears or concerns. Like the iceberg, much goes on below the surface.



*(Source: Gold Standards Primary Care Handbook of Community Palliative Care for Pilot Practices, 2002. Dr Keri Thomas, Macmillan GP Facilitator, Calderdale and Kirklees Health Authority)*

Carers may be frightened that the healthcare professionals won't deliver care or that they won't be able to cope as a carer. This in turn enlarges their fears, leading to a loss of confidence and a failure to cope. Unless help is offered, they may be unable to keep the patient at home.

Because needs may not be expressed openly it is important to offer first or make them aware of any help available so they can have the chance to opt out or accept the offer.

Finally, the results of research highlight three issues that stand out as things that doctors and other healthcare professionals should NOT do. These are:

- to wait for carers to identify themselves
- to believe that supporting carers will cost too much in terms of time and money
- to assume you have to do it all yourself without any specialist support.

Healthcare Professionals may need specific training in how to deal with carers, relatives and families. We should also bear in mind the needs of professional carers and support they need in caring for patients with difficult pain.

For resources and contact details that may be useful for carers, please see [Section I-3](#).

## C-6 The initial assessment of pain

### C-6-1 What is pain?

There are many definitions of pain in the literature. The International Association for the Study of Pain defines pain thus:

Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

*(Ref: International Association for the Study of Pain, Subcommittee on taxonomy (1979) Pain terms: a list with definitions and notes on usage. Pain 6, 249-52.)*

Although it is a brief definition it does take into account the physical and behavioural response to an individual's pain. However, this definition takes no account of the psychosocial ramifications of pain, i.e.

- its limitation of a patient's 'work, rest and play'
- the consequences of these limitations, eg. loss of independence
- its effect on a patient's relatives and carers, eg. disruption of future plans
- the reminder of our own mortality – 'the harbinger of doom'.

These consequences can all be described in everyday speech, as "pains". Healthcare professionals would consider them as aspects of "suffering". This suffering or distress needs to be distinguished from the "biomedical" pains, because medical therapies (drugs etc.) will not give relief of such suffering.

*Biomedical pains may be:*

- Nociceptive
  - tissue damage with stimulation of nociceptors
  - somatic (musculo-skeletal)
  - visceral (autonomic afferents)
- Neuropathic
  - nerve damage
  - altered functioning (peripheral and/or central sensitisation)

It is these aspects of pain at which medical and surgical therapies should be aimed, whereas suffering requires different strategies such as cognitive and supportive therapies.

### C-6-2 Pain myths and barriers to pain assessment

The key to successful pain management is thorough and appropriate pain assessment. In order to understand the context, it is first useful to consider the barriers to pain assessment.

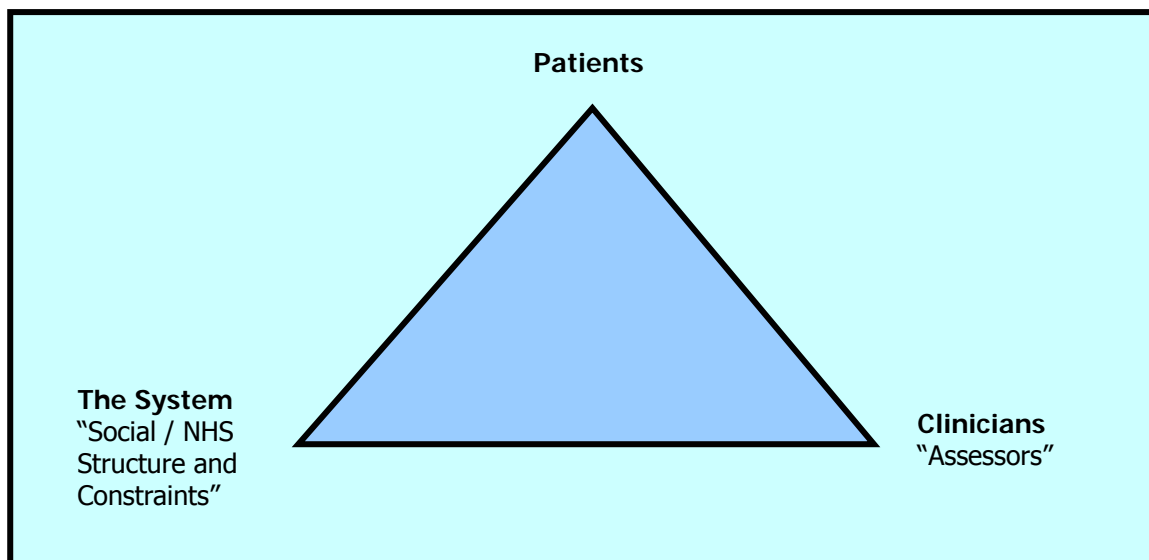
*Evidence for 'barriers' to pain assessment:*

- Pain has been constantly reported as being under-treated

- Patient / physician assessment discrepancies may predict inadequate pain management
- Pain is under-reported and under-treated in cognitively impaired older people
- Only 10-15% of chronic pain sufferers use health services, possibly due to dissatisfaction with conventional healthcare
- Current long-term pain relief rates remain at an unsatisfactory 40%
- Pain reporting is influenced by patients pain beliefs and fears
- Various factors influence pain perception and behaviour:
  - Culture
  - Previous pain experience
  - Gender
- Observational measures of assessment by clinicians have been associated with high scores and only moderate correlation between scores of pain behaviour and pain intensity rating
- In a survey of 569 GPs, 81% expressed an interest in receiving further training and education in pain management
- In the same survey of 569 GPs, 96% thought that chronic pain treatment could be improved in their locality
- Persistent pain may be attributed in part to defective healthcare treatment
- Institutions and healthcare organisations must implement means of holding clinicians accountable for adequate pain assessment and management

*(NB. full references available on request from Dr Nassif Abd-Mariam)*

*What might the barriers be?*



*Commonly identifiable barriers include:*

- Discrepancies between the patient and clinicians assessment of pain
- The patient's education, beliefs and fears
- The patient's culture, previous pain experience and gender
- The assessors knowledge of pain assessment and attitude towards pain presentations

- The low profile of chronic pain in healthcare strategies and patient management
- A lack of awareness and usage of assessment tools
- A lack of time and resources

#### *What can be done?*

Improvements in chronic pain assessment and treatment can be made either using existing resources or with improved resources. With reference to these Pain Management Guidelines, clinicians can ask of themselves:

1. What are the areas where pain assessment may be improved?
2. How may this be done (with existing or improved resources)?
3. What are the constraints?

The healthcare professional has to have an understanding of how pain affects a person so it is vital that an accurate pain assessment is carried out in order to plan their pain management. Improved pain assessment is the key to improving management outcome. In order for pain assessment to be improved, the patient and their pain must be viewed in a holistic, patient-centred way and reviewed often. As McCaffery quoted 'pain is what the patient says it is, existing when he says it does' (McCaffery M, Pasero C [1999] *Pain; Clinical Manual. St. Louis MO, Mosby*) so self-report is the most reliable method of assessing an individual's pain. However not all patients are able to self report their pain, so functional assessment, observation of behaviour and vital signs may have to be used.

### **C-6-3 Aims of the initial assessment**

The aim of an initial assessment is to triage patients with pain as "acute", "chronic" or "acute on chronic" in order to allow appropriate subsequent management.

#### ***Acute Pain***

Most doctors and nurses investigate and treat patients on the basis that "pain means injury or disease", or "pain is Nature's warning". This is appropriate for recent onset acute pain, and current algorithms for investigation and treatment should be followed. (See [Section E-1](#))

#### ***Chronic Pain***

Pain lasting more than 6 to 8 weeks gives rise to changes in the functioning of the nervous system, i.e. sensitisation. This may be the result of

- continuance of the *peripheral sensitisation* of an acute injury
- development of *central sensitisation* at spinal cord level, or above
- both *peripheral* and *central* sensitisation.

### **C-6-4 The assessment process**

All patients reporting pain need to be asked for a pain history, however obvious or urgent the situation appears.

***Where? When? and How?*** would be an absolute minimum.

With chronic pain, it can be helpful first to determine where pain lies on the list of a patient's other problems. It should be remembered however that people in severe pain may well have difficulty in answering questions and that some patients may get tired with prolonged talking, in which case assessment may be best completed over a number of consultations. Also bear in mind that it may be difficult for the patient to describe a pain which is not actually present at the time when it is being described. It may also be helpful for the patient to complete a pre-assessment questionnaire, such as an anxiety and depression scale.

*The pain history:*

- site(s) of pain eg. main site and radiation
- severity (see *pain scoring* section)
- onset and duration i.e. how and when pain started
- verbal descriptors eg. aching, burning, terrible, sickly etc. (use patient's own words)
- exacerbating and relieving factors
- variability throughout the day, week, month etc. as appropriate
- interference with sleep, activities of daily living, mood and emotions, social and family life as appropriate (see *questionnaires* section)
- therapies - current and past (remember to ask about "herbals", alcohol, complementary)
- what the patient (and family) think the pain means

*The pain examination:*

- be aware that preconceived ideas from the pain history can influence your interpretation of your examination findings; remember to record these "odd things which do not fit in"
- usual examinations for inflammation, trauma, neurology etc. as appropriate
- record pain sites with altered, diminished or no sensations
- record increased sensitivity to mechanical stimulation i.e. touch, palpation, pin prick
- record any neuropathic element to the pain suggested by allodynia (normal touch evoking pain) and by hyperalgesia (excessive pain from a noxious stimulus) - (see *questionnaires* section)
- tenderness:
  - present or absent at pain sites
  - present elsewhere
  - try to determine which "structure" is tender eg. skin, musculo-skeletal, neural or visceral
- other observations:
  - how the patient moves eg. slowly, guardedly, sprightly
  - vocalisations eg. sighing on moving
  - reactions of any accompanying persons

*Pain scoring:*

- is inevitably subjective

- observers tend to underscore, especially professionals
- in cancer pain, relatives and carers can overscore (pain as suffering)
- present pain intensity (how bad now) is most useful, especially for acute pain

*Numerical rating scales (NRS) for pain:*

- 4 point scale of "none, mild, moderate, severe"
- some scales add a fifth point of "very severe"
- note that the scale is non-linear, i.e. the difference between mild and moderate pain need not be the same as between moderate and severe
- advantages of being quick and easy to administer, and providing a record of change in pain over time (but limited by the observer proviso)
- should be recorded as a matter of routine on the "TPR" chart (the level 0 chart) for all inpatients with pain
- (also 11 point scale - see *questionnaires* section)
- the "faces" pain scale should be used for those unable to understand "mild, moderate and severe", such as adults with learning difficulties (and children)
- for adults with cognitive difficulties, there are specialised scoring systems using observable proxies for distress and presumed pain (see [Section H](#))

*Other pain scores:*

- *Pain relief scoring* measures other things besides changes in pain intensity with treatment (eg. gratitude for receiving comfort or care)
- *Visual Analogue Scales (VAS)* are good but require more patient education than the *Numerical Rating Scales*

*Questionnaires:*

- Are used mainly for chronic pain
- LANSS Pain Scale: the Leeds Assessment of Neuropathic Symptoms and Signs gives a score indicating the likelihood of neuropathic pain playing a part.
- Pre-consultation patient questionnaire (such as in A Practical Guide to the provision of Chronic Pain Services for adults in Primary Care) gives an indication of the extent of the patient's problems.
- Brief Pain Inventory: a series of 11 point Numerical Rating Scales covering four aspects of pain intensity, and seven aspects of interference of pain with life. Reasonably easy to complete and repeat over time.
- Other pain questionnaires eg. the McGill Pain Questionnaire are less useful for repeated use.
- Other questionnaires for disability, quality of life, psychological and emotional wellbeing etc. are mainly used by those professionals with a special interest in such matters.



*The evaluation:*

- Decide "what the pain means" and "what is happening" (in the ideal world, make the diagnosis and understand the aetiology).
- Explain to the patient (and relatives) about what the pain means etc. without being too dogmatic, i.e. the most likely explanation at the moment.
- Consider further investigations depending on the possibilities suggested by the differential diagnosis.
- Consider appropriate "medical" treatments for identified biomedical causes.
- Consider appropriate strategies for psychosocial suffering.

A number of clues may help to distinguish chronic or acute on chronic pain from acute pain:

1. Duration: similar pain for more than 2 months. Check for previous records, investigations etc.
2. Variation in intensity: bouts of worse pains (acute on chronic) are often related to relatively minor over-exertion or injury. This is understandable once the sensitisation process is appreciated.
3. Associated autonomic symptoms, such as pallor, sweating, fainting: these are concomitant with any severe pain, and can occur occasionally with acute on chronic pain, but are usually absent with chronic pains.
4. Associated distress with chronic pain:
  - emotionally charged descriptive words such as "horrible" or "killing" pain
  - social disruption, involving work, rest and play. Relatives are often involved and concerned for various reasons.

*Special Cases:*

Patients with cancer can also have a pre-existing chronic pain which can be mistakenly attributed to the cancer or can have acute on chronic cancer pain, which was previously controlled; consider

- advancement of the cancer
- changes to the drug regime (concordance etc.)
- psychosocial changes (bad news, carer fatigue etc.)

**C-7 The use of pain assessment tools**

These Guidelines include some examples of the more commonly encountered pain assessment tools:

- C-7-1 Level 0 TPR (Temperature, Pulse, Respiration) Chart** - an example of a 4-point Numerical Rating Scale for monitoring pain alongside other basic functions.
  
- C-7-2 The Faces Pain Scale** - should be used for those unable to understand "mild, moderate and severe", such as adults with learning difficulties (or for use with children).
  
- C-7-3 Pre-consultation Patient Questionnaire** - gives an indication of the extent of the patient's (long standing) problems.  
  
(Bear in mind that although some patients may not like completing a questionnaire before seeing a healthcare professional, such questionnaires do have a role in helping patients think through aspects of their pain and ensure that all these aspects are covered, thus avoiding the need to go through a tick-list during the consultation. Their use allows more time to cover relevant aspects of the pain; they can also act as a tool for discussion and can be useful for audit.)
  
- C-7-4 The LANSS Pain Scale** – used to assess the likelihood of neuropathic pain playing a part.
  
- C-7-5 Brief Pain Inventory (short form)** - useful as it is reasonably easy to complete and repeat over time.
  
- C-7-6 Brief Pain Inventory (follow up form)** – to be used in conjunction with the BPI short form above.
  
- C-7-7 A Pain Assessment Chart (for Chronic Pain)** – a quick visual aid for the patient notes.
  
- C-7-8 Short Form McGill Pain Questionnaire and Pain Diagram** – a valid and comprehensive, multi-dimensional pain assessment tool, but less useful for repeated use.



**NB.** Pain Scales in multiple languages can be downloaded and printed free whenever required from [http://www.britishpainsociety.org/pain\\_scales.html](http://www.britishpainsociety.org/pain_scales.html)

## C-7-1 Temperature, Pulse &amp; Respiration (TPR) level 0 chart NRS

Name:				Unit Number:				Date of Birth: / /				Ward:				Normal BP	
DATE:																Weight	
TIME [24 hr]:																Admission Weight	
FREQUENCY:																Kg	
BLOOD PRESSURE & PULSE	240																40° C
	230																39° C
	220																38° C
	210																37° C
	200																36° C
	190																35° C
	180																
	170																
	160																
	150																
	140																
	130																
	120																
	110																
	100																
	90																
80																	
70																	
60																	
50																	
40																	
Respiratory Rate																bpm	RESPIRATORY
Oxygen																% or lpm	
O2 Saturation																%	
O2 Delivery System																	
MAP																mmHG	CARDIOVASCULAR
CVP																mmHG	
PERIPHERAL																W = warm C = cool	
GLUCOSE																mmol/l	
PAIN SCORE																0 - 3	PAIN / NAUSEA / SEDATION
SITE																abc	
SEDATION																0 - 3	
NAUSEA																0 - 3	
PAIN SITE																a b c	
ANALGESIA GIVEN																	
																	OTHER
NURSE SIGN																INITIAL	

PAIN SCORE: 0 = no pain, 1 = slight pain\*, 2 = moderate pain\*,  
3 = severe pain\* \* = on movement

SEDATION SCORE: 0 = awake, 1 = occasionally drowsy\*,  
2 = frequently drowsy\*, 3 = difficult to wake up, S = asleep  
\* = easy to wake up

NAUSEA / VOMITING SCORE: 0 = none, 1 = nausea,  
2 = vomited once\*, 3 = vomited more than\*  
\* = last hour

## OUTREACH EARLY WARNING SYSTEM - BLEEP 075/076 [HRI] OR 471 [CHH]

RESPIRATORY	CARDIOVASCULAR / RENAL	NEUROLOGICAL	OTHER
1. FIO2 > 50% or SpO2 < 94% [continuous monitoring] 2. Respiratory rate > 25 [or trend quickly worsening] 3. Inability to expectorate [inform physio] 4. Tracheostomy Patient [humidification / support]	1. Urine output < 30 ml / hr for > 2 hrs 2. Systolic < 100 [or 30 below normal for > 2 hours] 3. Heart Rate > 140	1. Abnormal Mentation [confusion aggression] 2. None Responsive to Voice	1. Gut Feeling [unhappy with patient] 2. Multiple adverse trends, but not fulfilling other referral criteria

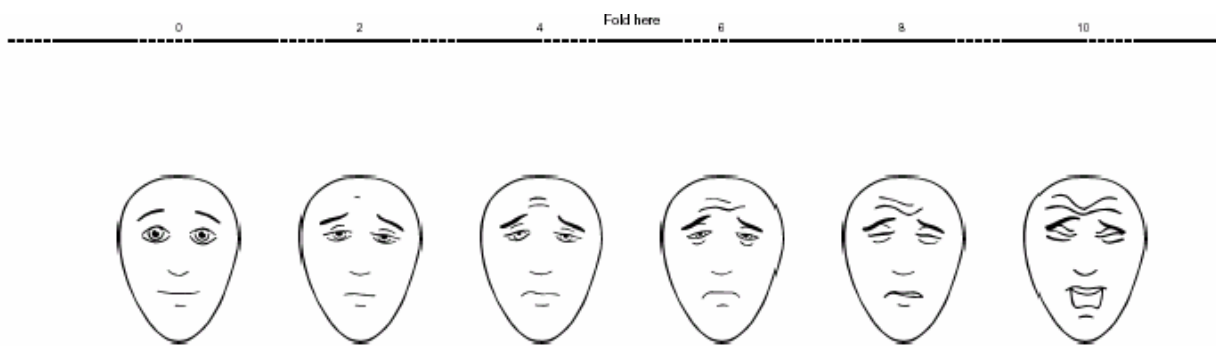
(Source: HEYHT)

**C-7-2 The Faces Pain Scale**

*In the following instructions, say "hurt" or "pain," whichever seems right for a particular patient.*

"These faces show how much something can hurt. This face [*point to left-most face*] shows no pain. The faces show more and more pain [*point to each from left to right*] up to this one [*point to right-most face*] – it shows very much pain. Point to the face that shows how much you hurt [*right now*]."

*Score the chosen face 0, 2, 4, 6, 8, or 10, counting left to right, so '0' = 'no pain' and '10' = 'very much pain.' Do not use words like 'happy' and 'sad'. This scale is intended to measure how the patient feels inside, not how their face looks.*



*Hicks CL, von Baeyer CL, Spafford P, van Korlaar I, Goodenough B. The Faces Pain Scale – Revised: Toward a common metric in pediatric pain measurement. Pain 2001; 93:173-183.*

*Scale adapted from: Bieri D, Reeve R, Champion GD, Addicoat L, Ziegler J. The Faces Pain Scale for the self-assessment of the severity of pain experienced by children: Development, initial validation and preliminary investigation for ratio scale properties. Pain 1990; 41:139-150.*

*From the Pediatric Pain Sourcebook. Original copyright © 2001. Used with permission of the International Association for the Study of Pain and the Pain Research Unit, Sydney Children's Hospital, Randwick NSW 2031, Australia. This material may be photocopied for clinical use.*

**C-7-3 Pre-consultation Patient Questionnaire**

(from *A Practical Guide to the provision of Chronic Pain Services for adults in Primary Care*  
[http://www.britishpainsociety.org/pdf/NAPP\\_RESOURCEPACK.pdf](http://www.britishpainsociety.org/pdf/NAPP_RESOURCEPACK.pdf))

Dear Patient

The doctors and nurses at this practice are very keen to ensure that you are being treated to the very best standards. Taking a few moments to answer the following questions will help us to understand what's needed to improve the services we offer to patients who are in chronic pain.

If you are not suffering pain regularly there is no need to fill out this questionnaire.

Otherwise, thank you for taking the time to answer the following questions.

*Please circle the appropriate response or add your comments*

1. I am ..... years old

2. I am female/male

3. Ethnic group .....

4. Do you know the cause of your pain? Yes/No

5. If 'Yes' what is the cause of your pain?

.....

6. What do you believe is the cause of your pain?

.....

7. Do you have pain on most days? Yes/No

8. Where is your pain?

.....

9. Do you have pain in more than one place? Yes/No

10. If so, where else is your pain?

.....

11. How long has your pain lasted?

A few days

More than 6 months

A few weeks

2 years or more

Between 1 and 2 months

5 years or more

Between 2 and 4 months

More than 10 years

Between 4 and 6 months

12. What pain-relieving medication do you take that has been prescribed by a doctor or nurse?

.....

13. What pain-relieving medication do you take when you feel you need it? (that has not been prescribed by a doctor or nurse)

.....

14. What other medication do you take (prescribed or self-medicated)

.....

15. How would you describe your pain?

Burning

Aching

Stabbing

Cutting

Gripping

Tightening

Pricking

Shooting

Pain at rest

Pain on movement

16. How well is your pain controlled? Put a mark along this line to show how severe your pain is:

no pain



worst pain imaginable

17. Does pain regularly stop you getting to sleep? Yes/No

18. Does pain regularly wake you from your sleep? Yes/No

19. What else does your pain stop you from doing?

.....

20. Has the pain affected your mood?

.....

21. Have you had any of the following to improve your pain?

TENS (Nerve Stimulation)

Yes/No

If 'yes' did it help? .....

Acupuncture

Yes/No

If 'yes' did it help? .....

Surgery

Yes/No

If 'yes' did it help? .....

Counselling / support

Yes/No

If 'yes' did it help? .....

Nerve blocks

Yes/No

If 'yes' did it help? .....

Medication

Yes/No

If 'yes' did it help? .....

Pain Management Programme

Yes/No

If 'yes' did it help? .....

Other (specify)

Yes/No

If 'yes' did it help? .....

22. Have you seen the following other people to help control your pain?

Chiropractor	Yes/No	If 'yes' did it help? .....
Osteopath	Yes/No	If 'yes' did it help? .....
Physiotherapist	Yes/No	If 'yes' did it help? .....
Psychologist	Yes/No	If 'yes' did it help?.....
Occupational Therapist	Yes/No	If 'yes' did it help?.....
Pain Management Services	Yes/No	If 'yes' did it help?.....

23. Do you think your doctor or nurse understands how much pain you are in? Yes/No

24. Do you feel more could be done to control or manage your pain? Yes/No

25. If you feel more could be done, in what way do you think your pain control could be improved?

.....

26. What do you hope to get out of your appointment with the doctor or nurse today?

.....

If you are happy to give your name and which doctor or nurse you see or are about to see, please enter these details here:

Your name.....

Doctor you usually see or are about to see .....

Nurse you usually see or are about to see.....

**Please give your completed questionnaire to your doctor.**

**Thank you for your time.**

**C-7-4 The LANSS Pain Scale (Leeds Assessment of Neuropathic Symptoms and Signs)**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

This pain scale can help to determine whether the nerves that are carrying your pain signals are working normally or not. It is important to find this out in case different treatments are needed to control your pain.

**A PAIN QUESTIONNAIRE**

- Think about how your pain has felt over the last week.
- Please say whether any of the descriptions match your pain exactly.

1. Does your pain feel like strange, unpleasant sensations on your skin? Words like pricking, tingling, pins and needles might describe these sensations.

- a) NO – My pain doesn't really feel like this ..... (0)
- b) YES – I get these sensations quite a lot ..... (5)

2. Does your pain make the skin in the painful area look different from normal? Words like mottled or looking more red or pink might describe the appearance.

- a) NO – My pain doesn't affect the colour of my skin ..... (0)
- b) YES – I've noticed that the pain does make my skin look different from normal..... (5)

3. Does your pain make the affected skin abnormally sensitive to touch? Getting unpleasant sensations when lightly stroking the skin, or getting pain when wearing tight clothes might describe the abnormal sensitivity.

- a) NO – My pain doesn't make my skin abnormally sensitive in that area..... (0)
- b) YES – My skins seems abnormally sensitive to touch in that area..... (3)

4. Does your pain come on suddenly and in bursts for no apparent reason when you're still? Words like electric shocks, jumping and bursting describe these sensations.

- a) NO – My pain doesn't really feel like this ..... (0)
- b) YES – I get these sensations quite a lot ..... (2)

5. Does your pain feel as if the skin temperature in the painful area has changed abnormally? Words like hot and burning describe these sensations.

- a) NO – I don't really get these sensations ..... (0)
- b) YES – I get these sensations quite a lot ..... (1)



**A SENSORY TESTING**

Skin sensitivity can be examined by comparing the painful area with a contralateral or adjacent non-painful area for the presence of allodynia (condition in which ordinarily non-painful stimuli evoke pain) and an altered pin prick threshold (PPT).

**1. ALLODYNIA**

Examine the response to lightly stroking cotton wool across the non-painful area and then the painful area. If normal sensations are experienced in the non-painful site, but pain or unpleasant sensations (tingling, nausea) are experienced in the painful area when stroking, allodynia is present.

- a) NO – normal sensation in both areas ..... (0)
- b) YES – allodynia in painful area only..... (5)

**2. ALTERED PIN-PRICK THRESHOLD**

Determine the pin prick threshold by comparing the response to a 23 gauge (blue) needle mounted inside a 2ml syringe barrel placed gently onto the skin in a non-painful and then painful areas.

If a sharp pin prick is felt in the non-painful area, but a different sensation is experienced in the painful area, eg. none / blunt only (raised PPT) or a very painful (lowered PPT), an altered PPT is present.

If a pinprick is not felt in either area, mount the syringe onto the needle to increase the weight and repeat.

- a) NO - equal sensation in both areas ..... (0)
- b) YES – altered PPT in painful area ..... (3)

**SCORING:**

Add values in brackets for sensory descriptions and examination findings to obtain overall score.

**TOTAL SCORE (maximum 24).....**

If score <12, neuropathic mechanisms are **unlikely** to be contributing to the patient's pain.

If score >12, neuropathic mechanisms are **likely** to be contributing to the patient's pain.

**C-7-5 Brief Pain Inventory (Short Form)**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

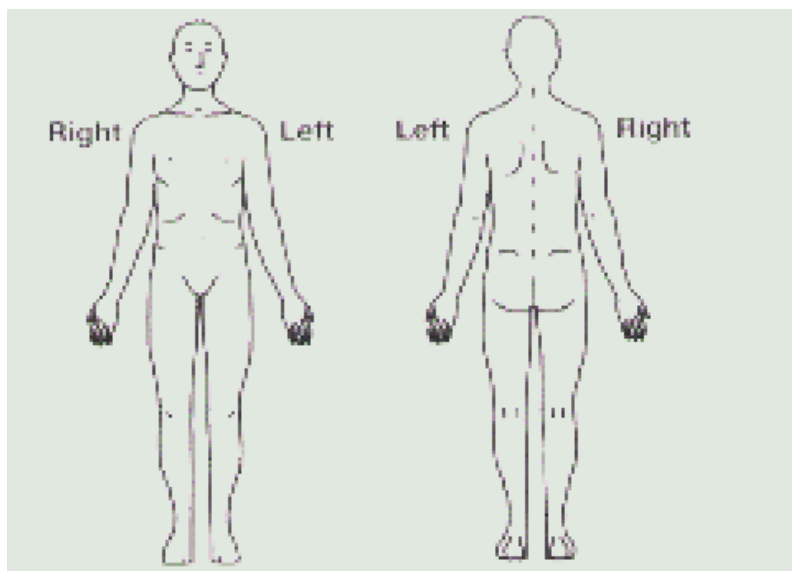
Time: \_\_\_\_\_

Name: \_\_\_\_\_  
Surname First Initial Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. yes                      2. no

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its **WORST** in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain								Pain as bad as you can imagine		

4) Please rate your pain by circling the one number that best describes your pain at its **LEAST** in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain								Pain as bad as you can imagine		

5) Please rate your pain by circling the one number that best describes your pain on **AVERAGE**.

0	1	2	3	4	5	6	7	8	9	10
No pain								Pain as bad as you can imagine		

6) Please rate your pain by circling the one number that tells how much pain you have **RIGHT NOW**.

0	1	2	3	4	5	6	7	8	9	10
No pain								Pain as bad as you can imagine		

7) What treatments or medications are you receiving for your pain?

---

8) In the past 24 hours, how much **RELIEF** have pain treatments or medications provided? Please circle the one percentage that most shows how much.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No relief										Complete relief

9) Circle the one number that describes how, during the past 24 hours, **PAIN HAS INTERFERED** with your:

**A. General Activity:**

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

**B. Mood**

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

**C. Walking ability**

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

**D. Normal work** (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

**E. Relations with other people**

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

**F. Sleep**

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

**G. Enjoyment of life**

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

*(Source: Pain Research Group, Department of Neurology, University of Wisconsin-Madison.*

*May be duplicated and used in clinical practice.)*

## C-7-6 Brief Pain Inventory - Follow up

# BPI ASSESSMENT FORM

**FOLLOW - UP**

## BRIEF PAIN INVENTORY

Please circle your response or ask for help if you are having problems

Locality

Date

Registration number

Patient's name

Date of birth

Seen by (HCP)

Management

1. How much RELIEF have pain treatments or medications FROM THIS CLINIC provided? Please circle the one percentage that shows how much.

100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	0%
COMPLETE RELIEF										NO RELIEF

2. Please rate your pain by circling the one number that best describes your pain at its WORST in the past week.

0	1	2	3	4	5	6	7	8	9	10
NO PAIN										PAIN AS BAD AS YOU CAN IMAGINE

3. Please rate your pain by circling the one number that best describes your pain at its LEAST in the past week.

0	1	2	3	4	5	6	7	8	9	10
NO PAIN										PAIN AS BAD AS YOU CAN IMAGINE

4. Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0	1	2	3	4	5	6	7	8	9	10
NO PAIN										PAIN AS BAD AS YOU CAN IMAGINE

5. Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0	1	2	3	4	5	6	7	8	9	10
NO PAIN										PAIN AS BAD AS YOU CAN IMAGINE

6. Circle the one number that describes how during the past week, PAIN HAS INTERFERED with your:

A. General activity

0	1	2	3	4	5	6	7	8	9	10
DOES NOT INTERFERE										COMPLETELY INTERFERES

B. Mood

0	1	2	3	4	5	6	7	8	9	10
DOES NOT INTERFERE										COMPLETELY INTERFERES

C. Walking ability

0	1	2	3	4	5	6	7	8	9	10
DOES NOT INTERFERE										COMPLETELY INTERFERES

D. Normal work (includes work both outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
DOES NOT INTERFERE										COMPLETELY INTERFERES

E. Relationships with other people

0	1	2	3	4	5	6	7	8	9	10
DOES NOT INTERFERE										COMPLETELY INTERFERES

F. Sleep

0	1	2	3	4	5	6	7	8	9	10
DOES NOT INTERFERE										COMPLETELY INTERFERES

G. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
DOES NOT INTERFERE										COMPLETELY INTERFERES

**C-7-7 A Pain Assessment Chart (for Chronic Pain)**

Case note N°

NHS N°

D.O.B

(Addressograph label if available)

**Place of assessment**

- ☐ Home   ☐ Hospice  
☐ Nursing/Residential home  
☐ Ward (*specify*)

**Body Chart**

Use a letter to indicate sites of pain  
Eg. A / B / C etc

RIGHT

LEFT

RIGHT

What makes the pain better or worse?

Anything else about the pain?  
Eg. things already tried

Supine

Prone

**Descriptive Words**

- Throbbing
- Cutting
- Burning
- Stinging
- Aching
- Tiring
- Blinding
- Intense
- Penetrating
- Nagging
- Shooting
- Gnawing
- Searing
- Dull
- Tender
- Comfortable
- Coping
- Happy
- Unusually quiet
- Irritable
- Content
- Frightful
- Annoying
- Unbearable
- Radiating
- Nauseating
- Stabbing
- Crushing
- Smarting
- Hurting
- Splitting
- Vicious
- Miserable
- Spreading
- Piercing
- Disturbing sleep
- Pain Free
- Relaxed
- Lethargic
- Active – Indoors
- Active – outdoors
- Over active

**Chronic Pain**

0	1	2	3	4	5	6	7	8	9	10
Pain free	Mild		Moderate		Severe		Very severe			Overwhelming

- Other (specify)

**C-7-8 Short Form McGill Pain Questionnaire and Pain Diagram**

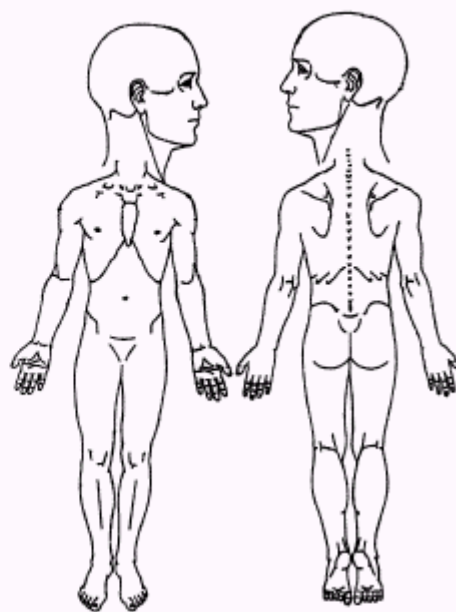
(from *Pain*. 1987 Aug; 30(2):191-7 Dr. Ron Melzack, .Department of Psychology, McGill University, Montreal, Quebec, Canada.)

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Check the column to indicate the level of your pain for each word, or leave blank if it does not apply to you.

		Mild	Moderate	Severe
1	Throbbing	_____	_____	_____
2	Shooting	_____	_____	_____
3	Stabbing	_____	_____	_____
4	Sharp	_____	_____	_____
5	Cramping	_____	_____	_____
6	Gnawing	_____	_____	_____
7	Hot-burning	_____	_____	_____
8	Aching	_____	_____	_____
9	Heavy	_____	_____	_____
10	Tender	_____	_____	_____
11	Splitting	_____	_____	_____
12	Tiring-Exhausting	_____	_____	_____
13	Sickening	_____	_____	_____
14	Fearful	_____	_____	_____
15	Cruel-Punishing	_____	_____	_____



Mark or comment on the above figure where you have your pain or problems.

Indicate on this line how bad your pain is—at the left end of line means no pain at all, at right end means worst pain possible.

No Pain	_____	Worst Possible Pain
---------	-------	---------------------

S	/33	A	/12	VAS	/10
---	-----	---	-----	-----	-----

**SECTION D    MEDICINES MANAGEMENT**  
*(Principal author = Mrs Jackie Matthews)*

**D-1        Professional codes of conduct**

D-1-1    Nurses and midwives

D-1-2    Doctors

D-1-3    Key responsibilities of a pharmacist

**D-2        Safe prescribing practice**

D-2-1    Principles in relation to prescribing

D-2-2    Principles for the administration of medicines

**D-3        The role of the pharmacist**

D-3-1    The new Community Pharmacy contract

**D-4        Records and documentation**

**D-5        Disposal of medicines**

**D-6        Controlled drugs**

D-6-1    Brand name prescribing

**D-7        Patient-held drug charts**

D-7-1    An example of a patient-held drug chart

**D-1        Professional codes of conduct**

**D-1-1      Nurses and midwives**

*The Nursing & Midwifery Council – Code of Professional Conduct (2002) states that:*

“You are personally accountable for your practice. This means that you are answerable for your actions and omissions, regardless of advice or directions from another professional.”

*The Nursing & Midwifery Council – Guidelines for the Administration Of Medicines (2002) states that:*

“The administration of medicines is an important aspect of the professional practice of persons whose names are on the Council’s register. It is not solely a mechanistic task to be performed in strict compliance with the written prescription of a medical practitioner. It requires thought and the exercise of professional judgement...”

*The Code of Professional Conduct also states that:*

“To practise competently, you must possess the knowledge, skills and abilities required for lawful, safe and effective practice without direct supervision. You must acknowledge the limits of your professional competence and only undertake practice and accept responsibilities for those activities in which you are competent.”

**D-1-2      Doctors**

*The General Medical Council – duties of a registered doctor states that:*

“Respect the rights of patients to be fully involved in their care”

“Keep your professional knowledge and skills up to date and recognise the limits of your professional competence”

“Work with colleagues in the ways that best serves patients interests”

### **D-1-3 Key responsibilities of a pharmacist**

Pharmacists understand the nature and effect of medicines and medicinal ingredients, and how they may be used to prevent and treat illness, relieve symptoms or assist in the diagnosis of disease. Pharmacists in professional practice use their knowledge for the wellbeing and safety of patients and the public.

At all times pharmacists must act in the interests of patients and other members of the public, and seek to provide the best possible health care for the community in partnership with other health professions. Pharmacists must treat all those who seek their professional services with courtesy, respect and confidentiality. Pharmacists must respect patients' rights to participate in decisions about their care and must provide information in a way in which it can be understood.

Pharmacists must ensure that their knowledge, skills and performance are of a high quality, up to date, evidence based and relevant to their field of practice.

Pharmacists must ensure that they behave with integrity and probity, adhere to accepted standards of personal and professional conduct and do not engage in any behaviour or activity likely to bring the profession into disrepute or undermine public confidence in the profession.

## **D-2 Safe prescribing practice**

### **D-2-1 Principles in relation to prescribing**

As a Doctor, Registered Nurse, Pharmacist or Midwife you are accountable for your actions and omissions. In administering any medication, or assisting or overseeing any self-administration of medication, you must exercise your professional judgement and apply your knowledge and skill in the given situation.

When administering medication against a prescription written manually or electronically by a registered medical practitioner or another authorised prescriber, the prescription should: -

- Be based, whenever possible, on the patient's informed consent and awareness of the purpose of the treatment.
- Be clearly written, typed or computer-generated and be indelible (for nurses, please refer to the NMC's *Guidelines for records and record keeping, 2002* available at <http://www.nmc-uk.org/>).
- Clearly identify the patient for whom the medication is intended.
- Record the weight of the patient on the prescription sheet where the dosage of medication is related to weight.
- Clearly specify the substance to be administered, using its generic or brand name where appropriate and its stated form, together with the strength, dosage, route, timing, frequency of administration, start and finish dates and any special instruction for administration.
- Be signed and dated by the authorised prescriber.



- Not be for a substance to which the patient is known to be allergic or otherwise unable to tolerate.
- In the case of controlled drugs, specify the dosage and the number of dosage units written in accordance with the controlled drug regulations. (For more on Controlled Drugs, see [Section D-6](#))

*(Source: 'Management of Cancer Pain in Adults' from the joint North and North East Lincolnshire Palliative Care Group)*

#### **D-2-2 Principles for the administration of medicines**

In exercising your professional accountability in the best interests of your patients, you must: -

- Know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications
- Be certain of the identity of the patient to whom the medicine is to be administered
- Be aware of the patient's care plan
- Check that the prescription, or the label on medicine dispensed by a pharmacist, is clearly written and unambiguous
- Have considered the dosage, method of administration, route and timing of the administration in the context of the condition of the patient and co-existing therapies
- Check the expiry date of the medicine to be administered
- Check that the patient is not allergic to the medicine before administering it
- Contact the prescriber or another authorised prescriber without delay where contra-indications to the prescribed medicine are discovered, where the patient develops a reaction to the medicine, or where assessment of the patient indicates that the medicine is no longer suitable
- Make a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, ensuring that any written entries and the signature are clear and legible; it is also your responsibility to ensure that a record is made when delegating the task of administering medicine
- Where supervising a student nurse or midwife in the administration of medicines, clearly countersign the signature of the student.

*(Source: 'Management of Cancer Pain in Adults' from the joint North and North East Lincolnshire Palliative Care Group)*

#### **D-3 The role of the Pharmacist**

Pain is a common complaint in Primary Care. Early intervention with adequate doses of analgesia, both simple and adjuvant, can provide faster relief for the patient and obviate the need for a hospital referral. Specialist intervention is then more readily available for those patients with more complex needs.

Minor analgesics are amongst the most widely used over-the-counter (OTC) medicines, accounting for some 20% of the OTC medicines market. Pharmacists respond to several requests for advice about analgesics each working day. Pharmacists have extensive training in the actions, uses and side effects of medicines and

they have an important role and contribution to make in improving services for patients in hospitals and in the community.

Chronic pain, especially in the elderly, is often not managed effectively. This may be due to a number of factors:

- Inadequate doses of prescribed analgesic
- Patient beliefs, leading them to take less than the full prescribed dose
- Use of a “cocktail” of medicines over a prolonged period of time
- Patient understanding of the reasons for, and correct use of, prescribed analgesia
- Other co-morbidities.

Pharmacists potentially have a key role to play in addressing these factors. Medication review is an inherent part of pain management, the role of the pharmacist being to:

- appraise all current medications in relation to the patient’s clinical history and morbidities
- agree and remove any unnecessary medication
- agree and ensure optimum dosage
- educate patients in how to use analgesia to control their pain
- explore patients’ beliefs about their medications.

Primary care based pharmacists (Community Pharmacists and Practice Support Pharmacists) therefore have an important role to play, as part of the multi-disciplinary team, in supporting patients to manage and optimise pain medication in the primary care setting.

Secondary-care pharmacists with a specialised knowledge in pain control are of importance in managing the more complex patient in conjunction with the specialist team, usually in a hospital clinic.

### **D-3-1 The new Community Pharmacy contract**

Implemented in April 2005, this new contract is based on three tiers of service and provides for more clinical input from Community Pharmacists.

1. Essential services – pharmacists must offer support and advice for self-care. This could involve brief unplanned interventions with patients to discuss pain management and analgesic use.
2. Advanced services – accredited pharmacists can arrange Medication Use Reviews (MURs) face-to-face with patients. These are not clinical reviews per se, as the pharmacist does not have access to the patient record. However, via the Patient Medication Record held on the pharmacy dispensing system, compliance can be discussed with the patient and any issues discussed. The MUR also provides for a longer discussion with the patient about perceptions and beliefs regarding pain management. A record of the MUR and any relevant issues and recommendations is sent to the GP for further action.
3. Local Enhanced Services – these are services commissioned directly by the PCT, where a local need has been established. Community Pharmacists with a special interest in pain management could be commissioned to provide an intervention service for the more complex patient in either the community pharmacy, locality or GP setting. By 2004, 70 primary care based pain management

clinics had been set up in the UK, of which six were run by pharmacists. Both chronic pain and neuropathic pain are managed in these clinics.

The contract therefore provides the primary healthcare team and patients with several avenues for addressing many of the factors leading to inadequate analgesia use in the management of pain.

#### **D-4 Records and documentation**

The keeping of contemporaneous records is vital for both safety and audit purposes. Errors can occur at the prescribing, dispensing and administration stage, particularly the latter. It is therefore of importance that all prescribing is recorded, preferably electronically,

- in the patients record on the prescribing system,
- in the Patient Medication Record (PMR) of the dispensing system,
- and on the administration chart.

Details recorded should include:

- Patient's full name and address
- Age if under 12 years (and state the patient's date of birth)
- Name, quantity and strength of prescribed item
- Dosage
- Frequency
- Total amount to be supplied or total duration of treatment
- Directions for use
- Identification of administering practitioner
- Any medication not given due to refusal, wastage or lack of availability
- Identification, where a second practitioner checks the administration

#### **D-5 Disposal of medicines**

Any unused medicines should be returned, by the patient or carer, to a pharmacy for correct disposal. Controlled drugs contained in syringes should be disposed off in an approved Controlled Drug De-naturing kit.

#### **D-6 Controlled drugs**

Following the report of the Shipman Inquiry, many changes are taking place with regard to the prescribing, dispensing and administration of controlled drugs. The first change was introduced in November 2005, and removed the requirement for prescriptions for controlled drugs to be written by hand by the prescribing doctor.

Prescriptions for Controlled Drugs may now be computer-generated, but must conform to the legal requirements whereby the formulation, quantity in words and figures, and dosage must be present.

Within a fortnight of the change the local health community had its first adverse incident involving a computer-generated prescription. This highlighted the need for greater vigilance when checking prescriptions for controlled drugs.

Healthcare professionals should keep updated with changes in legislation involving controlled drugs.



*"A guide to good practice in the management of controlled drugs in primary care (England)"* has been published by the National Prescribing Centre and is available at <http://www.npc.co.uk>

The Royal Pharmaceutical Society of Great Britain has guidance on the *"Changes in the management of CDs affecting pharmacists (England)"* available from the Information Resources section of their website at <http://www.rpsgb.org>.

In addition the Department of Health has issued guidance documents on record keeping, prescribing and dispensing of Controlled Drugs available at <http://www.dh.gov.uk/controlleddrugs>.

#### **D-6-1 Brand name prescribing**

The Royal Pharmaceutical Society of Great Britain (RPSGB) recommended in February 2006 that sustained release morphine preparations and opioid patches should be **prescribed by brand name**. Brand name rather than generic prescribing is safer since it guarantees that patients receive the same brand each time a prescription is dispensed, which avoids the potential problem of the small but significant differences in release rates of the various sustained release preparations. The RPSGB considers this to be particularly important for Fentanyl where there are both matrix and reservoir patches available.

#### **D-7 Patient-held drug charts**

Many examples of patient-held drug charts are available. An example is shown overpage. They are particularly useful for patients on multiple medications. Their use demonstrates good governance, providing information on current medications when patients are admitted to a secondary care service.

**D-7-1      An example of a patient-held drug chart**

PATIENT NAME	DOB		
DRUG and REASON		STRENGTH	DOSE
FAILED DRUGS			
DRUGS HYPERSENSITIVITY			
DATE FORM COMPLETED			

*(Source: 'Management of Cancer Pain in Adults' from the joint North and North East Lincolnshire Palliative Care Group)*

**SECTION E PAIN MANAGEMENT****E-1 ACUTE PAIN MANAGEMENT**

*(Principal authors = Dr Ahmed Saleh, Dr Tim Jackson))*

**E-1-1 Self-help****E-1-2 Psychological approaches****E-1-3 Complementary therapies****E-1-4 The WHO analgesic ladder**

E-1-4.1 Diagram based on the 3-step WHO analgesic ladder

E-1-4.2 The HEYHT adult analgesia table

E-1-4.3 Flow chart for intermittent IV opioid administration (general hospital use Pain Scale 0-3)

E-1-4.4 Flow chart for intermittent IV opioid administration (A&E use Pain Scale 0-10)

**E-1-5 Medication options in A&E****E-1-6 Inpatient pain management****E-1-7 Discharge medication****Appendix 1 BAEM Guidelines for the Management of Pain in Adults****Appendix 2 Pain Relief while in Hospital (HEYHT patient leaflet)****E-1 ACUTE PAIN MANAGEMENT**

Acute pain is of sudden onset and has a meaning and purpose. It usually has a predictable and limited duration with a foreseeable end and is often accompanied by 'fight or flight' features such as pupil dilatation, increased sweating, pulse and respiratory rate. Patients in acute pain are often encountered in Accident & Emergency Departments, Surgical Wards and Critical Care Areas. Episodes of acute pain can also be self-managed, but for recent onset of severe acute pain of unknown cause then medical advice should be sought.

**E-1-1 Self-help**

People can self manage some acute pain episodes at home and do not need to seek medical help. Pharmacological agents can be purchased and advice sought from the local Pharmacy. Non-pharmacological pain management can be as effective, on occasions, as pharmacological pain management.

**E-1-2 Psychological approaches**

Relaxation techniques such as breathing exercises can be taught and self administered. This can help to reduce stress which can in turn reduce pain perception.

Distraction is another method and can take many forms. It involves the individual focusing attention on a stimulus rather than the pain eg. listening to music, watching television or reading.

Imagery is another option differing from distraction in that distraction usually depends on external stimuli as opposed to imagery depending on the mind and the exploitation of all the senses, including sight and smell. Wilkinson suggests that psychological approaches are effective but are of limited benefit in isolation (Wilkinson R: A non-pharmacological approach to pain relief. Professional Nurse 11, [4] 222-24. 1996). As pain is a multidimensional, private experience, a need for a multidimensional approach is needed for its management.

### **E-1-3 Complementary and non-drug therapies**

Many people rely on complementary and non-drug therapies to relieve acute pain. Examples are hot/cold compresses, aromatherapy, reflexology, hypnosis, homeopathy and TENS (Transcutaneous Electrical Nerve Stimulation). [Section F](#) deals with specific non-drug therapies in more detail.

### **E-1-4 The WHO Analgesic ladder**

The WHO analgesic ladder can be used as a guide for the treatment of acute pain.

Patients are normally given regular non-opioids and weak opioids (steps 1 and 2), with an immediate release strong opioid as PRN analgesia (PRN = *pro re nata* or when required) which can be titrated up to suit the needs of the patient.

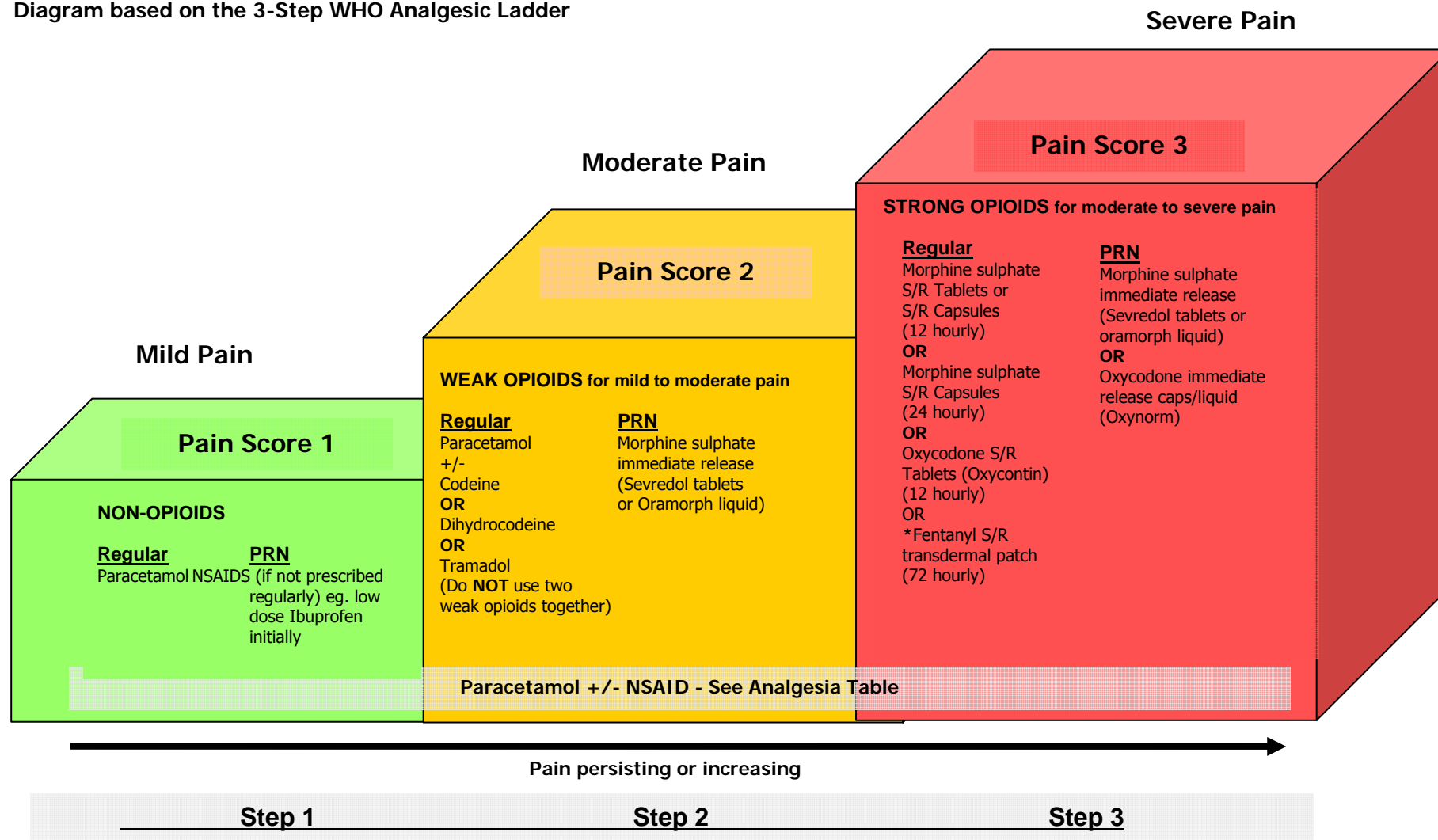
If the episode of acute pain is short lived, the analgesia is stepped down.

If the episode of acute pain is severe and protracted, the analgesia may be increased to step 3, and once pain is controlled a slow release strong opioid may be used. PRN analgesia would continue at an appropriate dose. When the acute phase is over, the patient would need to be stepped down slowly to avoid withdrawal symptoms. Withdrawal can occur in patients who have been on tramadol for a long time and who suddenly stop taking it, so again, slow step down is advised.

Non steroidal anti-inflammatory drugs (NSAIDs) and paracetamol can be used at all 3 steps, unless contraindicated. If pain is mild or as pain decreases in intensity, step 1 non-opioids may be given – paracetamol or NSAIDs regularly or as needed.

A diagram based on the 3-step WHO Analgesic Ladder and the HEYHT Adult Analgesia Table are included over the page, together with the Flow Charts for Intermittent IV Opioid Administration (for patients who are nil by mouth) – one chart for general hospital use (Pain Scale 0-3) and one chart for use in A&E (Pain Scale 0-10).

## E-1-4.1 Diagram based on the 3-Step WHO Analgesic Ladder

Notes:

- \* Fentanyl patches are NOT to be used for **acute pain** as this is not a licensed indication and the onset of action is too long.
- 1 SEE HEYHT ANALGESIA TABLE FOR ADULT DRUG DOSES
- 2 DO NOT CHANGE LONG -TERM ANALGESIA UNLESS OTHERWISE INDICATED
- 3 For chronic pain consider ADJUVANT analgesic therapy: eg amitriptyline or gabapentin
- 4 For patients who are nil by mouth, please see Flow Chart for Intermittent IV Opioid Administration

Abbreviations: NSAID = Non-Steroidal Anti-Inflammatory Drug    S/R = Slow Release    PRN = When Required



## E-1-4.2 Adult Analgesia Table (HEYHT)

Pain Management Service Adult Analgesia Table					
Pain Intensity Scale Scores	Drug	Dose	Frequency	Recommended Routes	Notes
1,2,3 NON-OPIOID	Paracetamol	1g	PRN 4-6 hourly OR Regular 4 times per day (Maximum 4g/day)	Oral, Rectal	Risk of liver damage if maximum dose is exceeded
1,2,3  NSAIDs	Diclofenac	50mg	6-8 hourly (Maximum 150mg/day)	Oral, Rectal	
	OR				
	Ibuprofen	400mg	3 times per day	Oral	
	OR				
	Ketoprofen	50-100mg	2-4 times per day (Maximum 200mg/day)	Oral, IM (IM = Max for 3 days)	
	OR				
2  WEAK  OPIOIDS	Piroxicam (Feldene® melt)	20-40mg	daily	Oral	Only while Nil by Mouth
	Codeine	30-60mg	4 - 6 hourly	Oral, IM	Maximum 240mg/day (also available as a combined preparation with paracetamol)
	OR				
	Dihydrocodeine	30mg	4 hourly	Oral	Maximum 240mg/day
	OR				
3  STRONG  OPIOIDS	Tramadol	50-100mg	Regular 3 or 4 times per day	Oral	Maximum 400mg/day
	Morphine	10mg to start	4 hourly	Oral	
	OR				
	Fentanyl patch	Take advice from Pain Team	72 hourly	Topical	When no oral route available
	OR				
	Oxycodone	Take advice from Pain Team		Oral	

**ADJUVANT ANALGESIC AGENTS - For chronic neuropathic pain:**

Amitriptyline	Initially 10mg NOCTE, increasing to 75mg NOCTE if necessary	Oral
Gabapentin	300mg NOCTE on day 1, 300mg twice daily on day 2, 300mg three times a day on day 3, then review	Oral

**Notes:** Do NOT use 2 weak opioids together - eg tramadol with codeine/dihydrocodeine  
Do NOT use 2 NSAID's together - eg diclofenac together with the patient's usual NSAID  
Diclofenac IM not recommended as injection painful

Date: October 2005  
Review Date: October 2007



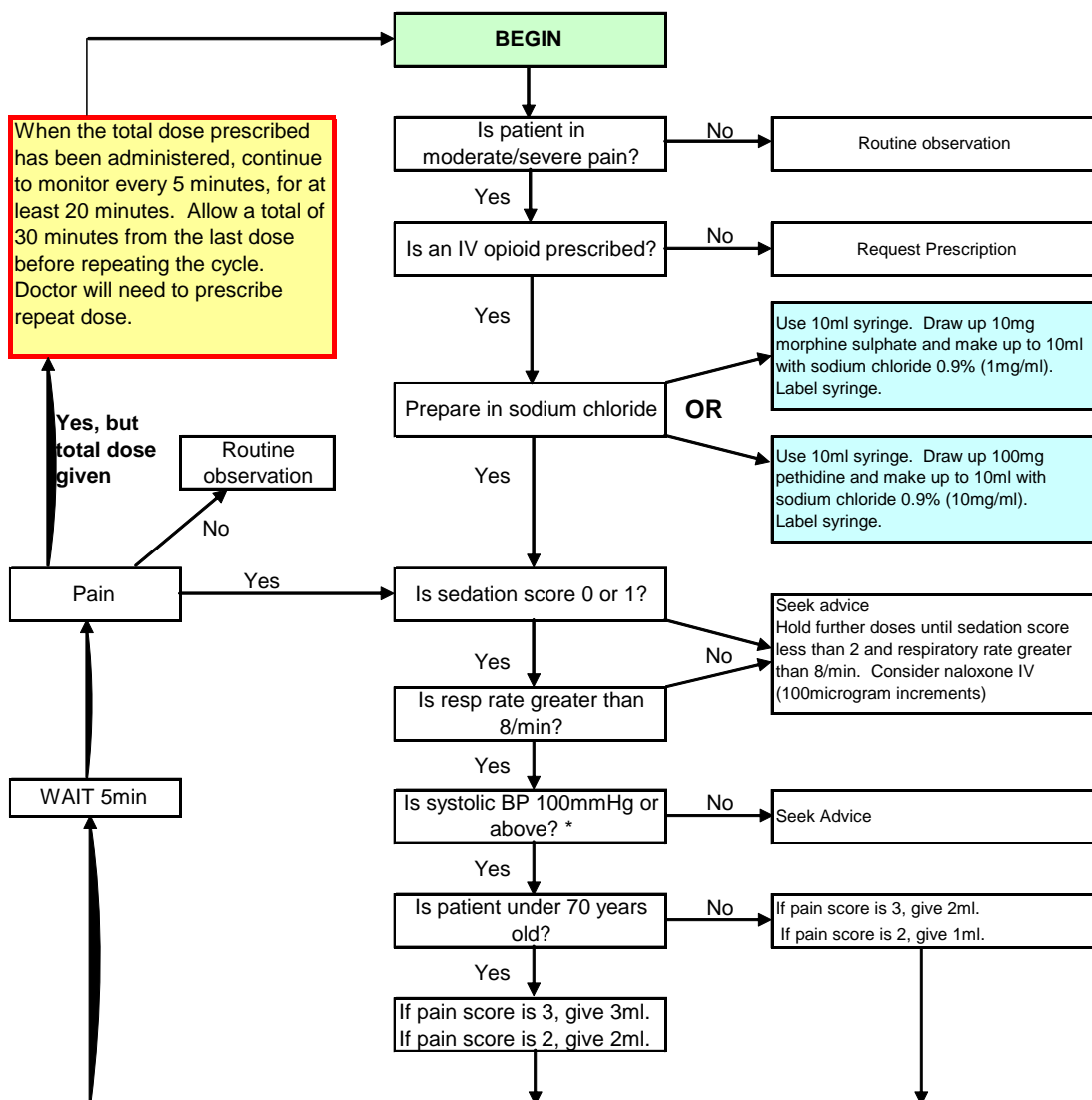
NB. A useful reference is the MEREK Bulletin Vol16 No4 May 2006,  
*The withdrawal of co proxamol: alternative analgesics for mild to moderate pain.*  
[http://www.npc.co.uk/MeReC\\_Bulletins/2006Volumes/Vol16\\_No4.pdf](http://www.npc.co.uk/MeReC_Bulletins/2006Volumes/Vol16_No4.pdf)

## E-1-4.3 Flow chart for general hospital use – (Pain scale 0-3)

**Pain Management Service.**  
**Flow Chart Guideline for**  
**Intermittent Intravenous**  
**Opioid Administration for**  
**Acute Pain.**

Hull and East Yorkshire Hospitals  
 NHS Trust **NHS**

- \* Only to be used by staff who have been instructed in this technique
- \* NOT appropriate for routine maintenance of analgesia in general wards
- \* Note that the peak effect of an intravenous dose may not occur for over 15 minutes so all patients should be observed closely during this time

**Pain Score:**

0 = No Pain  
 1 = Mild Pain  
 2 = Moderate Pain  
 3 = Severe Pain

**Sedation Score:**

0 = Patient Awake  
 1 = Occasionally drowsy, easy to wake up  
 2 = Frequently drowsy, easy to wake up  
 3 = Difficult to wake up  
 S = Asleep

**\* Note:**

If systolic BP less than 100mmHg it must be within 30% of the patient's normal systolic BP if known, or seek advice

**Notes:**

Use IV cyclizine/ondansetron for nausea - See antiemetic guidelines.  
 Continue to use PR or IV Non-Steroidal Anti-Inflammatory Drugs if prescribed together with the above flow chart.

Date: January 2005

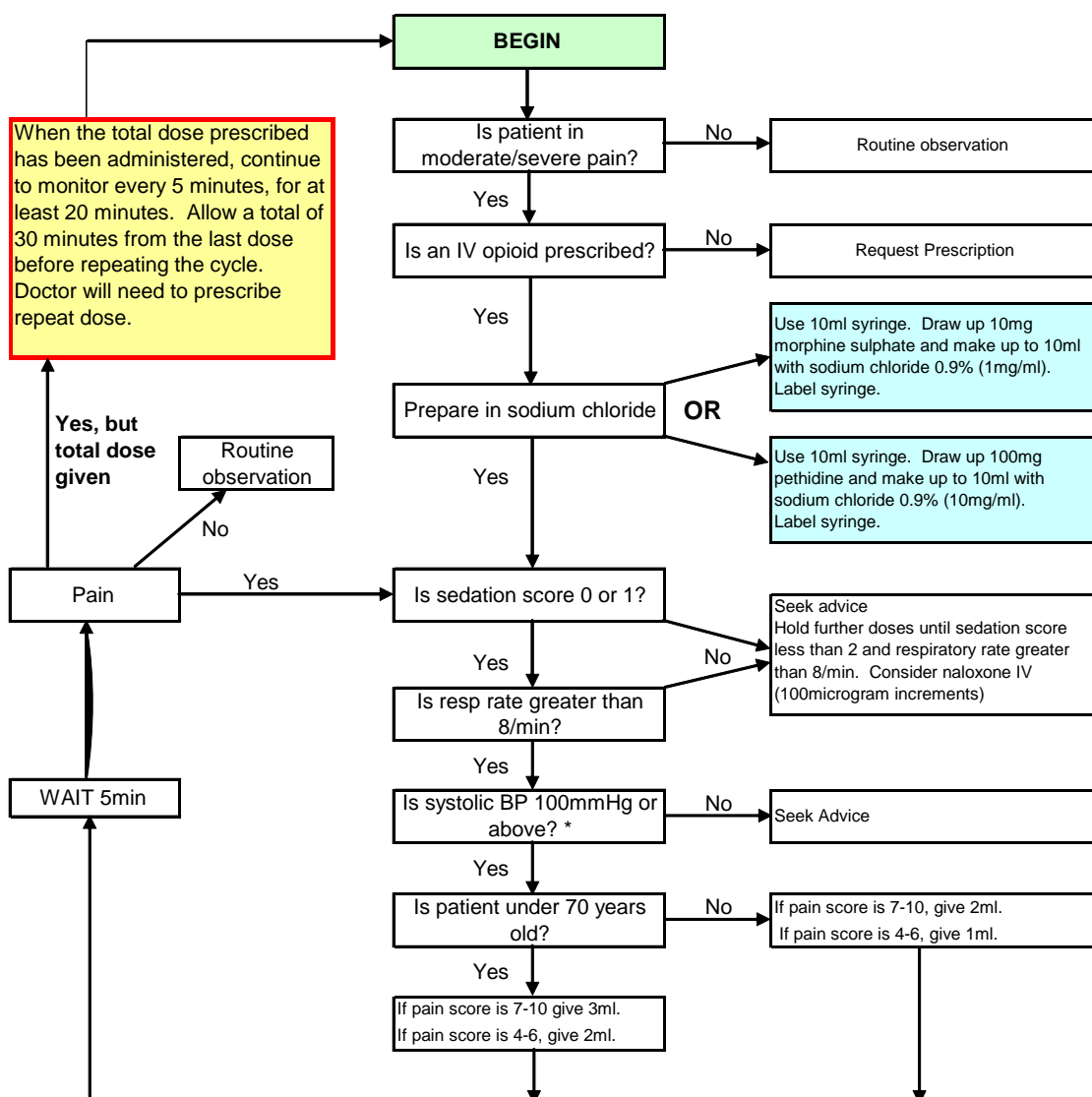
Review Date: January 2007

## E-1-4.4 Flow chart for use in A&amp;E – (Pain scale 0-10)

**Pain Management Service.**  
**Flow Chart Guideline for**  
**Intermittent Intravenous**  
**Opioid Administration for**  
**Acute Pain.**

Hull and East Yorkshire Hospitals  
 NHS Trust **NHS**

- \* Only to be used by staff who have been instructed in this technique
- \* NOT appropriate for routine maintenance of analgesia in general wards
- \* Note that the peak effect of an intravenous dose may not occur for over 15 minutes so all patients should be observed closely during this time

**Pain Score:**

0 = No Pain  
 1-3 = Mild Pain  
 4-6 = Moderate Pain  
 7-10 = Severe Pain

**Sedation Score:**

0 = Patient Awake  
 1 = Occasionally drowsy, easy to wake up  
 2 = Frequently drowsy, easy to wake up  
 3 = Difficult to wake up  
 S = Asleep

**\* Note:**

If systolic BP less than 100mmHg it must be within 30% of the patient's normal systolic BP if known, or seek advice

**Notes:**

Use IV cyclizine/ondansetron for nausea - See antiemetic guidelines.  
 Continue to use PR or IV Non-Steroidal Anti-Inflammatory Drugs if prescribed together with the above flow chart.

Date: January 2005  
 Review: January 2007

**E-1-5 Medication options in A&E**

The A&E department at Hull Royal Infirmary follows the British Association for Accident & Emergency Medicine (BAEM) Guidelines for the Management of Pain in Adults (included here as Appendix 1 to Section E-1). However, the department maintains a limited analgesic formulary for acute pain.

*Parenteral Analgesia*

1. Intravenous opiates are titrated in acute severe pain.
2. Ketoprofen 100mg intramuscular.

*Oral Analgesics*

1. Paracetamol
2. Ibuprofen 200mg / 400mg / 600mg
3. Dihydrocodeine, codeine and paracetamol preparations

*Other Considerations*

1. Entonox – particularly renal colic and musculoskeletal injuries.
2. Use of splints / slings / dressings etc
3. Femoral block for femoral fractures.
4. Prescriptions dispensed by the A&E department are limited to 30 tablets for paracetamol +/- codeine and 24 tablets for ibuprofen.
5. When appropriate, patients are advised to purchase equivalent analgesics OTC (over the counter).
6. Analgesics outside the departmental formulary are only prescribed in exceptional cases and after discussion with the senior doctor in the department.

Patients with pain are treated according to the BAEM Guidelines while they are in A&E. Once a diagnosis is made they are transferred to the relevant ward and their care (including pain management) becomes the responsibility of the team receiving them.

**E-1-6 Inpatient pain management**

HEYHT has produced a Patient Leaflet explaining pain medication options whilst in hospital. This is included in Appendix 2 to Section E-1.

**E-1-7 Discharge medication**

The patient's condition will determine what their analgesic discharge medication will be. Patients are discharged as soon as possible when they are able to manage at home with or without support services. Many patients will require 'To Take Out' (TTO) medication of analgesics. The directions for taking the medication should be clearly written on the container and the discharging nurse has a duty of care to ensure that the patient / carer understands the instructions. If the patient has any problems at home despite taking their prescribed analgesia they are advised to contact their general practitioner (GP).

## Appendix 1 BAEM Guidelines for the Management of Pain in Adults

### BRITISH ASSOCIATION FOR ACCIDENT AND EMERGENCY MEDICINE

THE ROYAL COLLEGE OF SURGEONS OF ENGLAND

35-43 LINCOLN'S INN FIELDS, LONDON, WC2A 3PN

*Telephone: 0207-831 9405 Fax: 0207-405 0318*

*E-Mail: [baem@emergencymedicine.uk.net](mailto:baem@emergencymedicine.uk.net)*

#### CLINICAL EFFECTIVENESS COMMITTEE

Guideline for Management of Pain in Adults

### Introduction

- Pain management is one of the most important components in patient care, which is why it is given such a high priority in the BAEM 'Clinical Standards for A&E Departments' (1) and the National Triage Scale (2).
- Pain is commonly under-treated and treatment may be delayed.
- Recognition and alleviation of pain should be a priority when treating the ill and injured. This process should start at the triage, be monitored during their time in A&E and finish with ensuring adequate analgesia at, and if appropriate, beyond discharge.
- *The BAEM Clinical Effectiveness Committee standard* of analgesia for moderate & severe pain within 20 minutes of arrival in A&E should be applied in all A&E departments. An audit against these standards should be done annually.
- It is difficult to overemphasise the importance of auditing pain management in order to monitor if the standards are being achieved or if a change in practice is required.
- Training for all staff involved in patient care is essential to ensure quality and timely management.

### Pain assessment

- Pain assessment forms an integral part of the National Triage Scale (2).
- Multiple assessment tools are in use. The better known scales have not been validated in the context of an A&E environment but are nevertheless satisfactory for the purpose of pain assessment and management.
- The pain ladder contains objective and subjective descriptions with a numerical scale. BAEM recommends the use of locally developed assessment tools similar to the one attached.
- The experience of the member of staff triaging will help in estimating the severity of the pain.

### How to manage pain

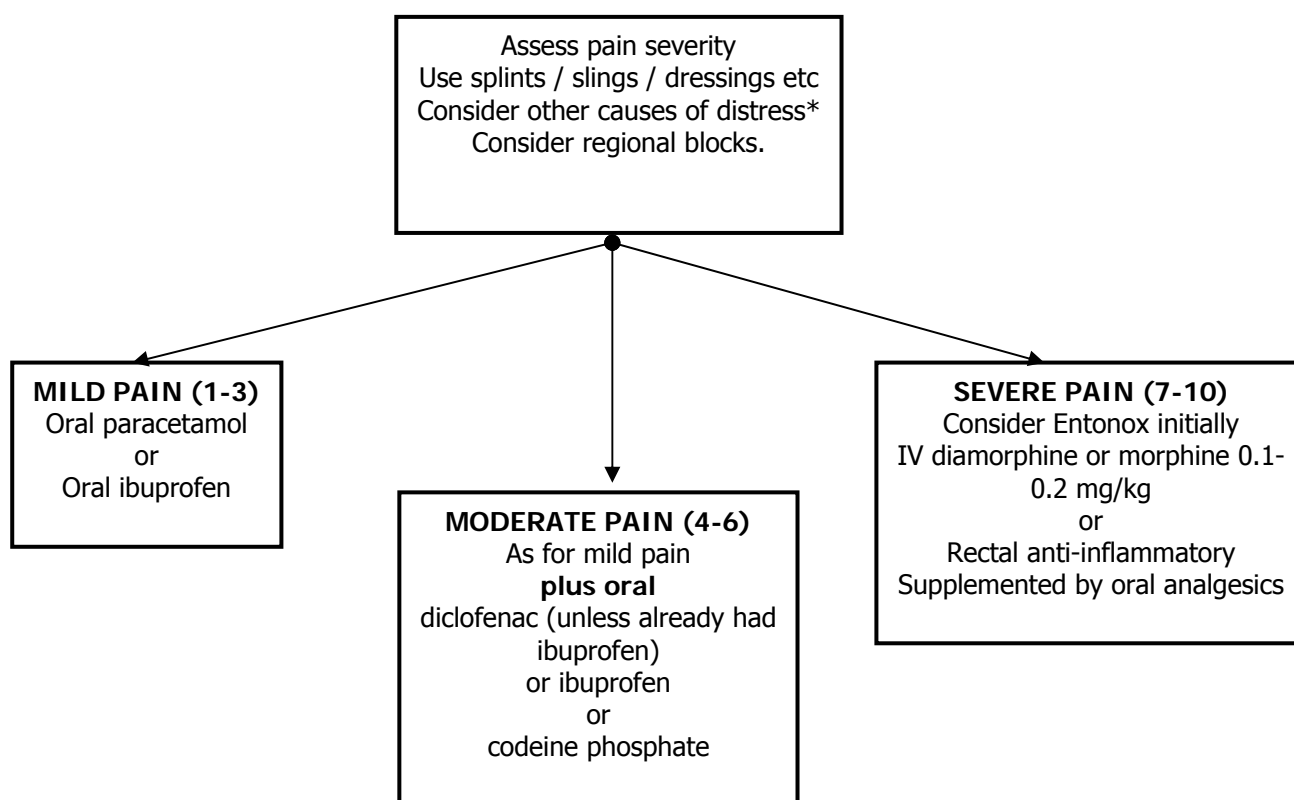
- Patients in severe pain should be transferred to an area where they can receive appropriate intravenous or rectal analgesia within 20 minutes of arrival.
- Patients in severe pain should have the effectiveness of analgesia re-evaluated within 30 minutes of receiving the first dose of analgesia.

- Patients in moderate pain should be offered oral analgesia at triage / assessment.
- Patients with moderate pain should have the effectiveness of analgesia re-evaluated within 60 minutes of the first dose of analgesia.
- Documentation of the above on the A&E card is essential.

## References

- (1.) Clinical Effectiveness Committee. January 2002  
 (2.) Emergency Triage. BMJ Publishing Group, 1997.

### Algorithm for treatment of acute pain



\*Other causes of distress include: fear of the unfamiliar environment, needle phobia, fear of injury severity etc.

## CONTRA-INDICATIONS

Ibuprofen / Diclofenac: avoid if previous reactions to NSAIDs or in moderate or severe asthmatics

Intravenous morphine: use with caution if risk of depression of airway, breathing or circulation.

**Assessment of acute pain in A&E**

<b>No Pain</b>	<b>Mild Pain</b>	<b>Moderate Pain</b>	<b>Severe Pain</b>
0	1-3	4-6	7-10
No action	Oral analgesia	Oral analgesia +/- ant-inflammatory medication	I/V opiates or I/M / PR anti- inflammatory medication

NB. Refer to analgesic ladder and dose information chart

**Notes for use**

- Using this method of pain scoring it should be possible to adequately assess into one of four categories and treat pain appropriately.
- Once the category has been established, appropriate analgesia may be prescribed according to the flow chart.
- In all cases it is important to think of using other non-pharmacological techniques to achieve analgesia, which may include measures such as applying a dressing or immobilising a limb etc.
- Following reassessment if analgesia is still found to be inadequate, stronger / increased dose of analgesics should be used along with the use of non-pharmacological measures.
- It is important to re-assess the pain control within 30 minutes in severe pain and within 60 minutes in moderate pain.

**Appendix 2 Pain Relief while in Hospital (Text of HEYHT patient leaflet)****Sept 2005****Pain Service / Anaesthetic Department**

This booklet has been produced to give you information about pain relief. It will explain the various types of pain relief and how they are used. Please read the following information carefully as it explains about any discomfort or pain you may have and how we will try and relieve it for you.

It is not meant to replace informed discussion between you and the nurse, doctor or anaesthetist, but can act as a starting point. If after reading this leaflet you require further explanation or advice on your pain relief options, please do not hesitate to ask the nurse, doctor or anaesthetist who will be caring for you. Not all types of pain relief are suitable for all patients or appropriate for all conditions/types of surgery. The doctor/anaesthetist will discuss the type of pain relief that will be best for you when he/she visits you.

**Oral pain killers**

Oral painkillers alone are often enough to help relieve your pain. If you are able to tolerate fluids you will be given oral painkillers. They may also be used to supplement other forms of pain relief after larger operations.

Tablets will usually be prescribed regularly. The nursing team will offer these to you when they do their regular 'drug rounds'. If you are in pain at other times do not be afraid to ask for extra tablets, as it is easier to control your pain by simple methods before it becomes uncomfortable. For example, it is advisable to ask your nurse for painkillers to help you have a comfortable night.

**Intramuscular injections**

Many types of acute and post-operative pain are well controlled by intramuscular injections. These injections will be given by a nurse and involve an injection into your thigh or buttock at regular intervals.

These injections may take up to 1 hour to work, so it is important that you tell the nurse when you begin to feel uncomfortable and do not wait until the pain becomes too bad.

**Suppositories**

Pain killing suppositories are often used when you cannot tolerate oral painkillers.

They can be used together with intramuscular injections. They help to reduce the amount of other types of painkillers that you need.

**Intravenous Patient Controlled Analgesia (IV-PCA)**

If you are about to have a major operation the anaesthetist may suggest that you have an IV-PCA pump afterwards. This is a device that allows you to give yourself painkilling drugs when you need them. It consists of a pump that is filled with painkilling drugs and is connected to the drip in your arm. When you press the button on the handset a small dose of the drug will be delivered directly into your drip. This takes about 5 minutes to work and during this period the pump will not deliver another dose even if you press the button. This prevents you from giving yourself an overdose.

Occasionally non-surgical patients experiencing severe acute pain will benefit from IV-PCA.



Further information is available on a separate information leaflet. Please ask for details.

An IV-PCA pump has the great advantage that you are in control of your pain relief.

### **Patient Controlled Epidural Infusion Analgesia (PCEA)**

An epidural infusion is an effective form of pain relief usually used after certain types of major surgery. It involves a small plastic tube that is inserted in your back by the anaesthetist at the time of the operation. This allows painkilling drugs to be injected into your epidural space to keep you comfortable during the operation and while you are recovering on the ward. Further information is available on a separate information leaflet. Please ask for details.

### **Going home**

When you leave the hospital you may be given painkillers to take home. Follow the printed instructions on the box/bottle of medication. These medicines are usually labelled "take when required for pain relief".

When you go home you will probably need to take them regularly for the first day or two. As you recover you will be able to reduce the amount you take each day.

If you are unable to manage your pain you should contact your own Doctor (GP) for advice. You should not usually need to continue on the strong painkillers given to you from the hospital. Mild pain can usually be managed with simple painkillers, eg. Paracetamol.

However, some people do need to take regular strong painkillers. If this applies to you, this will be explained to you by the nurse when your take home prescription (TTO) is given to you.

Some painkillers can cause constipation. If this is a problem, laxatives can be bought at your local Pharmacy or prescribed by your GP.

Further information about your medicines is contained on the information leaflet inside the pack. Ask your Nurse, Pharmacist or Doctor if you have any questions.

### **Information about you**

As part of your care, when you come to the hospital, information about you is shared between members of a health care team, some of whom you may not meet. It may be used to help train any staff involved in your care. Information we collect may also be used after you have been treated to help us to maintain and improve the quality of our care, to plan services, or to research into new developments.

We may pass on information to other health organisations to help improve the quality of care provided by the NHS generally.

All information is treated as strictly confidential, and is not given to anyone who does not need it. If you have any concerns please ask your doctor, or the person caring for you.

Under the Data Protection Act (1998), Hull and East Yorkshire Hospitals Trust is responsible for maintaining the confidentiality of any information we hold about you.

This leaflet was produced by the Pain Service, Hull and East Yorkshire Hospitals NHS Trust, and will be reviewed in September 2008.

## **E-2 CHRONIC PAIN MANAGEMENT**

*(Principal author = Dr Bruce Millar)*

### **E-2-1 Chronic pain management and the biopsychosocial model**

### **E-2-2 Definition and understanding of chronic pain**

### **E-2-3 Chronic pain management techniques**

#### **E-2-3.1 Behavioural approaches**

*Problem solving*

*Relaxation*

*Biofeedback techniques.*

*Contingency Management / Operant Methods*

*Self help*

*Pacing and goal setting*

#### **E-2-3.2 Social approaches**

#### **E-2-3.3 Cognitive approaches**

*Cognitive restructuring*

*Cognitive strategies that alter the subjective component of pain*

*Somatisation*

*Attention and distraction*

*Coping skills training*

#### **E-2-3.4 Psychodynamic approaches**

#### **E-2-3.5 Humanistic and integrative approaches**

### **E-2-4 The Expert Patients Programme and other Chronic Disease Management services**

### **E-2-5 Chronic pain management options in Primary Care**

### **E-2-6 Readiness to change**

#### **E-2-6.1 Stages of readiness to change**

#### **E-2-6.2 Assessing readiness to change**

#### **E-2-6.3 Motivational interviewing**

#### **E-2-6.4 Principles of motivational interviewing**

*Interviewing techniques*

*For ambivalent clients*

### **E-2-7 Assessing factors associated with chronic pain**

#### **E-2-7.1 Assessing coping measures**

#### **E-2-7.2 Assessing the affective component of pain**

#### **E-2-7.3 Health related questionnaires**

#### **E-2-7.4 Control and quality of life measures**

### **E-2-8 Roles of specialist and support services**

### **E-2-9 Selected section references**

**NB.** The pathway for using adjuvant analgesia in chronic neuropathic pain can be found in [Section G-2-1.1](#)

**E-2-1 Chronic pain management and the biopsychosocial model**

It is important that the biopsychosocial approach is used in the treatment of chronic pain. No matter which approach is being used - biological, social or psychological - it is important to view the problem from all of these aspects in order to have an explanatory model of healthcare. Pain Management Services provide a multi-disciplinary approach that not only addresses the biomedical component of the pain experienced, but also the social, emotional and economic context of the experience for both patients and their carers. The focus is on symptom management rather than diagnosing the cause of pain (as in many instances no cause is found or the cause is untreatable).

**E-2-2 Definition and understanding of chronic pain**

Chronic pain is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage. Chronic pain either persists beyond the point that healing would be expected to be complete (usually taken as 3-6 months) or occurs in disease processes in which healing does not take place. The pain may be continuous or intermittent. Nearly 1 in 7 people suffer from chronic pain and 20% of these have suffered it for more than 20 years. Studies of chronic pain show that it is often persistent and seldom totally resolves, even with treatment (Pain in Europe, 2003).

Pain can occur from neuropathic pain, musculoskeletal conditions, underlying disease, or from complicated surgery. It may be experienced by those who do not have evidence of tissue damage. If no structural cause can be found, this does not mean pain is imagined or exaggerated. Untreated pain can have an enormous impact on mood and morale and can affect the quality of life both for sufferers and carers, resulting in helplessness, isolation, depression and family breakdown.

Ways of coping can be separated into several types of approach. These are outlined below, with examples of each.

**E-2-3 Chronic pain management techniques**

Previous experience, current mood, alertness and expectations all play a part in our response to pain. Whether we feel we have control over an event is an important determinant of how we respond. We can use our brain to influence our experience of pain. Psychological techniques include biofeedback, hypnosis and cognitive strategies.

**E-2-3.1 Behavioural approaches**

These consider how pain behaviours may be learned and maintained or strengthened through conditioning. Interventions involve changing pain thresholds and pain tolerance, and altering learned helplessness and sick role behaviour, either individually or by involving the family. Various behavioural approaches to pain management are outlined below.

**Problem solving** involves shifting the attention away from pain being the sole problem and seeing the impact it has on other areas of life. The six steps of problem solving are problem identification, goal

selection, generation of alternatives, decision making, implementation and evaluation. Within this, there may be a need to accept that the problem may not be solvable now but may be revisited at a later time.

**Relaxation** is easy to learn and effective, and has been widely used in the treatment of chronic pain. Learning to relax is really important when it comes to managing chronic pain. Stress or anxiety will increase pain in chronic pain conditions and the patient may be less able to manage pain effectively. Also, the pain itself can lead to anxiety, tension and stress. Relaxation techniques have been shown to decrease anxiety, stress, muscle tension and pain levels whilst improving pain management and sleep. It can therefore prevent major exacerbations of pain and reduce fear and muscle spasms when tackling new goals.

Relaxation works mentally by directing attention away from the pain, and physically by slowing down the breathing and heart rate and decreasing muscle tension. Chronic increases in sympathetic nervous system activation, leading to increased skeletal muscle tone, may set the stage for hyperactive muscle contraction and possibly for the persistence of a contraction following conscious muscle activation. Anxiety and muscle relaxation produce opposite physiological states and therefore cannot exist together. There are many different methods of relaxation, but the most commonly used are outlined below:

- *Progressive muscle relaxation* – Muscles are alternately relaxed and contracted so the patient learns to recognise the difference between a tense and a relaxed muscle. This is important as over used muscles have a higher tone as they contract more often without relaxing enough, leading to pain and fatigue.
- *Deep breathing exercises* – These encourage slow deep breathing, increasing the effectiveness of the oxygen supply to your body and inducing muscle relaxation.
- *Relaxation imagery* – The creation of a pleasant scene in your mind that is not associated with pain.

Seers (1997) describes the impact of a community based programme using relaxation skills for sufferers of chronic non-malignant pain. Patients taught relaxation skills experienced a decrease in their pain intensity and an improvement in sleep, both in the short and long term. The efficacy of relaxation for chronic pain conditions other than headache has been reviewed by Linton (1986) and its value confirmed. Chapman (1983a) reported that after one 60 minute session of relaxation using a tape for home practice, 60% found it very helpful and 34% found it somewhat helpful. These figures exceed those for almost all other treatments, including TENS and nerve blocks.

**Biofeedback techniques** have been applied to the problem of chronic pain. Biofeedback involves the use of equipment to teach patients to change their physiological responses by providing them with immediate feedback from their responses. Feedback of EMG (electromyogram), EEG (electroencephalogram), skin temperature and pulse volume have all been applied to chronic pain patients. However, there is little evidence that biofeedback is any more effective than relaxation.

**Contingency Management / Operant Methods** aim to increase the frequencies of well behaviours and decrease that of pain behaviours. Whatever the initial underlying cause of the pain problem, Fordyce (1976) considers that pain behaviours such as complaining of pain, inactivity or taking medication may be

maintained by their reinforcing consequences. No attention is given to pain behaviours or requests for analgesics, but provide social reinforcement for increase patient activity levels. Activity is increased and progress is charted. Several researchers have found that operant factors influence pain behaviours. Reports of pain levels have been found to vary with solicitousness of spouse (Anderson and Rehm, 1987) and variables such as activity level, drug intake, and pain report can be altered systematically through the application of operant reinforcement contingencies.

**Self help** instructions should be given to patients on how to self manage their pain in the first instance. Non-pharmacological options such as TENS and physiotherapy can be considered.

**Pacing and goal setting.** Patients with chronic pain may find they have good days and bad days. As time goes on they may find themselves having more bad days than good days. When suffering from chronic pain, it is very easy to become trapped in the inactivity / overactivity cycle. A patient will complete a task that subsequently causes them to be in pain. A period of inactivity then follows until the pain subsides. When pain is severe patients are unable to do anything and so they rest. Whilst pain settles down, the muscles become a little weaker. Frustration ensues as patients are unable to complete the activities they want to do. Once pain has settled there is a tendency to overdo the work in order to catch up. Pacing is about breaking this pattern and gradually increasing what they do, and is the key to learning how to manage pain effectively. Tasks that cause pain when done all at once need to be split in to more manageable chunks. To achieve this requires planning. Pacing requires goal setting by working out how much activity is achievable without causing pain to flare up – always underestimate the first time, and stick to this level of activity for a few days until the patient is confident the level is correct. Once pain has been stable for a few days, start to increase activity a little at a time. This could be done as one activity, or the patient can divide a week's activities and complete them at a level that is achievable.

Goal setting is like pacing – used to gradually build up the activities the patient does. It puts the patient back in control of the pain, instead of the pain controlling them. The rules for setting goals are – the goal must be realistic and measurable, it should not be picked by someone else or be too over ambitious to begin with. Goal setting helps you to plan (a) what you are going to do and (b) how much you are going to do.

### **E-2-3.2 Social approaches**

These are based on social learning theory, communication theory and knowledge of groups and social support systems. Interventions include developing improved pain assessment techniques, paying attention to subtle cues from body language, providing appropriate role models and setting up group therapy sessions and support groups.

### **E-2-3.3 Cognitive approaches**

These are based on health belief models and include models of confronting and avoiding attitudes to pain. Interventions are aimed at helping people to examine their beliefs, memories and expectations about their pain and their ability to manage it. Strategies include the use of distraction, imagery, information giving and the facilitation of self efficacy.

The cognitive behavioural perspective on pain management focuses on modifying sensory, affective, cognitive and behavioural facets of the experience while providing patients with techniques to help them gain a sense of control over the effects of pain on their lives. Cognitive techniques (eg. self monitoring to identify relationship among thoughts, mood, and behaviour, or distraction using imagery) help to place cognitive, affective, behavioural and sensory responses under the patients' control. Studies demonstrate that patients are capable of more than they assumed, can reduce fear of activities, and increase their sense of personal competence.

***Cognitive restructuring*** is a technique designed to help patients identify and modify maladaptive thoughts. Alternative thoughts emphasise adaptive ways of thinking to minimise emotional distress and behavioural dysfunction.

A study of the effectiveness of group cognitive therapy compared with group relaxation training and a waiting list control showed cognitive therapy was superior to relaxation training on self ratings of improvement (Turner, 1982). Cognitive methods involve teaching the patient to identify and monitor cognitive responses to stressful situations and then develop alternative, more adaptive responses. Morley, Eccleston and Williams (1999) concluded that Cognitive Behavioural Therapy (CBT) significantly improved pain experience, cognitive coping, appraisals and behavioural expressions of pain. However, for treatment to be effective, patients must adhere to the treatment recommendations.

There are two main categories of cognitive methods, those that are directly concerned with modifying pain related cognitions and those aiming to modify cognitive responses to stress on the assumption that pain may be avoided / minimised if stress is dealt with more effectively.

***Cognitive strategies that alter the subjective component of pain:***

- Imaginative inattention – imagine a scene incompatible with experience of pain, eg. lying on a beach
- Transformation of context – imagine the pain occurring in another context, so they assume a different meaning. The assumption is that if the sensations are associated with courageous thoughts rather than fear and anxiety, pain will be reduced.
- Imaginative transformation – patient re-labels the pain as numbness/tightness, ie. An experience that is less distressing than pain.

***Somatisation***

The patient is taught to acknowledge the pain but think about it in a detached way, eg. imagine it is being observed in someone else's body.

***Attention and Distraction***

Pain tends to grab our entire attention. Chronic pain has no useful warning function, so it is important to recognise that chronic pain can also be ignored. Distraction is the single most important alternative to drugs. Sitting around doing nothing reduces the number of factors in the environment competing for our attention and allows us to focus on the pain. We have to provide opportunities for ourselves to be focus

away from the internal and emotionally distressing experience of pain. In other words we have to learn to DISTRACT ourselves, by doing the following:

#### ALTERING SENSORY INFORMATION

- Hot shower or bath
- Heated pads / hot water bottle
- Ice pack
- Massage
- TENS

#### DISTRACTION

- Rhythmic breathing
- Concentrating on something you can see
- Singing and rhythmic tapping
- Use earphones to listen to music
- Listening to or watching something funny

***Coping skills training*** aims to enhance patients' adaptive coping, to help patients resume a productive and enjoyable life despite pain, by altering the perception of intensity of pain and one's ability to manage it. Active coping strategies are associated with adaptive functioning. Coping is the cognitive, emotional and behavioural way that people manage stressful situations. How well patients adjust to chronic illness can be explained in part by their individual coping processes.

Lazarus and Folkman's (1984) transactional model has the largest impact on the current conceptualisation of coping with chronic illness. This model sees the patients' coping response being determined by both their appraisal of the degree of threat posed by an illness, and the resources seen as being available to help them cope in the situation.

Some emotion-focussed strategies show positive benefits across illnesses. Reframing an illness in a positive light, acceptance of the illness and utilising social support systems seem to be adaptive coping strategies across many chronic illnesses. Problem focussed strategies, which in theory should have a greater adaptive potential, have frequently failed to demonstrate a strong outcomes in chronic illness. Seeking information about the illness and planning seem to be two strategies that do have positive outcomes.

These strategies seem to have the greatest effect when the stressor is appraised by the patient as controllable. Evidence suggests that coping may be more important in explaining the adjustment to chronic pain than medical variables such as evidence of underlying tissue pathology (Keefe et al, 1987). Coping with pain can generally be conceptualised as thoughts and behaviours that serve to manage or decrease pain and the distress caused by pain.

The cognitive behavioural model of pain coping maintains that two processes are important in understanding chronic pain coping – the specific cognitive and behavioural coping strategies used to deal with the pain, and the perceived effectiveness of those strategies. They form a conceptual basis for the most widely used pain coping instrument, the Coping Strategies Questionnaire (CSQ) (Rosenstiel and Keefe, 1983). The CSQ is now widely used in clinical pain assessment and in research examining the efficacy of cognitive behavioural interventions. It measures a variety of pain coping strategies as well as identifying a patient's sense of efficacy for controlling pain.

In conclusion, coping efforts which focus on thinking rationally about pain and taking concrete cognitive and behavioural steps to control pain seem to be the most effective methods for managing chronic pain.

#### **E-2-3.4 Psychodynamic approaches**

These encourage exploration of repressed memories and conflict, relating to early experiences and the way in which defensive behaviour may have developed. The aim is to improve insight and work towards more effective management of the pain.

#### **E-2-3.5 Humanistic and integrative approaches**

These aim to empower the patient, giving them control over the amount of analgesic to be given, and involvement in care and planning. Any approach which interrupts a habitual cycle of pain and distress can help the patient towards more positive pain management. Multimodal pain management may include complementary therapies such as Alexander technique to teach beneficial posture and movement, hypnosis, exercise, relaxation, acupuncture, massage, aromatherapy, shiatsu, yoga and similar techniques to improve muscle tone and reduce tension and pain, chiropractic and osteopathy to promote healthy movement of bones and muscles. Faith healing may be used.

#### **E-2-4 The Expert Patients Programme and other Chronic Disease Management services**

Patient support groups are centrally encouraged and may be of benefit to some patients with chronic pain. However their content and style vary considerably and they rarely bring about improved function, although they may help mood.

Research shows that people living with chronic medical conditions are often in the best position to know what they need in managing their own condition. Expert Patients Programmes bring about a fundamental shift in the way in which chronic diseases and long-term conditions are dealt with – a shift which will empower and liberate patients to play a central role in decisions about their illness. They help people living with long-term conditions to maintain their health and improve their quality of life. Various cognitive techniques are used to encourage people to become good self-managers of their chronic illness. These techniques include helping people to manage the pain-symptom cycle, action planning, problem solving, relaxation etc. Via the Programme patients can become key decision-makers in the treatment process and can become empowered by confidence building to take some responsibility for managing their chronic condition using their own skills and knowledge. By working in partnership with their health and social care



providers, patients can be given greater control over their lives. (For more on the local Expert Patients Programme see [Section I-2-3](#))

Chronic Disease Self-Management Programme – a means of helping people to manage life roles and deal with the negative emotions that come with almost all chronic illness. This incorporates 5 core self management skills – problem solving, decision making, resource utilisation, developing effective partnerships with health care providers, and taking action. ‘Lay led’ self management approaches consistently show benefits on quality of life. User led self-management programmes should be mainstreamed within the NHS. Self-management can reduce the severity of symptoms, significantly decrease pain, improve life control and activity, and improve resourcefulness and life satisfaction. The Chronic Disease Self Management Course is the lay led self-management programme that is most used in the UK, using trained tutors who have a long-term condition. It uses a manual and represents a distillation of expert opinion. The primary aim is to facilitate the development of self-management skills.

Living with Long Term Illness (LiLL) aims to increase the availability of lay led self-management interventions for people living with long term conditions. The Living Well project aims to develop and sustain high quality lay led self management programmes, by being the first point of contact for anyone interested in lay led self management. They provide advice and consultancy to organisations interested in developing lay led self management programmes, establish a system of professional development and support for volunteer tutors, facilitate national information sharing networks for organisations using a range of self management interventions, and compile and publish high quality information materials.

#### **E-2-5 Chronic pain management options in Primary Care (where available)**

Cognitive behavioural therapy (CBT) and a psychologically based rehabilitation programme have shown good evidence for clear benefits across pain, mood, activity and reduced healthcare use. It can be extended to incorporate return to work. It is often delivered by a multi-disciplinary team in a group programme format with exercise, education and other rehabilitative initiatives. Referral to general psychology, mental health services, or psychiatry will not necessarily result in appropriate diagnosis or help, although it is essential that clinical depression be appropriately treated.

GPs may refer to physiotherapy, occupational therapy, orthopaedics, occupational health, the centre for pain medicine, the chronic pain management service, bibliotherapy / education about the condition, or relaxation training.

The local community chronic pain management service operates from Marfleet Healthcare Centre (Monday-Friday, Tel: 01482 344294) led by a GP with input from a specialist nurse and 2 pharmacists, with future plans to employ a psychologist, physiotherapist and occupational therapist.

Currently the majority of referrals are from Eastern Hull, although it is anticipated that after the formation of the single Hull PCT the community chronic pain management service will expand.

The primary care chronic pain management service offers a detailed assessment followed by a recommendation to attend individual sessions with a clinical psychologist, a medication use review (MUR) with a pharmacist, and/or attendance at a pain management group programme (incorporating relaxation, overcoming sleep problems, reducing medication, pacing and goal setting, challenging negative thoughts, using attention and distraction etc). The group programme is based on cognitive behavioural methods, working on the basis that it is the person's interpretation of events rather than the events themselves that determines the subjective experience and behavioural response to the event. Cognitive behavioural methods seek to modify a person's thinking about the pain, and change their patterns of adaptation to it. The central technique is the identification of thoughts and actions exhibited during painful episodes. Dysfunctional methods of thinking can be modified by a set of cognitive techniques such as challenging beliefs, providing alternative ways of construing events (reattribution) and learning alternative coping responses. Behavioural approaches are directed at modifying pain behaviour rather than the subjective experience of pain, eg. activity level and medication intake.

#### **E-2-6 Readiness to change**

Readiness to change is a series of stages a client may pass through whilst recovering from problems such as addictive behaviours (eg. drug and alcohol addiction). The client is helped to maintain the progress achieved and take active steps before discharge to reduce or prevent 'relapse'. This model is useful also as a guide to the clinician in insuring they match and work with the patient's current understanding of their condition and the possibility of adjusting to the condition. It is particularly useful in helping to understand and work with patients who appear to be unwilling or unable to accept personal responsibility for improving their ability to cope with chronic pain.

##### **E-2-6.1 Stages of readiness to change (Prochaska & Diclemente)**

- Precontemplation – not considering changing behaviour
- Contemplation – ambivalent about changing behaviour
- Determination – committed to changing behaviour
- Action – involved in changing behaviour
- Maintenance – behaviour has changed
- Relapse – undesired behaviours re-occur
- Termination – change is very stable

##### **E-2-6.2 Assessing readiness to change**

This can be done through a detailed interview with the client to assess their thoughts and feelings surrounding the problem. In problems such as eating disorders, there is a tool used to formally assess readiness to change called the Readiness and Motivation Interview (RMI).

##### **E-2-6.3 Motivational interviewing**

Motivational Interviewing is a technique used within Readiness to Change, and is used to help the client move through the stages of change and for unhelpful/inappropriate behaviours to be reduced and behaviour to become stable. Properly used it can help reduce or eliminate 'relapse'. Motivational interviewing is a

client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.

Motivational Interviewing is a useful strategy for those who have ambivalence about changing behaviour (including drug use). It can be used at all stages of change for differing reasons. It can raise awareness at the pre-contemplation stage, help in decision making during contemplation, and during action and maintenance it can enhance and remind of resolution to change. Following relapse it enables reassessment. Its greatest use tends to be around contemplation.

Staff should be mindful of the appropriate timing for this strategy within overall case management, by assessing the client's readiness to change.

#### **E-2-6.4 Principles of motivational interviewing**

1. Advice – give advice only when individuals will be receptive, by assessing their stage of readiness to change.
2. Reduce barriers – bolster client's self efficacy and address logistical barriers to changing behaviour.
3. Provide choices – whether to change, how to change.
4. Empathy – develop and communicate an understanding of the individual's situation and feelings around the behaviour, explore pain around the behaviour.
5. Feedback – support self efficacy and the client's belief that they are able to carry out and succeed to overcome the problem.

#### ***Interviewing techniques***

1. Open ended questions – avoid closed and leading questions.
2. Reflective listening – mirror what the client says, to help them understand themselves.
3. Affirmation – convey support, respect and encouragement to the client; help them to reveal less positive aspects about themselves.
4. Summarise – consolidate what has been discussed and the implications.
5. Elicit self motivational statements regarding recognition of the problem, intention to change, optimism.

#### ***For ambivalent clients***

1. Develop discrepancy between client's present behaviour (or lack of it), and the goals they want to achieve (health, social etc.). Compare positives and negatives of behaviour, and of changing. Help individuals decrease their perceptions of the desirability of the behaviour and identify other behaviours to replace the positive aspects of these behaviours. Help the individual identify and understand relevant risks and negative consequences of the behaviour.
2. Empathise - Discuss ambivalence and the pain of engaging in behaviour that hinders goals.
3. Avoid arguments. Arguing is counterproductive. Be non-judgemental and don't blame the client for their non-compliance.
4. Roll with resistance – change strategies in response to resistance from the client. Acknowledge reluctance and ambivalence as natural and understandable.

5. Support self efficacy – bolster the clients responsibility and ability to succeed, and help them to foster hope by making options clear to them.

### **E-2-7 Assessing factors associated with chronic pain**

Assessment of chronic pain has 3 main aims:

1. to determine the suitability of the patient for treatment (though there are few predictors of outcome despite a wide range of measures),
2. to determine the individual's strengths and deficits so the programme can be tailored to their needs, and
3. to evaluate change during treatment.

#### **E-2-7.1 Assessing coping measures**

- Ways of Coping Checklist (WCCL) (Folkman and Lazarus 1980)
- The Vanderbilt Pain Management Inventory (Brown and Nicassio, 1987) measures frequency with which patients use active or passive coping strategies when their pain reaches moderate levels. It comprises a mixture of cognitive and behavioural items. High scores on the active coping scale are related to low pain intensity ratings, low depression and less functional impairment, whilst high scores on the passive coping scale show the opposite.

#### **E-2-7.2 Assessing the affective component of pain**

These measure general psychosocial factors which may be associated with chronic pain – eg. marital distress, social interactions, recreational activities, employment status and domestic arrangements.

- Spielberger State Trait Inventory (Spielberger et al 1970)
- Zung Depression Inventory (adapted for pain patients by Main and Waddel, 1984).
- Beck Depression Inventory (Beck et al, 1961).
- The Profile of Mood States (McNair et al 1971) has been used in the assessment of pain patients and has the advantage of having a range of scales assessing different emotional states. (However, adjectives are American in meaning and the scale only has American norms.)
- Lucock and Morley (1996) Health Anxiety Questionnaire
- Minnesota Multiphasic Personality Inventory (MMPI) is useful as a comprehensive screening instrument for psychological problems and for its ability to identify psychologically defensive patients or those with personality disorders whose self report data may be suspect and for whom long term management or compliance problems may develop. A very high score on the Hypochondriasis scale suggests a poor prognosis with a variety of outcome measures in pain rehabilitation.
- The Millon Behavioural Health Inventory (MBHI, Millon, Green and Meagher, 1979) provides a measurement of overt and covert behaviour patterns important in physical ailments in which behavioural or emotional components play a significant role. The focus is on a variety of personality dimensions, attitudes, events and cognitions that affect the development of physical illness and/or compliance or prognosis in medical treatment programmes.

**E-2-7.3 Health related questionnaires**

- Sickness Impact Profile (Bergner et al, 1976). Assesses illness related dysfunction which describes them on a given day, and are all health related. Score can be divided in to physical and psychosocial dysfunction. The items span 12 domains of life. Follick et al (1985) showed that it correlated well with a range of other pain measures.
- The Nottingham Health Profile (Hunt and McEwan, 1980) – provides an indicator of typical effects of illness – physical, social and emotional.
- Pittsburgh Pain Self Statement Scale (PSSS) which forms part of the multidimensional pain assessment battery (West Haven-Yale Multidimensional Pain Inventory - WHYMPI).
- The Symptom Checklist 90 assesses on a 5 point scale the amount a patient is affected by physical and emotional symptoms. It provides a good summary of self reported difficulties.

**E-2-7.4 Control and quality of life measures**

- Locus of Control Construct (Rotter, 1954)
- Quality of Wellbeing Scale (QWB) (Bush, 1984).
- The Multidimensional Health Locus of Control Scale (Wallston and Wallston, 1978) is an 18 item test which measures the extent to which respondents see their health as being attributable to their own behaviour, the behaviour of powerful others such as physicians, or fate. This may predict behaviour in a pain rehabilitation programme.
- The Pain Locus of Control Scale (Main et al)
- Index of Health Related Quality of Life (IHQL) (Rosser et al, 1993).
- The Pain Response Questionnaire (Pearce, 1986) has a mixture of cognitive and behavioural items, and yields 3 scales – negative cognitions, avoidance disruption and positive responses.

**E-2-8 Roles of specialist and support services**

A large number of pain management techniques and complex pharmacological therapies available in secondary care are not usually available in the primary care setting. For chronic pain, the decision needs to be made whether the pain can be managed in primary care or whether the patient needs to be referred to a specialist unit.

**E-2-9 Selected section references**

Napp Pharmaceuticals Ltd.		A practical guide to the provision of chronic pain services for adults in primary care.
		IASP Pain Terminology. International Association for the Study of pain.
	2003	Pain in Europe. Research project by NFO Worldgroup. Funded by an educational grant from Mundipharma International Limited, Cambridge, England.
Elliott, AM, Smith BH, Kenny, KI et al	1999	The epidemiology of chronic pain in the community. 354, 1248-1252.
Action on Pain Charity		Pacing Leaflet
Action on Pain Charity		Relaxation Leaflet
		Control Pain, Live Life – A guide for patients in chronic pain leaflet
LMCA Alliance for Health		Supporting Expert Patients – How to develop lay led self management programmes for people with long term medical conditions.
Department of Health.		The Expert Patient: A New Approach to Chronic Disease Management for the 21 <sup>st</sup> Century.
	2000	Assessing Readiness and Motivation for Change: Challenges and Practical Advice. Article from <i>Eating Disorders Review</i> November/December 2000. Volume 11, Number 6
Prochaska, J.O., Diclemente, C.C. & Norcross, J.C	1992	In search of how people change. Applications to Addictive Behaviours. <i>American Psychologist</i> , 47 (9), 1102 –1114.
Sweet, Rozensky and Tovian	1991	Handbook of Clinical Psychology in Medical Settings. Plenum Press.
Llewelyn and Kennedy	2003	Handbook of Clinical Health Psychology. Wiley.
Baum, Newman, Weinman, West and McManus	1997	Cambridge Handbook of Psychology, Health and Medicine. Cambridge University Press.
Adams and Bromley	1998	Psychology for Health Care – Key terms and concepts. Macmillan.
Peter Salmon	2000	Psychology of Medicine and Surgery. A guide for psychologist, counsellors, nurses and doctors. John Wiley and sons.
Pearce and Wardle	1989	The practice of behavioural medicine. BPS Oxford University Press.
Bennett, Weinman, and Spurgeon.	1990	Current Developments in Health Psychology. Harwood Academic Publishers.
McQuay HJ, Moore RA.	1997	Antidepressants and chronic pain. <i>BMJ</i> 1997;314:763-4.
McQuay HJ, Moore RA.	1998	An evidence based resource for pain relief. Oxford university press.
Bandalier website		<a href="http://www.jr2.ox.ac.uk/bandalier">http://www.jr2.ox.ac.uk/bandalier</a>

**E-3 CANCER PAIN MANAGEMENT** (in adults)

*NB. This Section of the Adult Pain Management Guidelines is broadly based on a document produced by The Joint North and North East Lincolnshire Palliative Care Group and was adapted by Pain Management Task Group members Angie Orr, Jackie Matthews and Helen Bowden with wide consultation and opportunity to comment via email.*

**E-3-1 Introduction to the management of cancer pain****E-3-2 Cancer pain assessment and management**

E-3-2.1 Factors influencing a patient's perception of pain (diagram)

E-3-2.2 A pain assessment chart

E-3-2.3 Non-drug therapies for pain management

E-3-2.4 WHO analgesic ladder

**E-3-3 Drug therapies for cancer pain**

E-3-3.1 Strong opioids

E-3-3.2 Immediate release opioids

E-3-3.3 Titration chart

E-3-3.4 Converting from immediate release morphine to modified release morphine

E-3-3.5 Starting a patient on modified release oral morphine

E-3-3.6 Breakthrough pain

E-3-3.7 How to increase the modified release morphine dose

E-3-3.8 Patients unable to take oral opioids

E-3-3.9 Subcutaneous route

E-3-3.10 Other opioids

E-3-3.11 Guidelines for the use of transdermal fentanyl

E-3-3.12 Starting transdermal fentanyl

E-3-3.13 Calculating the appropriate breakthrough dose

E-3-3.14 Application of transdermal fentanyl patches

E-3-3.15 Dealing with uncontrolled pain

**E-3-4 Anti-Emetics, Laxatives and Adjuvant Analgesics**

E-3-4.1 Anti-emetics

E-3-4.2 Laxatives

E-3-4.3 Adjuvants

E-3-4.4 Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

E-3-4.5 Corticosteroids

E-3-4.6 Bisphosphonates

E-3-4.7 Tricyclic anti-depressants

E-3-4.8 Anti-convulsants

E-3-4.9 Anti-spasmodics

**E-3-5 Palliative treatment options for bone pain****E-3-6 Advice & contacts****E-3-7 Section references**

### E-3-1 Introduction to the management of cancer pain

This section is for Doctors, Pharmacists and Registered Nurses (RNs) who are influential and involved in the prescribing and administration of cancer pain treatment. This section may also be of use to Allied Health Professionals (AHPs) and Health Care Assistants (HCAs) who may be involved in non-pharmaceutical measures in the management of cancer pain in adults. The client group is adults with cancer pain who are being cared for within a hospice, community, care home or hospital setting.

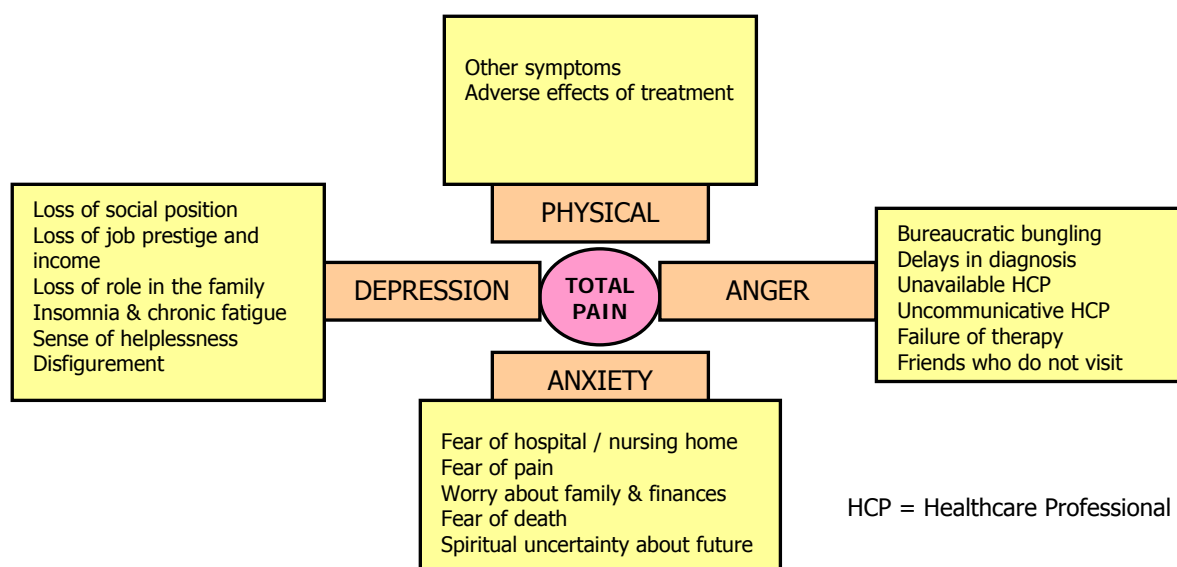
There is a high prevalence of pain in patients with cancer (around 80%, range 52 – 82%) (Doyle 1980; Wilkes 1984; Hockley et al 1988; Addington-Hall and McCarthy 1995; Millar et al 1998). Studies have shown that only 5 – 10% of this pain proves difficult to control in specialist palliative care units; however, in some generalist settings there has been evidence of poor pain control (Mills et al 1994; Addington-Hall and McCarthy 1995; Millar et al 1998).

Evidence suggests that most cancer pain can be controlled with appropriate intervention. The aim of this section, therefore, is to provide information and guidance to healthcare professionals on the safe management of patients with cancer pain. If symptoms prove difficult to control further guidance should be sought eg. from the Specialist Palliative Care Team (see [Section I-1-3](#)).

### E-3-2 Cancer pain assessment and management

'Pain is a common, although not inevitable, symptom in cancer and successful treatment requires an accurate diagnosis of the cause and a rational approach to therapy. There are many components to cancer pain and all relevant physical and psycho-social factors need to be taken into account. Pain in the cancer patient need not be caused by the cancer, and can be due to debility, previous treatment or to an unrelated cause'. (Wessex Palliative Physicians 2002)

#### E-3-2.1 Factors influencing a patient's perception of pain



(Source: Twycross, R G & Lack, S A. *Therapeutics in terminal cancer*. 2<sup>nd</sup> edition. London, Churchill Livingstone 1990)



An accurate assessment of the patient's pain should be made using a Cancer Pain Assessment Tool (Foley 1998, Ingham and Portenoy 1997, Twycross et al 1999), however; therapy should never be withheld whilst awaiting the outcome of tests or investigations. An example of a pain assessment chart follows on the next page.

In cancer patients several different pains often co-exist. Each pain should be assessed separately and treatment considered.

Regular and frequent review to ensure optimal pain control is paramount.

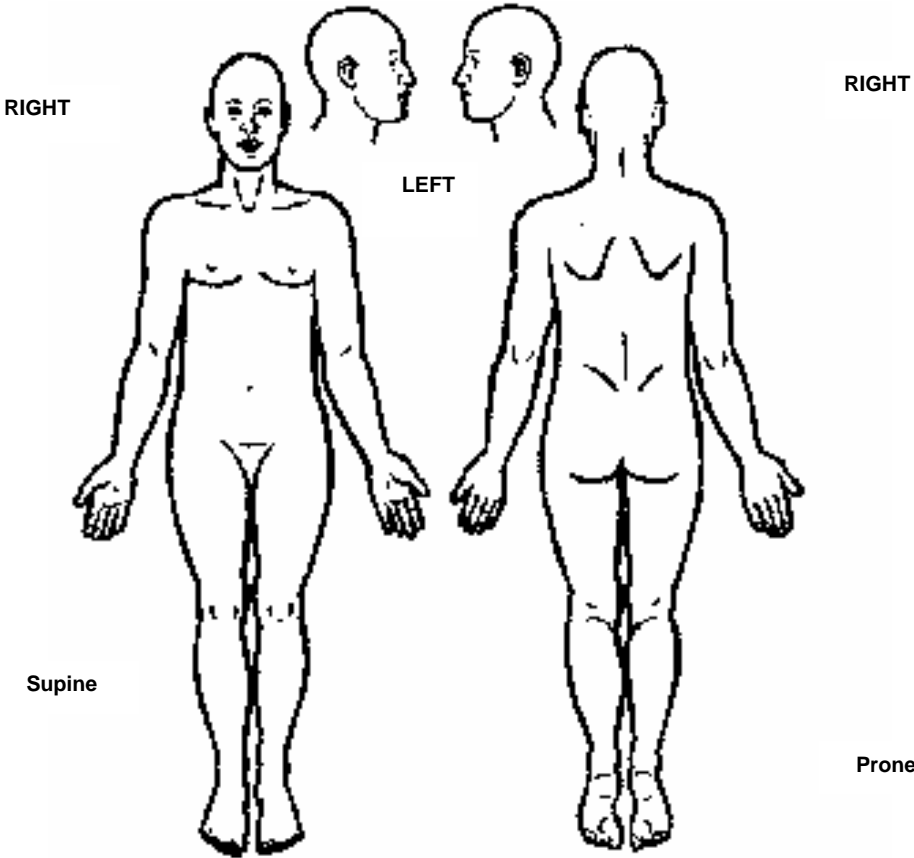
E-3-2.2 A pain assessment chart

DATE:    /    /

Case note N°  
Name  
D.O.B  
  
NHS N°  
*(Addressograph label if available)*

Place of assessment  
☐ Home    ☐ Hospice  
☐ Nursing/Residential home  
☐ Ward *(specify)*

Body Chart  
Use a letter to indicate sites of pain  
Eg. A / B / C etc  
  
What makes the pain better or worse?  
  
Anything else about the pain?  
Eg. things already tried



<u>Chronic Pain</u>	0	1	2	3	4	5	6	7	8	9	10
Pain free	Mild		Moderate		Severe		Very severe		<u>Overwhelming</u>		

- Descriptive Words
- Throbbing
  - Cutting
  - Burning
  - Stinging
  - Aching
  - Tiring
  - Blinding
  - Intense
  - Penetrating
  - Nagging
  - Shooting
  - Gnawing
  - Searing
  - Dull
  - Tender
  - Comfortable
  - Coping
  - Happy
  - Unusually quiet
  - Irritable
  - Content
  - Frightful
  - Annoying
  - Unbearable
  - Radiating
  - Nauseating
  - Stabbing
  - Crushing
  - Smarting
  - Hurting
  - Splitting
  - Vicious
  - Miserable
  - Spreading
  - Piercing
  - Disturbing sleep
  - Pain Free
  - Relaxed
  - Lethargic
  - Active – Indoors
  - Active – outdoors
  - Over active

• Other (specify)

### E-3-2.3 Non-drug therapies for pain management

It is vital to remember non-drug treatments for pain. Amongst the benefits are increased patient control, improved morale, feeling comforted and cared for and potentially a lack of side effects. Trial of relaxation techniques should be encouraged. Use of gentle (non-professional) massage to the affected part or shoulders, if it helps, or even pampering with a manicure or hair do can do wonders for a patient's morale and mood, helping to relieve pain. The use of warmth eg. microwaveable warm pack, warm hot water bottle or soaking in a pleasantly warm bath can all help relieve pain. Always stress to patients and carers the need to avoid excessive heat. Use of ice packs to relieve localised pain can also be beneficial to some.

Distraction is a very important technique which patients or carers can learn to recognise and benefit from. This is the use of activities (appropriate physical activities or occupying the patient's attention) so that pain is no longer at the forefront of the mind and therefore is not such a major part of the patient's experience. It is a well recognised phenomenon in hospices and hospitals that some visitors distract the patient and raise their mood and interest, whilst others focus attention on the pain and so extra painkillers are requested at their visiting times.

Adequate rest and sleep are also important and can be encouraged with a variety of non-drug measures. Adequate 'sleep hygiene' can make a difference here. If a patient is spending all their time in one room it may be helpful to make some changes at sleeping times eg. reduced lighting, change of position, slight changes of aroma or temperature, altering the volume and type of background noises or music, moving certain items of furniture slightly to give a pattern to the day and night.

Pain and discomfort from general debility or weight loss can respond to general care measures such as cushions and specific mattress types.

Where appropriate, spiritual support may have a useful contribution to pain management.

For more specific non-drug treatments see [Section F](#) of these Guidelines.



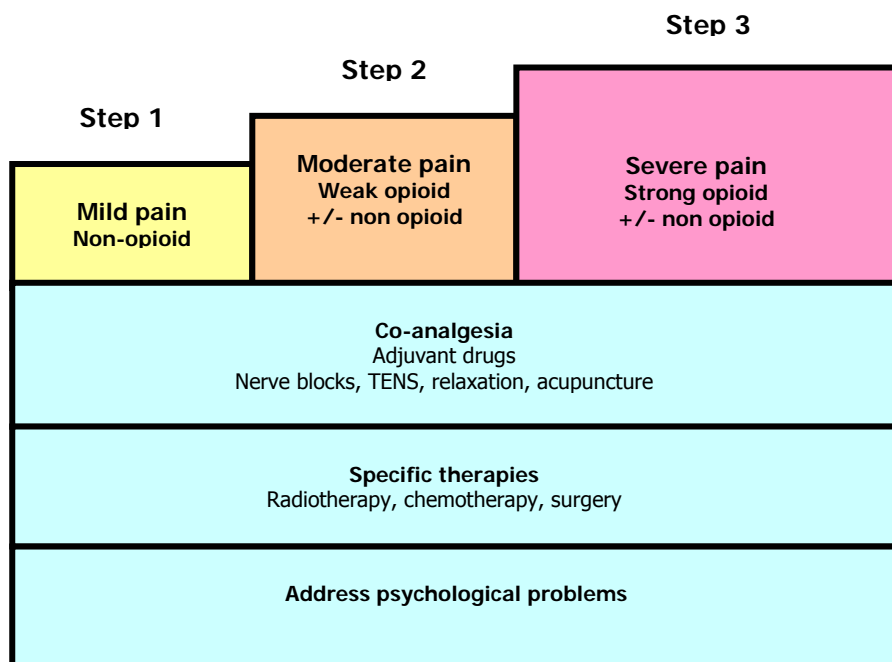
*Further reading:* Cancerbackup have a wealth of information for patients and carers regarding non drug therapies and pain.

See <http://www.cancerbackup.org.uk/> or Tel: 0808 800 1234.

### E-3-2.4 The WHO analgesic ladder

The World Health Organisation (WHO) 'Analgesic Ladder' emphasises that:

- Analgesics should be given regularly
- It is essential to use an analgesic appropriate to the severity of the pain
- A patient whose pain does not respond to weak opioids needs management with strong opioids
- Additional methods of pain control must be considered in all patients
- All patients taking opioids should be prescribed laxatives, at the time the opioid is commenced
- Also consider co-prescribing an appropriate anti-emetic for the first week



### Step 1

Medications in Step 1 are aimed at treating mild pain in patients, who have not had any form of analgesia at that point for their pain. An example of a Step 1 analgesic is paracetamol, one gram to be given four to six hourly, with no more than 4 grams in any 24-hour period (Doyle et al 1996; Hanks and Cherny 1998).

In addition, Non Steroidal Anti Inflammatory Drugs (NSAIDs), other adjuvants and non-pharmacological methods can be used at Step 1.

If pain is not controlled when a patient is taking the full dose of paracetamol in a 24-hour period and NSAIDs, adjuvants and non-pharmacological methods have also been considered, this is an indication to move to Step 2.

### Step 2

Step 2 of the ladder aims to address mild to moderate pain. It suggests the use of a weak opioid such as Codeine, with or without a non-opioid, such as paracetamol. An example of a Step 2 analgesic is Codeine Phosphate.

If pain is not controlled when a patient is taking the full 24-hour dose and NSAIDs, adjuvants and non-pharmacological methods have also been considered, this is an indication to move to Step 3 (Twycross 1997; National Council for Hospice and Specialist Palliative Care Services (NCHSPCS) 1998; Hanks and Cherny 1998).

### Step 3

Step 3 aims to address moderate to severe pain and involves the use of a strong opioid such as morphine. The use of strong opioids is covered in detail in the next section of these Guidelines.

### E-3-3 Drug Therapies for cancer pain

#### E-3-3.1 Strong opioids

The Expert Working Group of the European Association for Palliative Care 1996 and 2001 recommended the use of strong opioids for patients who have been assessed to be in moderate to severe pain (Twycross 1997; Hanks and Cherny 1998) i.e. Step 3 of the WHO Analgesic Ladder. Initial titration should be with immediate release morphine. Depending on circumstances, modified release morphine may provide a more convenient option for both patient, carer and healthcare team but early review is essential.

#### E-3-3.2 Immediate release opioids

Immediate release Morphine preparations have an onset of action of about 20 minutes and reach a peak around 60 minutes. The rapid onset of analgesia makes these preparations suitable for use in initiating therapy for severe pain and for breakthrough pain. Foley (1998) defines breakthrough pain as 'an unexpected increase in pain to greater than moderate intensity, occurring on a baseline pain of moderate intensity or less'.

#### E-3-3.3 Titration chart

(for breakthrough pain see [Section E-3-3.6](#))

Drug	Dose	Comments
<b>SEVREDOL</b> Available as: - <ul style="list-style-type: none"> <li>• 10mg</li> <li>• 20mg</li> <li>• 50mg</li> </ul>	Prescribe immediate release oral Morphine using Sevredol or Oramorph 4 hourly <b>and</b> 'as required'  Starting dose: Sevredol 10mgs 4 hourly <b>and</b> 'as required'  Or	*Additional doses can be administered 'as required' for breakthrough pain. Leave a minimum period of 1 hour between doses.  Calculate the total amount of oral morphine used in 24 hours. Divide by 6 to get the new 4 hourly and 'as required' dose of Morphine.
<b>ORAMORPH</b> Available as: - <ul style="list-style-type: none"> <li>• 2mg/ml</li> <li>• 20mg/ml (Concentrate)</li> </ul> (NB Unit dose vials are also available)	Oramorph 10mgs 4 hourly <b>and</b> 'as required' (For frail or elderly a lower starting dose may be considered eg. 2.5 - 5mgs 4 hourly and 'as required')  Continue for 24 – 48 hours to titrate to individual opioid requirements in 24-hour period (NCHSPCS 1998).	<b>Pain not controlled</b> Consider adjuvants and other factors i.e. not all pains are opioid responsive.

#### E-3-3.4 Converting from immediate release morphine to modified release morphine

Once suitable pain control is achieved by the use of immediate release morphine, conversion to the same total daily dose of modified release morphine should be considered ([SIGN publication Number 44 2000](#)).

Examples of modified release morphine preparations are: -

- MST Continus
- Zomorph Capsules

**CONVERSION TO MODIFIED RELEASE PREPARATION**

Calculate the total amount of immediate release oral morphine administered in a 24-hour period and divide by 2 to convert to 12-hourly, modified release Morphine (Hanks et al 1998; Regnard and Tempest 1998). The total amount of morphine administered over the 24-hour period should include any additional doses given for breakthrough pain.

**Example of calculation:**

- Patient received 10mgs oral morphine 4-hourly over 24 hours. This equals 60mgs in total.
- Divide this by 2 to obtain twice daily dose for modified release oral morphine.
- 60mgs divided by 2 = 30mgs twice daily of modified release oral morphine

**If patient received additional doses for breakthrough pain:**

- Add total of any additional doses for breakthrough pain to total of 4-hourly doses received in 24 hours

**For example:**

- Patient received 4 additional doses of 10mgs for breakthrough pain during 24 hours
- The total amount of morphine given over 24 hours would therefore be 60mgs plus 40mgs = 100mgs
- Divide 100mgs by 2 to calculate twice daily dose of modified release oral morphine = 50mgs bd (Please note, bd = *bis die* or twice daily)

**E-3-3.5 Starting a patient on modified release oral morphine**

If it is preferred to start a patient directly on modified release oral morphine:

- If the patient was previously receiving full dose weak opioid regularly give 20 - 30mg modified release morphine twice daily
- If the patient is frail and elderly, a lower dose helps to reduce initial drowsiness, confusion and unsteadiness eg. 15mg modified release morphine twice daily

**E-3-3.6 Breakthrough pain**

Once the dose of modified release morphine has been calculated, a dose equal to one sixth of the total daily morphine to be taken should be prescribed as immediate release morphine 'as required' for any breakthrough pain. This is established practice when using morphine for cancer pain according to the Expert Working Group of the European Association for Palliative Care (BMJ 1996)

**Examples of how to calculate dose for breakthrough pain:****Example 1:**

- Patient receives 30mgs bd modified release morphine = total of 60mgs in 24 hours
- Dose for breakthrough pain = 60mgs divided by 6
- Dose for breakthrough pain = 10mgs immediate release oral morphine 'as required'

**Example 2:**

- Patient receives 150mgs bd modified release morphine = total of 300mgs in 24 hours
- Dose for breakthrough pain = 300mgs divided by 6
- Dose for breakthrough pain = 50mgs immediate release oral morphine 'as required'

**E-3-3.7 How to increase the modified release morphine dose**

For patients who require breakthrough analgesia on a frequent basis, the dose of modified release oral morphine should be increased in order to achieve pain control.

The new total daily dose of modified release oral morphine should be calculated by adding the total of any breakthrough doses of immediate release morphine in a 24-hour period, to the existing daily dose of modified release oral morphine (SIGN publication number 44 2000).

Example of calculation:

Total in 24 hours

- |  |                     |
|--|---------------------|
| ▪ Patient takes modified release morphine 30mgs twice daily                            | 60mgs               |
| ▪ Patient required six doses of 10mgs immediate release morphine for breakthrough pain | +                   |
|  | <u>60mgs</u>        |
|  | Total <u>120mgs</u> |
| ▪ Divide total by 2 to obtain new modified release dose                                |                     |
| ▪ New dose = 120mgs divided by 2   |                     |
| ▪ New dose = 60mgs twice daily modified release morphine                               |                     |

**To calculate the new dose for breakthrough pain:**

Prescribe one sixth of the total daily dose as a rescue dose for breakthrough pain. In the example above this would be 120mgs divided by 6 to obtain a breakthrough dose of 20mgs immediate release oral morphine 'as required'.

**NB: Recommendations for patients unable or unwilling to use rescue facility for breakthrough pain**

Some patients may experience breakthrough pain, but be unwilling or unable to use the breakthrough pain facility. Reasons for this include opioid phobia, the patient not being lucid enough or simply reluctant to request additional analgesia. In such circumstances it is not possible to calculate the true opioid requirement of the patient based on the amount of 'as required' doses administered for breakthrough pain. It is

recognised practice in such cases to increase the dose of sustained release oral morphine by one third or one half.

#### Examples:

For a patient taking 120mgs modified release oral morphine in 24 hours (in 2 equal doses of 60mgs)

##### To increase this dose by one third:

- Calculate one third of 120mgs = 40 mgs
- Increase the total 24 hour dose by 40mgs to 160mgs, to be given in 2 equal doses
- New dose is 80mgs modified release oral morphine twice daily

##### To increase this dose by one half:

- Calculate one half of 120mgs = 60mgs
- Increase the total 24 hour dose by 60mgs to 180mgs, to be given in 2 equal doses
- New dose is 90mgs modified release oral morphine twice daily

#### E-3-3.8 Patients unable to take oral opioids

When patients with moderate to severe pain are unable to take oral opioids, alternative routes of administration must be considered. Subcutaneous continuous infusion is the preferred route; however, transdermal patches may also be considered (Regnard and Tempest 1998).

- Pethidine is **not** a suitable opioid for patients with cancer pain due to its short duration of action and the necessity for repeated injections. It may also contribute to epilepsy and renal failure (Twycross 1997).
- The intramuscular route is **not** suitable.

#### E-3-3.9 Subcutaneous route

Indications for subcutaneous administration of opioids:

- Inability to take oral medication
- Nausea and/or vomiting
- Gastrointestinal obstruction
- Any pathology limiting gastrointestinal absorption



For more information on the use of Syringe Drivers for symptom control in patients with cancer please refer to the 'Prescribing in palliative care' section at the front of the British National Formulary (BNF) (see <http://www.bnf.org/bnf/bnf/current/index.htm>) or seek specialist advice.



**Conversion from oral morphine to subcutaneous diamorphine:**

From clinical practice, subcutaneous diamorphine is approximately three times as potent as oral morphine. To convert from oral to the subcutaneous route, add up the total oral morphine requirement for the previous 24 hours (both regular and any breakthrough doses). Divide this amount by three to calculate subcutaneous dose and prescribe as a subcutaneous infusion over 24 hours (Expert Working Group of the European Association for Palliative Care BMJ 1996). Oral analgesia should be discontinued once the syringe driver is commenced.

**Example 1:**

Patient received 60 mgs modified release oral morphine in 24 hours (30mgs bd). Divide by three to calculate subcutaneous diamorphine dose. **Subcutaneous dose = 20mgs diamorphine via syringe driver over 24 hours**

**Rescue dose for breakthrough pain:** One sixth of the total daily dose (to be given at any time by bolus subcutaneous injection) should be prescribed for breakthrough pain. 20mgs divided by 6 = 3.3mgs. The breakthrough dose would therefore be 5mgs (rounded up to the nearest practical dose)

**Example 2:**

Patient received 200mgs modified release oral morphine in 24 hours (100mgs bd). Divide by three. **Subcutaneous dose = 60mgs diamorphine via syringe driver over 24 hours**

**Rescue dose for breakthrough pain:** One sixth of the total daily dose = 10mgs diamorphine by subcutaneous injection prn.

**E-3-3.10 Other opioids**

To date most experience in palliative care has been gained in the use of oral morphine, subcutaneous diamorphine and Fentanyl patches. Other opioids are available but it is recommended that you seek further specialist advice when considering their use.

**E-3-3.11 Guidelines for the use of transdermal Fentanyl****Indications for use**

Fentanyl is a strong opioid, which has been shown to have similar clinical efficacy in pain relief as morphine (Ahmedzai and Brooks 1997; Payne et al 1998). It is indicated in patients with **stable pain** who have difficulty with morphine or with the oral route of administration. It is formulated in a patch delivery system and the patch is generally replaced every 72 hours (Portenoy et al 1993). It has a time lag of 6-12 hours to onset of action (Portenoy et al 1993), hence its use for stable pain only. Specifically use of transdermal Fentanyl should be considered in patients with: -

- Dysphagia or difficulty swallowing oral medication
- Vomiting
- Gastrointestinal obstruction
- Patients unable to take oral medication appropriately
- Unacceptable toxicity from morphine

**Contraindications**

- Transdermal Fentanyl is not a suitable analgesic for uncontrolled pain
- Transdermal Fentanyl is not suitable for patients with fever or excessive perspiration, as this can affect absorption

**E-3-3.12 Starting transdermal Fentanyl**

It is recommended that Fentanyl patches are prescribed by brand name only (see [Section D-6-1](#))

**a) PATIENTS PREVIOUSLY ON MAXIMUM REGULAR DOSE OF WEAK OPIOIDS**

Transdermal Fentanyl is only indicated as a first line strong opioid in patients with the indications noted above. It should be initiated with caution and only in patients tolerant of Codeine or Dihydrocodeine  $\geq 240$  mg/day or Tramadol  $>400$  mg/Day.

- Start with a 25 microgram per hour over 72 hours patch.
- Continue pre-existing analgesic for first 12 hours after applying a patch.
- Dosage should be titrated for optimum pain relief only after 72 hours.
- There is evidence that in some patients, Fentanyl causes less constipation than morphine (Ahmedzai and Brooks 1997; Donner et al 1998), however a stimulant laxative should still be prescribed.

Breakthrough pain:

- Immediate release opioids, usually morphine, should be administered for any breakthrough pain (eg. Oramorph or Sevredol) at 4 hourly equivalent dose, see chart below.

**b) PATIENTS PREVIOUSLY ON STRONG OPIOIDS**

- Calculate the correct patch size using the conversion chart in Table 1, based on the patient's previous 24-hour morphine requirement.

Converting from immediate release morphine:

- Continue to give 4-hourly morphine for the next 12 hours after applying the patch.

Converting from modified release morphine:

- Apply the first patch at the same time as giving the last 12-hourly Morphine tablet.

Breakthrough pain:

- Immediate release opioids should be prescribed 'as required' for breakthrough pain.
- The initial dose prescribed for breakthrough pain should be one sixth of the previous total daily dose of oral morphine.
- Remember: If the patch strength is increased, the 'as required' rescue dose should also be increased accordingly.

- If, after 48 hours on the same patch strength, patients require more than 2 rescue analgesic doses in a 24 hour period, the dose may be titrated upwards in increments of 12-25 micrograms/hr patches N.B. it takes 17 – 24 hours to achieve stable plasma levels. Do not increase the patch strength at less than 48 hour intervals.

### E-3-3.13 Calculating the appropriate breakthrough dose

We recommend using an appropriate conversion chart to calculate the correct dose of immediate release opioid. Oral morphine is usually used for breakthrough pain for patients using Fentanyl patches.

**Table 1: Oral Morphine to Transdermal Fentanyl Patch conversion chart:**

Breakthrough dose oral Morphine (mg)	Transdermal Fentanyl Patch Strength (micrograms/hr)*	24 Hourly Oral Morphine equivalent (mg per day)
<20	25	<90
20 - 25	37	90 - 134
25 - 35	50	135 - 189
35 - 40	62	190 - 224
40 - 50	75	225 - 314
55 - 65	100	315 - 404
70 - 80	125	405 - 494
85 - 95	150	495 - 584
100 - 110	175	585 - 674
115 - 125	200	675 - 764
130 - 140	225	765 - 854
145 - 155	250	855 - 944
160 - 170	275	945 - 1034
175 - 185	300	1035 - 1124

\* NB This table includes the Fentanyl 12 patch available for titration purposes.

### E-3-3.14 Application of transdermal Fentanyl patches

- Apply to normal skin on the chest or upper arm.
- If there is a need to wash the skin only use cold water and pat completely dry. Do not use soap or talcum powder.
- Patches are waterproof – patients can shower and bathe.
- But do not soak the patch site in the bath.
- Avoid applying the patches to lymphoedematous or recently irradiated areas.
- If the patient is particularly hairy, clip body hair close to the skin – do not shave.
- Apply the patch and press for 30 seconds lightly with a flat hand.
- Do not cut the patch.
- Micropore, Opsite or Tegaderm can be used around the edges of the patch to aid adhesion. Do not place over the whole patch site.
- Alternate the patch site every 72 hours.
- Ensure the used patch is removed and disposed of in a safe manner.

**E-3-3.15 Dealing with uncontrolled pain**

- Increasing the Fentanyl patch will not be effective immediately due to time lag to onset of analgesia.
- Check that the patches have been used correctly and are adherent to the skin.
- Reassess the patient to ascertain why the pain has worsened (eg. pathological fracture).
- Check that the dose for breakthrough pain is correct and that the pain is responsive to opioids.
- If the patient can take oral medication, supplement with immediate release morphine as required until pain is stabilised and then titrate the patches accordingly.
- If the patient cannot take oral medication, give a subcutaneous diamorphine injection (see table below). If two or more breakthrough doses are required in a 24 hour period consider a subcutaneous diamorphine infusion in addition to the patch, using the guidelines below.
- Whenever a diamorphine syringe driver is commenced subcutaneous diamorphine injections should also be prescribed 'as required' for breakthrough pain (See Table 2 for dosage).

**Table 2: Initial dose of subcutaneous diamorphine in addition to a Fentanyl Patch**

Transdermal <b>Fentanyl</b> Patch	24 Hourly dose/ADDITIONAL Diamorphine s.c. This represents an increase of 50% in the overall analgesic dose.	Breakthrough/PRN Diamorphine s.c. dose.
25	15mg	5mg
50	30mg	10mg
75	45mg	15mg
100	60mg	20mg
150	90mg	30mg
200	120mg	40mg
300	180mg	60mg

**If a patient is already on a Fentanyl patch and diamorphine in a syringe driver and still has pain seek specialist advice. (The calculation is complex)**

**E-3-4 Anti-Emetics, Laxatives and Adjuvant Analgesics**

An anti-emetic and laxative should always be co-prescribed when commencing strong opioids.

**E-3-4.1 Anti-emetics**

In clinical practice it appears that in opioid naïve patients, 30-60% will develop nausea and/or vomiting. Tolerance in some of patients may occur within 5-10 days. Patients should therefore be prescribed an anti-emetic when first commencing opioids eg. low dose haloperidol 1.5mg orally at night or metoclopramide 10mg three times daily should be prescribed for one week. (see Wessex Palliative Care Handbook for more details). Also consider an anti-emetic when increasing the opioid dose.

**E-3-4.2 Laxatives**

The majority of patients taking opioids will develop constipation. Little or no tolerance develops. It is recommended therefore to prescribe prophylactic stimulant and softening laxatives when commencing opioids (Doyle et al 1996)

- Always assess the patient and titrate the laxative according to individual requirements
- Constipation can be prevented in the majority of patients
- A softening agent alone may be ineffective, consider using a stimulant in conjunction eg. Co-danthramer strong (only for terminally ill patients as per BNF) or lactulose and senna or Movicol.
- When increasing opioids always titrate laxative accordingly
- In intestinal obstruction never use a stimulant laxative. In partial obstruction a softener may be used eg. Docusate
- About a third of patients also need rectal measures (Twycross et al, PCF2)

**E-3-4.3 Adjuvants**

Adjuvant analgesics are a miscellaneous group of drugs that relieve pain in specific circumstances. They can be used in combination with opioids and may achieve synergistic effects, producing better pain relief at lower doses of opioids, leading to fewer opioid side effects (Doyle et al 1996). It is important to choose the appropriate adjuvant according to the nature of the patient's pain.

**E-3-4.4 Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)****Indications:**

- NSAIDs are of particular benefit for pains associated with inflammation eg. soft tissue infiltration and bone metastases
- Also indicated for Liver pain

**Suggested drugs and dosage:**

- Diclofenac 50mgs three times daily or
- Ibuprofen 200 – 400mgs three times daily

**Cautions:**

- Consider co-prescribing gastric protection.
- Extra caution should be exercised in patients with gastric problems, taking Warfarin, renal failure, dehydration and/or asthma.
- extra caution should be exercised in patients with cardiac failure and the elderly

Poor pain relief and adverse effects may be overcome by changing to a NSAID in a different chemical group (seek Specialist Palliative Care advice)

**E-3-4.5 Corticosteroids**

The general anti-inflammatory effect of corticosteroids reduces total tumour mass, resulting in a reduction of pain. Steroids are often beneficial for pain associated with tumour pressure on structures sensitive to pain, for example: cerebral or liver metastases that are not as responsive to opioids.

**Indications and dosage:**

- Nerve root / nerve trunk compression / Soft tissue infiltration eg. 4 - 8mg (PCF2)
- Spinal cord compression / raised intra cranial pressure eg. 8 - 16mg (PCF2)
- Liver pain eg. 8 - 16mg (Wessex Palliative Physicians 2002)
- Bone pain – seek dosage advice from the patient's consultant or specialist nurse
- Inoperable intestinal obstruction 8 - 20mg (Baines 1997)

**Directions:**

- Dexamethasone should be taken once daily in a morning or in two equal doses
- Should not be given after 2pm (unless on first day of treatment) as it can cause insomnia

**Cautions:**

- Consider co-prescribing gastric protection.

It is usual to give a trial of seven days and stop if ineffective. If steroids are taken for longer the dose should tapered slowly.

**E-3-4.6 Bisphosphonates****Indications and dosage:**

Bone pain - IV infusions of bisphosphonates may reduce pain in patients with bone metastases, especially from breast and prostate cancer and myeloma:

- Pamidronate 60-90mg
- Sodium clodronate 1500mg every 3-4 weeks, depending on identified response. Expensive.

**E-3-4.7 Tricyclic anti-depressants****Indications:**

Neuropathic pain especially if of a constant aching or burning nature.

It is important when starting anti-depressants to explain the rationale for their use to the patient (Working Party on Clinical Guidelines in Palliative Care 1998).

**Drugs and dosage:**

- Amitriptyline starting dose of 10mgs – 25 mgs at night.
- Increase dose at weekly intervals by 25mgs up to a dose of 75mgs
- If no improvement at that dose, consider an alternative – seek specialist palliative care advice

**Cautions:**

- Because of potential sedative effects should be administered at night
- Caution should be taken with patients with cardiac arrhythmia

**E-3-4.8 Anti-convulsants****Indications:**

- Used for neuropathic pain especially if of a shooting or stabbing nature

**Drugs and dosage:**

- Carbamazepine: start at 100mgs twice daily and gradually increase to a maximum of 400mgs three times daily or until pain controlled (increase by 200mgs every 2 – 3 days) (Working Party on Clinical Guidelines in Palliative Care 1998)
- Gabapentin 300mg increasing dose according to schedule until pain controlled or side effects outweigh benefits.

**GABAPENTIN INCREASING DOSE SCHEDULE**

DAY	A.M.	MIDDAY	P.M.
DAY 1			300mg
DAY 2		300mg	300mg
DAY 3	300mg	300mg	300mg
DAY 4	300mg	300mg	300mg
DAY 5	300mg	300mg	300mg
DAY 6	300mg	300mg	300mg
DAY 7	300mg	300mg	600mg
DAY 8	300mg	600mg	600mg
DAY 9	600mg	600mg	600mg
DAY 10	600mg	600mg	600mg
DAY 11 Onwards	600mg	600mg	600mg

**Cautions:**

- Anticonvulsants work in different ways so different ones can be tried
- Withdraw treatment immediately if vomiting, anorexia or jaundice occurs which is suspected to be as a result of the anticonvulsant drugs
- If pain is difficult to control seek specialist advice

**E-3-4.9 Anti-spasmodics**

For colicky abdominal pain due to inoperable / intermittent intestinal obstruction (not constipation)

- Avoid / stop stimulant and bulking laxatives
- Avoid prokinetic anti-emetics (metoclopramide, domperidone)

**Drugs and dosage:**

- Hyoscine Butylbromide 20mg as required subcutaneously.
- Hyoscine Butylbromide 60 - 200mg via syringe driver over 24 hours (Baines 1997)

**Muscle spasm:**

- Consider diazepam 2 - 5mg up to three times daily

**E-3-5 Palliative treatment options for bone pain**

- Consider early referral for palliative radiotherapy - usually a single fraction is effective. Patients with multiple sclerotic metastases may benefit from radioactive strontium treatment.
- When pain in a long bone is of sudden onset or severe, consider the possibility of a pathological fracture: obtain x-ray and consider orthopaedic opinion.
- Spinal cord compression is an oncological emergency which can cause severe back pain and may respond to treatment - immediate referral is indicated.

**E-3-6 Advice & contacts**

If in any doubt or if symptoms are difficult to control, seek specialist palliative care advice from the specialist Macmillan palliative care team, community Macmillan nurse teams, the oncology health centres etc. See [Section I](#) – Contacts and Further Resources.



**E-3-7 Section references**

Addington-Hall and McCarthy	1995	Dying from Cancer: results of a national population-based investigation. Palliative medicine 1995; 9:295-305
Ahmedzai and Brooks	1997	Transdermal Fentanyl versus sustained release oral morphine in cancer pain: preference, efficacy and quality of life. The TTS-Fentanyl Comparative Trial Group. J Pain Symptom Management 1997; 13:254-261
Baines M	1997	ABC of palliative care: nausea, vomiting and intestinal obstruction. British Medical Journal. 315: 1148-1150
Donner et al	1998	Long term treatment of cancer pain with transdermal Fentanyl. J Pain Symptom Manage 1998;15:168-175
Doyle D	1980	Domiciliary terminal care. Practitioner 1980;224:575-582
Doyle et al	1996	Guidelines for Managing Cancer Pain in Adults. Working party on Clinical Guidelines in Palliative Care. The National Council for Hospice and Specialist Palliative Care services, London
Expert Working Group of the European Association for Palliative care (EAPC)	1996	Morphine in cancer pain: modes of administration. BMJ 1996;312:823-6
Foley K M	1998	Pain assessment and cancer pain syndromes. In: Doyle D, Hanks GW, MacDonald N (eds). The Oxford textbook of Palliative Medicine, 2 <sup>nd</sup> edition. Oxford: Oxford Medical Publications, 1998. pp.310-31
Hanks and Cherny	1998	Opioid analgesic therapy. P 334 in d Doyle, GWC Hanks and N MacDonald (eds). Oxford Textbook of Palliative Medicine. Oxford University Press
Hanks et al	2001	Morphine and alternative opioids in cancer pain: the EAPC recommendations. British Journal of Cancer 2001;84 :5: 587-93
Hockley et al	1988	Survey of distressing symptoms in dying patients and their families in hospital and their response to a symptom control team. BMJ 1988;296:1715-7
Ingham and Portenoy	1997	The measurement of pain and other symptoms. Oxford Textbook of Palliative Medicine; p.203
Millar et al	1998	Palliative care at home: an audit of cancer deaths in Grampian region. Br J Gen Pract 1998; 48: 1299-302
Mills et al	1994	Care of dying patients in hospital. BMJ 1994; 309: 583-6
Payne et al	1998	Quality of life and cancer pain: satisfaction and side effects with transdermal Fentanyl versus oral morphine. J Clin Oncol 1998; 16: 1588-93

Portenoy et al	1993	Transdermal Fentanyl for cancer pain. Repeated dose pharmacokinetics. <i>Anesthesiology</i> 1993; 78: 36-43
Regnard and Tempest	1998	A guide to Symptom Relief in Advanced Disease, 4 <sup>th</sup> edition. Using Opioids p.19. Hochland and Hochland Ltd
SIGN publication number 44	2000	Control of Pain in Patients with Cancer. A National Clinical Guideline. Scottish Intercollegiate Guidelines Network June 2000
Twycross R	1997	Symptom Management in Advanced Cancer. 2 <sup>nd</sup> edition Radcliffe Medical Press
Twycross and Lack	1990	Factors Influencing a Patient's perception of pain. Therapeutics in Terminal Cancer, 2 <sup>nd</sup> edition. London. Churchill Livingstone.
Twycross et al	1999	Palliative Care Formulary, PCF 1; 107. Radcliffe Medical Press
Twycross et al	2002	Palliative Care Formulary, PCF 2 Second edition, Radcliffe Medical Press
Wilkes E	1984	Dying now. <i>Lancet</i> 1984; 1: 950-2
World Health Organisation (WHO)		WHO's Pain Relief Ladder. <a href="http://www.who.int/cancer/palliative/painladder/en/">http://www.who.int/cancer/palliative/painladder/en/</a>
Working Party on Clinical Guidelines in Palliative Care	1998	Guidelines for managing cancer pain in adults. 2 <sup>nd</sup> edition. National Council for Hospice and Specialist Palliative Care Services
Wessex Palliative Physicians	2002	The Palliative Care Handbook. Advice on clinical management, 5 <sup>th</sup> edition, Dove House Hospice in association with the Wessex Specialist Palliative Care units

**SECTION F NON-DRUG THERAPIES FOR PAIN MANAGEMENT**

*(Principal and contributing authors = Dr Derek Haines, Dr Nassif Abd-Mariam, Mr John Fielding, Ms Ann English, Ms Jane Clappison)*

**F-1 Introduction****F-2 Complementary therapies for chronic and cancer pain**

F-2-1 Acupuncture

F-2-2 Therapeutic hypnosis

**F-3 Physiotherapy**

F-3-1 Physiotherapy and pain in palliative care

F-3-2 Physiotherapy and chronic pain

F-3-3 CSP standards for physiotherapists working in pain management programmes

**F-1 Introduction**

There is evidence for the use of a range of non-drug therapies in pain control. Some therapies have a stronger evidence base than others. Most evidence exists for the efficacy of Cognitive Behavioural Therapy (CBT). (See [Section E2](#) for more detail on CBT and other non-drug therapies for chronic pain management) For some people spiritual support, prayer or meditation may be an important aspect of their overall pain management, as may self-help and relaxation techniques.

**F-2 Complementary therapies for chronic and cancer pain.**

Complementary Therapy must be distinguished from 'Alternative Medicine' which, by definition, is offering a different system of 'medicine' to conventional medicine; complementary therapies can be used alongside conventional medicine; not in competition with it.

Complementary therapies include:

- Acupuncture
- Therapeutic hypnosis
- Aromatherapy\*
- Homoeopathy
- Reflexology\*
- Reiki\*
- Therapeutic Touch\*
- Therapeutic Massage\*

(Asterisks indicate the core therapies provided within The Humber and Yorkshire Coast Cancer Network.

Dove House hospice only provides complementary therapies to its current day-hospice or in-patients as part of a holistic care package after thorough assessment following a referral to the hospice.)

They have certain features in common such as:

- the individual has the undivided attention of the therapist for half an hour or more
- therapy is adjusted to the patient's response

- the therapist believes in the efficacy of the therapy
- explanations for biomedical and/or psychological phenomena are based on beliefs which either cannot be substantiated, or which do not correlate with current scientific knowledge; (not all conventional medicine can claim this, either!).

The possible benefits of complementary therapies:

1. An efficacy as good as placebo (a neurochemical / neurogenic response based on patient expectation)
2. The focus of attention is directed away from pain and suffering, worry and anxiety (a better way to pass the time) 'one day at a time'.
3. Patients report improvements in their quality of life.

However, there may also be possible harms:

#### *Physical*

- acupuncture needles: infection, tissue damage, mishaps such as pneumothorax or skin abrasion

#### *Chemical (aromatherapy)*

- allergies, infection

#### *Psychological*

- unrealistic expectations of what the therapy can achieve
- unhelpful mental framework of beliefs contrary to current understanding of mind and body functioning
- overdependence of the patient on the therapist

#### *General*

- straying from complementary therapy into alternative medicine can put the patient at risk of missing timely and appropriate conventional therapy.

For the evidence base see:

1. Complementary Therapies on the Bandolier website  
<http://www.jr2.ox.ac.uk/bandolier/booth/booths/altmed.html> for 'conventional' controlled trial evidence.
2. However, trial methodologies developed to test drug therapies may be the wrong tools to test complementary therapies.  
Paterson C, Dieppe P. Characteristic and incidental (placebo) effects in complex interventions such as acupuncture. *BMJ* (21 May 2005) 330; 1202-5.
3. Also Ernst E, Pittler M, Stevenson C, White A (Eds). The desktop guide to complementary and alternative medicine: an evidence based approach. London: Mosby (2001)
4. National Guidelines for the Use of Complementary Therapies in Supportive and Palliative Care. The Prince of Wales's Foundation for Integrated Health & The National Council for Hospice and Specialist Palliative Care Services (May 2003) – NB. This is not a systematic review.

In practice:

1. Not all patients will respond (compare the variability placebo responses in conventional medical trials).
2. To minimise harm and maximise benefit, therapists should be appropriately trained and should hold a current registration with a professional body.
3. Different approaches are used for complementary therapies in chronic pain, or in cancer pain as part of palliative care:
  - chronic pain: mainly interventional therapies such as acupuncture.
  - cancer pain as part of palliative care: for current standards see "The Humber and Yorkshire Coast Cancer Network Guidance for Complementary Therapies within Palliative Care".
4. There is a cost utility of complementary therapies:
  - the main cost is staff time
  - there are potential savings from reduced inappropriate drug therapy for distress and suffering
  - there are potential savings from reduced use of other health and social care services.

## F-2-1 Acupuncture

### *Introduction*

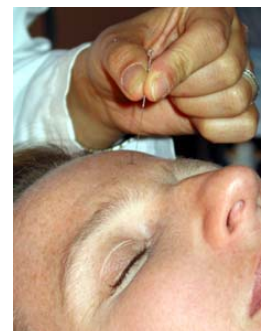
Acupuncture was first brought into Europe in the 17<sup>th</sup> century. This holistic Chinese medicine is based on a causal relationship, non-linear logic and non-reductionistic phenomenology. Controlled trials on chronic pain have proved that acupuncture helps from 55% - 85% of patients, while placebo controls benefit only 30% - 35% of cases. Moreover, hundreds of rigorous publications have revealed the reductionistic, causal mechanisms for many of the acupuncture effects. Acupuncture stimulates nerve fibres in the muscle, which sends impulses to the spinal cord and activates three centres (spinal cord, midbrain and hypothalamus–pituitary) to cause analgesia. The spinal site uses enkephalin and dynorphin to block in-coming messages. The midbrain uses enkephalin to inhibit spinal cord pain transmission. Finally in the third centre, the hypothalamus–pituitary, the pituitary releases  $\beta$ -endorphin into the blood and CSF to cause analgesia at a distance.



(Picture Source: <http://www.qichina.demon.co.uk/acupuncture.html>)

### *Patient's perspectives*

Around 2000 years B.C. the basic tenets of Chinese medicine were recorded in a classic work, the Huang Di Nei Jing, the yellow Emperor textbook of physical medicine. The Chinese doctors saw man as an integral part of nature and in a state of intensive interaction with his environment. They expressed that Tao (pronounced Dao) is the force that creates all things. The Tao brings out the polarity between Yin and Yang; all things in nature develop with this field of tension between Yin and Yang. Tao as the creative force gives rise to the flow of life force called "Qi" (pronounced Chi). If the Qi of an organ is weakened, the function of this organ will be incomplete or faulty,



but if Qi is present in excess, the result is excessive function. Life force (vital energy) flows through a system of conjectural channels called meridians that regulate the body function. It is possible to exert a direct beneficial effect on the channels and organs and, thus, in turn on body functions through needling acupuncture points that are widely distributed along meridian pathways.

### *Clinician's perspectives*

The important basis for a successful acupuncture treatment includes:

- Comprehensive diagnosis with the methods of western medicine
- Analysis of symptoms, clarifying them according to the system of traditional diagnosis. The differentiation with the most bearing on therapy is that into excess or deficiency conditions
- Examination and allocation of pain and of other symptoms to channels and organs
- Knowledge of the main channels
- Knowledge of World Health Organisation (WHO) list of indications for acupuncture (See <http://tcm.health-info.org/WHO-treatment-list.htm> or Acupuncture: A clinical Review by Sierpina.V and Frenkel. M, South Med J .2005,98(3):330-337)

### *Accessing Acupuncture*

All patients referred to the Centre for Pain Medicine at CHH (from primary or secondary care) have access to acupuncture within that service, (see [Section I-1-2.1](#)) and the Eastern Hull PCT community chronic pain clinic that is accessed by GP's and all primary care workers incorporates the current primary care acupuncture service see [Section E-2-5](#)). There is an acupuncture clinic available at Dove House Hospice, only treating day therapy patients at the present time.

### *Further resources and relevant articles*

1. The integration of acupuncture within medicine in the UK. Baldry, P., 2005. Acupuncture in Medicine, March 2005,vol.23(1),p1-12
2. Survey of adverse events following acupuncture. White, A., et al, 2001. Acupuncture in Medicine, December 2001,vol.19(2),p84-92
3. Safety aspects of acupuncture in palliative care, Filshie, J., 2001. Acupuncture in Medicine, December 2001,vol.19(2),p117-122
4. A meta-analysis of acupuncture for chronic pain. Patel, M., 1989. International Journal of Epidemiology,1989;18(4):900-6
5. The British Medical Acupuncture Society (BMAS) <http://www.medical-acupuncture.co.uk>
6. Acupuncture Association of Chartered Physiotherapy (AACP) <http://www.aacp.uk.com>
7. British Acupuncture Council Body (BACC) <http://www.acupuncture.org.uk>

## **F-2-2 Therapeutic Hypnosis**

### *Introduction*

Hypnosis has been described as a psychological state in which certain human capacities are heightened whilst others fade into the background. During hypnosis a person's critical faculty or logical mind is suspended or diminished, leading to an increase in the probability of the acceptance of therapeutic suggestions.

Hypnotic practices have been traced back at least as far as ancient Egypt, but the first therapeutic use has been attributed to Austrian physician Anton Mesmer in 1778 from whom the word 'mesmerism' came. In the 1880's mesmerism was used by British Surgeon James Esdaile as the sole anaesthetic whilst performing operations in India. James Braid (1796 - 1860) is credited with making hypnosis respectable to the medical community, whilst Milton Erickson M.D., is arguably the primary influence on modern day approaches to medical and therapeutic hypnosis.

Hypnosis was recognised by the British and American Medical Associations as a legitimate medical procedure in the 1950s.

### *Patient's Perspectives*

Hypnosis in clinical settings is usually associated with feelings of comfort and deep relaxation. The client may experience a "waking state of awareness.....detached from his or her immediate environment and absorbed by inner experiences such as feelings, cognition and imagery." (Heap 1996). It has been suggested that hypnosis is the art of using this dreamlike state to effectively communicate ideas that enhance motivation and change perceptions. Although there are numerous theories regarding hypnosis, as yet there is no universally accepted mechanism to explain all hypnotic phenomena.

### *Contraindications and Limitations*

These include:

- Patients with a history of psychosis or personality disorder
- Epilepsy
- Children under five years
- Care should be taken with the phrasing and content of questions used in hypnosis due to the phenomenon of suggestibility and illusory memories in the therapeutic setting (Yapko 1994).
- Individuals may vary in their response to hypnotic suggestions. For hypnosis to be effective, patients need to be receptive to the idea of hypnosis.

### *Evidence Base*

Whilst studies are fairly limited there is strong anecdotal and sufficient clinical trial evidence to indicate that hypnotherapy can produce a significant reduction in acute pain. For example, a meta-analysis of 18 studies of the analgesic effects of hypnosis found a moderate to large positive effect in pain management (Montgomery, Du Hamel and Redd, 2000).

Within cancer care, Levitan (1992) describes a number of unique advantages for patients including improvement in self-esteem, involvement in self-care, return of locus of control, lack of unpleasant side effects and continued efficacy. In addition, Marchiro et al (2000) highlights the potential value of hypnosis in the management of anticipatory nausea and vomiting.

However, there are generally few randomised controlled trials for hypnosis in chronic pain management. As referred to consistently throughout these Guidelines, chronic pain is a complex area of medicine involving

factors at the psychological and physiological levels whereby a single form of treatment is unlikely to be sufficient on its own. A recent review of the evidence suggests that hypnosis is consistently superior to no treatment but is probably most effective when combined with other treatments in a multi-disciplinary programme (Patterson and Jensen, 2003).

### *Accessing Therapeutic Hypnosis*

All patients referred to the Centre for Pain Medicine at Castle Hill Hospital have access to therapeutic hypnosis on referral from the pain management consultant.

### *References*

1. Heap M. (1996). The Psychologist. Nov; 498-501.
2. Yapko M. (1994). Suggestibility and illusory memories in the therapeutic setting. The edited transcript of the seminar presented by The European Therapy Studies Institute at the Royal Society of Medicine, London.
3. Montgomery G H, Du Hamel K N, Redd W H (2000). A meta-analysis of hypnotically induced analgesia: how effective is hypnosis? Int J Clin Exp Hypn; 48; 138-153.
4. Levitan A A (1992). The use of hypnosis with cancer patients. Psychiatric Medicine. 10(1); 119-131
5. Marchioro G, Azzarello G, Viviani F, Barbato F, Pavanetto M, Rosetti F, Pappagallo G L, Vivante O, (2000). Hypnosis in the treatment of anticipatory nausea and vomiting in patients receiving cancer chemotherapy. Department of Oncology, Local Health Unit No. 13, Noale, Italy
6. Patterson D R & Jensen M P (2003). Hypnosis and clinical pain. Psychol Bull; 129(4): 495-521.

## **F-3      Physiotherapy**

Physiotherapy is a science-based healthcare profession, which views human movement as central to the health and well-being of individuals. Physiotherapists identify and maximise movement potential through health promotion, preventive healthcare, treatment and rehabilitation. The core skills used by chartered physiotherapists include manual therapy, therapeutic exercise and the application of electrophysical modalities. Fundamental to the physiotherapist's approach, however, is an appreciation of the psychological, cultural and social factors which influence the patient's own active role in helping themselves maximise independence and function.

Physiotherapy is an autonomous profession and practice is characterised by reflective behaviour and systematic clinical reasoning, both contributing to and underpinning a problem-solving approach to patient-centred care.

Chartered physiotherapists work to combat a broad range of physical problems, in particular those associated with neuromuscular, musculoskeletal, cardiovascular and respiratory systems. They can work alone or, increasingly, with other healthcare professionals in multi-disciplinary teams.



**F-3-1      Physiotherapy and pain in palliative care**

Physiotherapy aims to optimise the patient's level of physical function and takes into consideration the interplay between the physical, psychological, social and vocational domains of function. The physiotherapist understands the patient's underlying pathological condition, but this is not the focus of treatment. The focus of physiotherapy is, instead, the physical and functional consequences of the disease and/or its treatment on the patient.

Physiotherapy in palliative care has to be considered amongst many other treatments and as a part of the total management of the patient. Treatment approaches can be summarised as follows:

1. Commence treatment as soon as possible after assessing the patient's physical function. Little and often is the principle. Ongoing assessment and modification of goals is essential.
2. Consideration of multi-pathology by identifying actual and potential limitations to function, including pain and other problems of a musculoskeletal, respiratory or circulatory nature.
3. Adjust treatment programmes to suit the capabilities of the patient, so as not to make any deterioration obvious to them as a result of their physiotherapy.
4. Take a holistic approach, identify achievable realistic goals, negotiated with patients and carers, and the multi-disciplinary team (MDT).
5. Be prepared to listen to the patient, carers, team members and other healthcare professionals regarding the patient's functional status and potential.

*Physiotherapy Treatments:*

Assess for TENS (Transcutaneous Electrical Nerve Stimulation) and other appropriate electrotherapy, and hot and cold packs for pain relief. TENS is the only electrical modality currently recommended for use in the presence of active neoplastic disease. Evidence suggests that TENS is a useful form of analgesia, particularly for chronic pain. However the use of other electrical modalities on normal tissue may be of benefit in the palliative stage.

Relaxation techniques, progressive, physiological and visualisation, are used at the hospice for pain relief and also breathlessness. Patients can access an outpatient dyspnoea clinic, where they learn various coping strategies including relaxation and anxiety management. Pain can cause great problems for the breathless patient, altering depth and rate of breathing. Pain is a subjective experience and it not only inhibits breathing, but also increases oxygen consumption.

Acupuncture is used for pain relief, stress and anxiety. (see [Section F-2-1](#))

Massage with or without essential oils can have a positive effect on anxiety. Complementary therapies are gaining recognition in many fields of health care, although evidence of their effectiveness is often lacking.

Lymphoedema and swelling can be treated with hosiery, massage and gentle exercise. There is good evidence to support the effectiveness of these treatments. A lymphoedema clinic is available at Scarborough Hospice, run by the Clinical Specialist in Physiotherapy. There is also a local service provided at the Princess Royal Hospital.

### *Reduction in the perception of pain*

Perception of pain varies with some factors that physiotherapists cannot modify, eg. previous experience. However physiotherapists can modify other factors, such as physical tension that can be eased by posture changes or relaxation. Anxiety can be reduced, by keeping patients informed. Locally a 'panic hand' is used as part of the anxiety management programme; this has been shown to be very effective particularly for the breathless patient.

During rehabilitation and activity, patients need reassurance in words and actions that they will be heard and responded to. "Tell me if it hurts and I'll stop." Patients should be assured that they are in control, and analgesia given before treatment. Manual handling for patients in pain incorporates the principles of offering advice and support, but allowing patients to move themselves as much as possible. A little and often is the key.

The role of the physiotherapist, as an essential member of the MDT, is key to the successful rehabilitation and management of patients with cancer and palliative care needs. Physiotherapists conduct ongoing assessment of the needs of the patient and carers, in order to apply skilled interventions, which are vital for a patient's independence, functional capacity and quality of life.

### *References*

- The Association of Chartered Physiotherapists in Oncology and Palliative Care: <http://www.acpopc.org.uk>
- The Chartered Society of Physiotherapy: <http://www.csp.org.uk>

### **F-3-2 Physiotherapy and chronic pain**

Physiotherapists working in pain management may work;

- On a one-to-one basis with clients who have specific needs,
- In a group setting

This will depend upon the type of pain management service being offered. However, ideally a therapist would be able to offer both 1: 1 and group sessions depending on the needs of the client. An important aspect of their role will be collaborative as they play an essential role as part of a pain management team.

### *Core skills of the physiotherapist*

The physiotherapist brings unique core skills to a Pain Management Programme (PMP) team that are part of physiotherapy pre-qualifying and post-qualifying education, these being the use of;

- Manual therapy
- Therapeutic exercise
- Electrophysical modalities

These will be integrated into the PMP utilising cognitive-behavioural principles.

As a PMP team member the physiotherapist will develop skills common to all disciplines:

- Cognitive-behavioural theoretical principles
- Knowledge of all aspects of the PMP, including other disciplines' roles, to facilitate integration of the team approach
- How to approach some common situations occurring with patients on PMPs using cognitive-behavioural principles
- Interdisciplinary team working
- Education/teaching skills including working with groups of patients

The physiotherapist also:

- Applies cognitive-behavioural principles to improving fitness

The physiotherapist has a programme development and staff training role within the PMP team:

- Developing the exercise component of the programme
- Developing the information/education part of the programme on neuromusculoskeletal issues eg. the healing process, acute versus chronic pain, pain mechanisms, joint health, effects of inactivity
- Teaching other disciplines about the physiotherapist's role and the role of fitness in PMPs.
- Teaching other disciplines about the management of common pathologies and treatments that may occur in PMPs.

Not all physiotherapists working in pain management will be involved in actual multi-disciplinary pain management programmes although they may run pain management groups. However, joint working via a PMP would be the ideal situation.

### *Aims of pain management programmes*

- Improve fitness, mobility and posture and counteract the effects of disuse
- Return to more normal and satisfying activities
- Counteract unhelpful beliefs and improve mood and confidence
- Avoid adverse drug effects and reduce unhelpful drugs
- Improve stress management and sleep
- Reduce effects of pain on family and improve social relationships
- Independence and maintenance of treatment gains

### **F-3-3 Chartered Society of Physiotherapy standards for physiotherapists working in pain management programmes (PMPs):-**

Standard 1 Communication between the physiotherapist and other members of the interdisciplinary pain management team ensures a consistent approach to the management of the patient. (via systems for verbal communication, records accessible to all members of the pain management team, meetings, and patient management/collaboration.)

Standard 2 Information about the PMP approach is communicated to non-clinical team members of the service who come into contact with patients in the treatment environment eg. reception staff, domestic staff.

Standard 3 A physiotherapist trained in PMPs shall carry out an assessment of the patient to establish baseline data as part of the interdisciplinary team selection process for the PMP, and an individual management plan and evaluation process, using standardised, sensitive, reliable and valid measures where possible.

Written assessment includes:

- subject and objective findings,
- measures of functional ability,
- exercise and activity levels,
- patients attitudes and beliefs towards physical activity,
- fulfilment of physical criteria for entry into the PMP,
- evidence that goals are agreed with the patient and incorporated into the overall management plan,
- measures of functional ability that can be reassessed on completion of the programme.

Standard 4 The PMP will include an element to optimise physical fitness, posture and movement and counteract the effects of disuse.

- The fitness programme is agreed with the patient
- Pacing takes place in the fitness programme
- Goal setting is applied to physical activities
- Goal setting includes the reduced use of aids and appliances
- Written and verbal information is provided to patients and relatives/significant others regarding the effects of disuse.

Standard 5 The PMP will contain an element to increase confidence with exercise and physical activities

- Written and verbal information is provided to the patient relating to pain and factors influencing pain
- There is evidence that the individual management plan includes managing identified fear of movement, exercise and physical activity.
- There is evidence of use of graded exposure to improve confidence with exercise and physical activities

Standard 6 The physiotherapist participates with other interdisciplinary team members to provide support and advice to the patient and relatives/significant others.

Standard 7 The physiotherapist ensures that the intervention equips the patient with the knowledge and skill to enable them to maintain and develop pain management strategies after completion of the PMP.

- An individual flare-up/set-back plan is agreed with the patient
- The patient is provided with written and verbal information advising on flare-up/set-backs plans
- It is documented that the patient is invited to attend at least one follow-up session after completion of the PMP
- The patients maintenance plans are included in the interdisciplinary discharge report forwarded to agreed healthcare professionals

Standard 8 There is clear and accurate documentation of assessment findings, all interventions and contact with each patient to facilitate optimum patient care.

Standard 9 Education and information on pain and its consequences and the PMP is provided to patients and relatives/significant others.

Standard 10 Physiotherapists promote the role of physical fitness and a healthy lifestyle within the management and prevention of pain. Information, education and advice is provided to patients, their relatives/significant others and other healthcare workers on

- The role of exercise
- Maintenance of maximal health by applying improved fitness
- Pain and healthy use of the body
- Positive attitudes to health

Standard 11 Education and information about the PMP is provided to healthcare workers in primary and secondary care settings to promote the approach used to manage pain.

Standard 12 Information about approaches to pain management and the delivery of services is provided to managers, purchasers, policymakers and the general public to promote the approach to the management of pain and prevention of chronicity.

PMP Standard 13 The physiotherapist participates in programmes to evaluate practice and improve quality.

PMP Standard 14 The environment facilitates safe operation of the PMP.

PMP Standard 15 Equipment is available to meet the needs of patients attending the PMP

*(Source: The Chartered Society of Physiotherapy, Standards for physiotherapists working in Pain Management Programmes in association with The Physiotherapy Pain Association – Jan 1998)*

## **SECTION G    SPECIFIC DRUG THERAPIES FOR PAIN MANAGEMENT** (Principal authors = Dr Mark Hancocks, Mrs Jackie Matthews)

### **G-1        Drug usage and types of pain**

G-1-1    Non-opioid analgesics

G-1-2    Opioid analgesics

### **G-2        Appropriate prescribing and current resource use**

G-2-1    Gabapentin

G-2-1.1    Pathway for the use of adjuvant analgesia in chronic neuropathic pain

G-2-2    Fentanyl

G-2-3    Paracetamol / codeine

### **G-1        Drug usage and types of pain**

Analgesics act at many different sites and therefore not all types of pain respond to all analgesics.

#### **G-1-1        Non-Opioid Analgesics**

- **Paracetamol**

is useful in providing background analgesia, although its mechanism of action is unclear. Bandolier reports that, in rheumatic pain, 30 – 40% of patients found paracetamol to be moderately or slightly effective. Given the relatively good safety profile of paracetamol, it is a good place to start when initiating therapy for all types of pain.

- **Non-Steroidal Anti-inflammatory Drugs (NSAIDs) including COX-2-Selective NSAIDs**

act by inhibiting prostaglandin synthesis and reduce the sensitivity of peripheral pain receptors to pain impulses at the site of inflammation or trauma. They exhibit both analgesic properties (full effect after one week of maximum dosage) and anti-inflammatory properties (full effect not exhibited for up to three weeks). NSAIDs are therefore useful in treating **somatic pain**.

The safety profile of NSAIDs is poorer than paracetamol. They cause gastrointestinal side effects, including gastric bleeding, and can precipitate acute renal failure. The cardiovascular side effects of NSAIDs have been assessed recently and the CSM (Committee on Safety of Medicines) advises that they are best avoided in patients with cardiovascular disease

NSAIDs are often used in combination with opioid analgesics in order to minimise the dose-related side-effects of both drugs

#### **G-1-2        Opioid Analgesics**

The term 'opioid' is applied to any substance that produces morphine-like effects and can be classified into:

- Pure agonists (morphine, diamorphine, oxycodone)
- Weak agonists (codeine, dihydrocodeine, tramadol)
- Partial agonist or mixed-agonist antagonists
- Pure antagonists

Synthetic derivatives unrelated to morphine, but with similar pharmacological effects include

- **Pethidine and Fentanyl** (phenylpiperidine series – pure agonist)

- **Methadone and dextropropoxyphene** (methadone series – weak agonists)
- **Pentazocine** (benzomorphan series – mixed-agonist antagonist) (not currently used in NHS)
- **Buprenorphine** (thebaine series - partial agonist)

#### Weak Opioids

- **Codeine** has 1/12<sup>th</sup> potency of oral morphine
- **Dihydrocodeine** has 1/10<sup>th</sup> potency of oral morphine, but no advantage over codeine, except anecdotally in dental and bone pain.
- **Tramadol** has 1/10<sup>th</sup> potency of oral morphine and is thought to have fewer opiate side effects, but is associated with hallucinations and seizures.

#### Strong Opioids

- **Morphine** is a pure opioid receptor agonist and is the standard against which all other opioid analgesics are measured. Subcutaneous or intravenous morphine has twice the potency of oral morphine
- **Diamorphine** is three times as potent as oral morphine, with a shorter duration of action
- **Oxycodone** is twice as potent as oral morphine, with fewer side effects. Its use is usually reserved for those patients unable to tolerate morphine. Oxycodone has kappa antagonist as well as mu agonist actions, which can make it more appropriate for visceral and neuropathic pains in some patients.
- **Pethidine** has a shorter duration of action than morphine and may antagonise the effect of gastric motility drugs such as metoclopramide and domperidone. Pethidine is no longer thought to be an appropriate drug for chronic pain.
- **Fentanyl** has similar effects to morphine but a shorter duration of action. However, due to its higher lipid solubility it can be used transdermally, intravenously or as a buccal preparation
- **Buprenorphine** produces partial stimulation at the mu receptors, which can give rise to a "ceiling analgesic effect", but it also has anti kappa actions which can give rise to anti-hyperalgesic effects. It is given by the sublingual or transdermal routes (transdermal use is currently under local restrictions). It has an intermediate effectiveness between codeine and morphine.
- **Hydromorphone** may be used for the occasional patient who cannot tolerate any other opioid but its use is currently under local restrictions.

### G-2 Appropriate prescribing and current resource use

The local health economy prescribes significantly above the national averages of both gabapentin and fentanyl. For gabapentin we prescribe £380,000 above the national average and for fentanyl the figure is £370,000 above average per annum. These drugs can be effective and useful and the key issue is to adopt a structured approach to their use.

#### G-2-1 Gabapentin

Gabapentin is an antiepileptic drug licensed for the treatment of neuropathic pain. Efficient use of gabapentin means an accurate assessment of the level of pain followed by a rapid progression to optimal therapeutic dose. A reassessment of pain relief should then follow and the therapy be discontinued if not

proving beneficial. These principles are captured in the prescribing pathway for gabapentin developed by the Hull & East Riding Prescribing Committee (HERPC) in conjunction with local pain control specialists (see next page).

### **G-2-1.1 Pathway for the use of adjuvant analgesia in chronic neuropathic pain**

The following offers guidance for primary care in the use of adjuvant analgesics and should be used in conjunction with the analgesic ladder. This information is intended to be used as a reference source for General Practitioners in order to become familiar with the commonly used adjuvant analgesics. It should be noted that none of the tricyclic antidepressants are licensed for the treatment of neuropathic pain.



For information on interactions, cautions and side effects the latest BNF and summary of product characteristics should be consulted (available at: <http://www.medicines.org.uk>).

#### *Key Principles:*

1. Patients should be assessed before and during treatment to help monitor efficacy of treatment.
2. Both drug and non-drug treatments should be considered.
3. Generally start at a low dose and increase gradually.
4. Always ensure the patient has had a fair trial of the medication before stopping failed therapy and starting a new therapy.

#### *References:*

1. McQuay HJ, Moore RA. Antidepressants and chronic pain. BMJ 1997; 314:763-4.
2. McQuay HJ, Moore RA. An evidence based resource for pain relief. Oxford University Press. 1998.
3. Bandolier website (<http://www.jr2.ox.ac.uk/bandolier> )



## Pathway for the use of adjuvant analgesia in chronic neuropathic pain

### Step 1 – Tricyclic Antidepressants /Anticonvulsants

- Tricyclic antidepressants have been shown to be effective in neuropathic pain. If pain levels are reduced but side effects are problematic, another agent within the same class may be tried.
- Advise patient to take at about 8pm; if morning drowsiness is problematic the dose may be taken earlier in the evening.
- Amitriptyline** 25mg nocte (in frail patients consider 10mg nocte); this may be gradually increased by 25mg or smaller intervals according to response, to about 75mg nocte. (Side effects: dry mouth affects ~1 in 3 patients, drowsiness is also common. It is estimated 1 in 30 patients have to stop taking the amitriptyline because of unmanageable side effects)
- Nortriptyline**: Usual starting dose is 10mg nocte, increasing to 75mg nocte as tolerated. Generally less sedating and fewer antimuscarinic side effects than amitriptyline.
- Dosulepin** 25mg nocte increasing to 75mg nocte as tolerated.
- Carbamazepine** may be used as an alternative at step one, starting at 100mg bd, the dose should be increased gradually as the incidence of side effects is high, refer to the BNF and data sheet.
- Please also be aware of the possible drug interactions with Carbamazepine, including contraceptives and anticoagulants.

**NB** - Assess concordance to medication  
- Some adjuvant analgesics may take up to 1 month for effects to be noticed

### Step 2 – Gabapentin (remember to stop ineffective treatment)

- Gabapentin**: Start at a low dose then gradually increase (300mg nocte, then bd then tds and after 1 week increase to 600mg tds). If no benefit after 2 weeks on gabapentin 600mg tds, increase to 900mg tds, then to 1200mg tds. If still no benefit tail off within 1 week. (In the U.K. the max licensed dose is 1.8g per day, although up to 3.6g per day may be used under specialist supervision)
- Side effects are usually minor and subside within 4 weeks; dose escalation is thought to aid tolerance to adverse effects.
- Patients on maintenance doses of gabapentin may benefit by reducing doses every 3 months to see if gabapentin is still needed. Readjust the maintenance dose as above.
- If gabapentin is discontinued, or the dose reduced or substituted with an alternative medication, this should be done gradually over a minimum of one week.

**NB** - Assess concordance to medication  
- Some adjuvant analgesics may take up to 1 month for effects to be noticed

**Refer patient to specialist pain assessment centre for further management strategies**

### Step 3 – Pregabalin (remember to stop ineffective treatment)

- Pregabalin** is an amber drug therefore should be initiated by secondary care and after two months care passed to the GP.
- Starting dose is 150mg daily in 2 divided doses, based on patient response and tolerability, the dose may be increased to 300mg per day after 3-7 days. After an additional 7 days the dose may be increased to a maximum daily dose of 600mg per day
- A trial of 2 to 4 weeks at the maximum dose attainable should be sufficient to demonstrate any benefits.
- If Pregabalin is discontinued, or the dose reduced or substituted with an alternative medication, this should be done gradually over a minimum of one week.

Review = March 2008

See SPC for product specific prescribing information (available at <http://www.medicines.org.uk>)

### **G-2-2 Fentanyl**

Careful thought should be given to initiation of Fentanyl and its use limited to those patients who cannot take oral preparations. Particular care should be taken when considering the use of Fentanyl in opiate naïve patients. For detailed information on the use of transdermal fentanyl please refer to section [E-3-3.11 to E-3-3.15](#) of these Guidelines (indications & contraindications; starting transdermal fentanyl; calculating the appropriate breakthrough dose; application of transdermal Fentanyl patches; dealing with uncontrolled pain).

### **G-2-3 Paracetamol / codeine**

The preferred formulation is to use separate prescriptions for paracetamol with codeine phosphate prescribed as required. However, after discussion with hospital and primary care trust colleagues there was a clear wish to retain the option to use combined preparations such as cocodamol. The underlying principle is to use the **lowest dose of codeine necessary** to control pain.

**SECTION H PAIN MANAGEMENT IN SPECIAL GROUPS***(Principal authors = Mrs Jenny Walker, Dr David Armstrong)***H-1 Elderly people with cognitive impairments**

H-1-1 Introduction

H-1-2 The challenge

H-1-3 Choice of pain assessment tools

H-1-4 Mild to moderate cognitive impairment

H-1-5 Severe cognitive impairment

H-1-6 Non-verbal signs of pain

H-1-7 Pain management

H-1-8 Summary

H-1-9 References

Appendix 1 The Abbey Pain Scale

**H-2 Adults with learning disabilities**

H-2-1 Pain assessment &amp; management

H-2-2 Behavioural indicators used to determine pain in non-verbal, cognitively impaired individuals

H-2-3 Use of pain assessment tools

H-2-4 References

**H-3 Opiate dependent adults**

H-3-1 Pre and post operative pain relief

H-3-2 Patients prescribed high dose Buprenorphine (Subutex)

**H-1 Elderly people with cognitive impairments****H-1-1 Introduction**

Pain is common in older people because of the prevalence of painful acute, chronic or progressive conditions associated with ageing, (eg. osteoarthritis, low back pain, neuropathy, malignancy, post-herpetic neuralgia) irrespective of cognitive status. In older people pain is often under-reported, under-recognised and under-treated, more so in the cognitively impaired. Difficulties arise for a number of reasons, including the specific challenges relating to drug therapy in older people:

- Anxiety about a perceived risk of chemical dependency
- Undesired side-effects of drugs
- Increased sensitivity to side-effects
- Decreased liver metabolism leading to slower drug excretion

Other difficulties may arise from a lack of confidence in non-drug pain management approaches (by staff and patients) or a lack of continuity of care on hospital discharge.

**H-1-2 The challenge**

It is well established that effective pain management depends on accurate knowledge and beliefs about pain and above all, accurate pain assessment. It is most important therefore to accurately assess the pain, specific to the individual, consider any impinging pathology and actively involve the patients and carers where possible.

Accurate pain assessment can be difficult in people who have cognitive or communication difficulties. It is estimated that 15% of older adults have some form of cognitive impairment, and the prevalence increases with age.

Cognitive impairment is characterised by a deterioration in one or more of the following:

- memory,
- attention,
- visual spatial skills,
- language,
- behaviour.

Cognitive impairment may mask pain and may be exacerbated by the presence of pain. In older people with Alzheimer's disease, pain thresholds may be no different to elderly people without dementia, but pain tolerance may be significantly increased due to damage to the pain message processing centres of the brain. Alzheimer's patients may not understand the meaning of the pain sensation and have difficulty placing it in context. Unmanaged pain is associated with the presence of depression and challenging behaviours including aggression and disruptive vocalisations.

Confused older adults are less likely to have their pain assessed and managed. The risk of under-treatment increases with severity of the dementia. This is despite research showing that cognitively impaired older people can provide valid self-reports of pain when asked (there is also no evidence they exaggerate or fabricate reports of pain); but unprompted self-reports of pain are uncommon. Direct questioning (using a variety of words to describe pain) and regular, documented assessment is therefore essential in this patient group.

The choice of pain assessment tool must be tailored to the individual person and their abilities.

**H-1-3 Choice of pain assessment tools**

It is a common misconception that pain cannot be assessed in older adults with a cognitive impairment. Studies have shown that over 80% of older people with a cognitive impairment are capable of completing at least one of the available pain assessment tools, and those who cannot, could at least identify the presence of pain in answer to direct questioning. Most can point to painful areas of their own body, more so than using dolls or pictures. The recognition of the person's remaining capacity to self-report and locate pain is important.

Carers and nurses should be proactive in detecting and assessing pain in this group. Current pain experience may be better explored rather than changes in pain, due to memory difficulties. Time should be given for the person to answer questions and the environment should be optimised. The room should be well lit, calm with no distractions, and glasses, hearing aids and dentures should be in place. The person should be helped into an upright position to use assessment tools and visual aids. Large print versions can be used if needed. A number of assessments may be made and documented initially – for example, pre-existing pain conditions, physiological measures of pain (blood pressure, pulse, respiration and temperature), any self-reports of pain, facial expressions and behaviours – and then the most appropriate simple assessment tool may be repeated at intervals before and after any pain management interventions.

Below is a checklist to help identify the most appropriate type of pain assessment tool in elderly people with cognitive impairments.

Patient checklist	Remedy
Comprehension?	Use an observational tool
Verbal?	Adopt a visual presentation and pointing response
Sight?	Ensure glasses, good light, large font, high contrast or verbal response
Hearing?	Use a visual tool
Manual dexterity?	Adopt a verbal response
Memory?	Assess frequently; explain tool clearly each time
Stoicism?	Assess frequently; give reassurance

*(Source: Kane et al (2004) Pain assessment in older people: problems and solutions)*

#### **H-1-4 Mild to moderate cognitive impairment**

The tools with the highest completion rate in older people with a mild to moderate cognitive impairment are the **Present Pain Index** from the **McGill Pain Questionnaire**:

0-No pain / 1-Mild / 2-Discomforting / 3-Distressing / 4-Horrible / 5-Excruciating

and the **Verbal Rating Scale** (Feldt 1998):

Slight Pain / Mild pain / Moderate pain / Severe pain / Extreme pain / Pain as bad as it could be.

The 'Faces' pain scale has also been used successfully with this patient group but its validity and reliability has not been established, and some older people find it condescending.

Numerical scales or the visual analogue scale can also be used, but low completion rates may be seen in people with visual impairments or who are unable to perceive pain as numbers. Time must be spent with the person to ascertain the best tool to use with them and then healthcare staff should be trained to use the tool consistently with that person. However, the limitations of any pain assessment tool should always be considered when using it.

**H-1-5 Severe cognitive impairment**

Pain management remains very challenging in severely cognitively impaired older people who are also unable to communicate verbally about the pain. Assessment focuses on the presence or absence of pain rather than the pain characteristics. Monitoring and documenting the presence of non-verbal signs of pain becomes an important aspect of care in this patient group and astute observational skills are required. (Some clinicians advocate the use of observational scales in assessing pain in all older people, irrespective of cognitive status). It must be emphasised that facial expressions may be difficult to interpret if the person has Parkinson's disease or has suffered a stroke. In such cases it is especially important to work with carers and family members in the assessment process, as they may provide information on the particular expressions and pain associated behaviours that the individual is likely to demonstrate.

**H-1-6 Non-verbal signs of pain**

Pain may be signalled in a number of non-verbal ways. It is important that observations are made over time, by someone who knows the individual well, to recognise when changes in usual behaviour may signal the presence of pain.

Four types of body movement have been identified to accompany pain:

- Immobilisation, rigid body position
- Purposeless movements (especially with acute pain)
- Protective guarding and rubbing
- Rhythmic movements

in addition to behaviours such as:

- Vocalisations ('ouch', whimpering, crying out on movement, swearing, gasping)
- Flinching
- Fidgeting and restlessness
- Aggressive behaviour
- Pulling at tubes, perhaps away from the painful body part
- Withdrawal
- Increased confusion
- Sleep disruption
- Change in appetite

Facial expressions may be the first or only sign of pain; common expressions are:

- Clenched teeth
- Grimacing
- Wrinkled forehead
- Biting lower lip
- Wide open or tightly shut eyes
- Clenched jaw

The study by Paolo (2003) concluded that clinical observations of facial expressions and vocalisations are an accurate means for assessing the presence of pain, but NOT its intensity, in patients unable to communicate verbally because of advanced dementia.

In the last 10-15 years, specific pain assessment tools have been developed for use in non-communicative older people, but none have yet been firmly established in routine use because behavioural interpretation remains subjective, eg;

- DS-DAT (Discomfort Scale for Dementia of the Alzheimer Type, Hurley et al 1992) – however this is complex and time-consuming
- Behavioural Pain Tool (Simons & Malabar 1995) – may not indicate pain intensity due to different coping behaviours but designed to distinguish pain from depression
- DOLOPLUS 2 (Wary et al 1993, see <http://www.doloplus.com/versiongb/index.htm>)
- Checklist of on Non-verbal Pain Indicators (CNPI, Feldt 2000) - Designed to differentiate between indicators varying levels of pain in cognitively impaired older adults
- ADD (Assessment of Discomfort in Dementia, Kovach et al 1999)
- PAINAD (Pain assessment in Advanced Dementia, Warden et al 2003)
- Abbey pain scale (Abbey et al 2004) - see Appendix 1 (a quick and simple tool developed in Australia)

No one tool (non-verbal measures or otherwise) is appropriate for assessing pain in all cognitively impaired older adults. Individual circumstances, history and abilities must be considered. With all older people, whatever tool is used, the key to accurate assessment is a combination of time, patience and ingenuity. Assessment should involve a combination of physiological and behavioural indicators, followed up after implementation of pharmacological or non-drug interventions.

#### **H-1-7 Pain management**

Analgesic and adjuvant drug therapy have been well described in these Guidelines. Appropriate medication for existing medical conditions obviously improves pain management. In addition, the recognition that descending pathways from the brain can modulate the pain experience, has demonstrated the importance of alternative means of pain relief. The use of relaxation, TENS, physical activities, physiotherapy and massage could all be considered for use in elderly people with or without a cognitive impairment.

#### **H-1-8 Summary**

The recommended strategies to assess pain in cognitively impaired older people include:

- Asking the patient - many patients who appear cognitively impaired may still be able to provide useful information concerning pain;
- Interviewing carers and family - patterns of particular behaviours may have developed that indicate pain;
- Reviewing the medical record for known pain-causing conditions;

- As appropriate, performing a physical examination and directed laboratory tests to assess for common pain-inducing problems.

In addition to these measures, clinicians should use a validated observational pain rating system for the cognitively impaired, examples of which have been described. The most appropriate assessment tool for the individual should be chosen and used consistently with that individual.

#### H-1-9 References

Author	Title	Ref
Scherder et al (2005)	Recent developments in pain in dementia.	BMJ v330; p361- 64 (26 Feb).
Bird J (2003)	Selection of Pain Measurement Tools.	Nursing Standard. v18, n13, p33- 39.
Murdoch & Larsen (2004)	Assessing pain in cognitively impaired older adults.	Nursing Standard v18, n38, p33-39.
Briggs (2001)	Principles of pain assessment in older people – part 2.	Nursing Older People v13, n9, p27-28.
Davies et al (2004)	Pain assessment & cognitive impairment: part 1.	Nursing Standard v19, n12, p39-42.
Davies et al (2004)	Pain assessment & cognitive impairment: part 2.	Nursing Standard v19, n13, p33-39.
Paolo et al (2003)	Pain assessment in elderly patients with severe dementia.	Journal Pain & Symptom Management v25, n1, p48-52.
Kane et al (2004)	Pain assessment in older people: problems and solutions.	Nursing & Residential Care v 6, n4, p177-180.
Kane et al (2004)	Pain management in older adults in care.	Nursing & Residential Care v 6, n5, p223-227



## Appendix 1 – The Abbey Pain Scale

Abbey Pain Scale							
For measurement of pain in people with dementia who cannot verbalise.							
How to use scale: While observing the resident, score questions 1 to 6							
Name of resident: .....							
Name and designation of person completing the scale: .....							
Date: ..... Time: .....							
Latest pain relief given was.....at .....hrs.							
Q1.	<b>Vocalisation</b> eg. whimpering, groaning, crying <i>Absent 0    Mild 1    Moderate 2    Severe 3</i>	Q1	<input style="width: 40px; height: 30px;" type="text"/>				
Q2.	<b>Facial expression</b> eg: looking tense, frowning grimacing, looking frightened <i>Absent 0    Mild 1    Moderate 2    Severe 3</i>	Q2	<input style="width: 40px; height: 30px;" type="text"/>				
Q3.	<b>Change in body language</b> eg: fidgeting, rocking, guarding part of body, withdrawn <i>Absent 0    Mild 1    Moderate 2    Severe 3</i>	Q3	<input style="width: 40px; height: 30px;" type="text"/>				
Q4.	<b>Behavioural Change</b> eg: increased confusion, refusing to eat, alteration in usual patterns <i>Absent 0    Mild 1    Moderate 2    Severe 3</i>	Q4	<input style="width: 40px; height: 30px;" type="text"/>				
Q5.	<b>Physiological change</b> eg: temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor <i>Absent 0    Mild 1    Moderate 2    Severe 3</i>	Q5	<input style="width: 40px; height: 30px;" type="text"/>				
Q6.	<b>Physical changes</b> eg: skin tears, pressure areas, arthritis, contractures, previous injuries. <i>Absent 0    Mild 1    Moderate 2    Severe 3</i>	Q6	<input style="width: 40px; height: 30px;" type="text"/>				
Add scores for 1 – 6 and record here			Total Pain Score <input style="width: 40px; height: 30px;" type="text"/>				
Now tick the box that matches the Total Pain Score							
<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="padding: 5px; text-align: center;">0 – 2 No pain</td> <td style="padding: 5px; text-align: center;">3 – 7 Mild</td> <td style="padding: 5px; text-align: center;">8 – 13 Moderate</td> <td style="padding: 5px; text-align: center;">14+ Severe</td> </tr> </table>				0 – 2 No pain	3 – 7 Mild	8 – 13 Moderate	14+ Severe
0 – 2 No pain	3 – 7 Mild	8 – 13 Moderate	14+ Severe				
Finally, tick the box which matches the type of pain							
<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="padding: 5px; text-align: center;">Chronic</td> <td style="padding: 5px; text-align: center;">Acute</td> <td style="padding: 5px; text-align: center;">Acute on Chronic</td> </tr> </table>				Chronic	Acute	Acute on Chronic	
Chronic	Acute	Acute on Chronic					
Dementia Care Australia Pty Ltd Website: <a href="http://www.dementiacareaustralia.com">www.dementiacareaustralia.com</a>							
Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L; Parker, D and Lowcay, B. Funded by the JH & JD Gunn Medical Research Foundation 1998 – 2002 (This document may be reproduced with this acknowledgment retained)							

## **H-2 Adults with learning disabilities**

### **H-2-1 Pain assessment & management**

The 'Valuing People' definition of learning disability says it includes the presence of:

- A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;
- A reduced ability to cope independently (impaired social functioning);
- that started before adulthood, with a lasting effect on development.

This definition encompasses people with a broad range of disabilities. The presence of a low intelligence quotient, for example an IQ below 70, is not, of itself, a sufficient reason for deciding whether an individual should be provided with additional health and social care support. An assessment of social functioning and communication skills should also be taken into account when determining need.

Assessment of pain in people with profound learning and multiple disabilities is fraught with difficulties and many of the considerations set out above on severely cognitively impaired older people, also apply to this client group. As in older people, pain assessment is made harder because visual and hearing impairments are common.

Severe communication problems often mean individuals are unable to articulate the degree, type and nature of their painful experiences. There are few publications on this topic to inform practice, despite this patient group frequently experiencing severe health problems, many of which cause pain, or requiring surgical procedures that cause pain, much more so than the general population.

It must be emphasised that distress can be caused by many different factors including physical pain, psychological problems, social or spiritual issues. Distress is what the person says it is, but in non-communicative people, this obviously raises problems, especially when moving between care environments or to new carers.

People with profound learning difficulties are typically non-verbal and carers have to rely on knowledge of the person, careful observation and clinical judgements to assess if the person is in pain. Intuition is central to the process. It must be emphasised though that behaviours typically indicating pain in the general population may be inconsistent and difficult to interpret in the profoundly learning disabled. A lack of awareness of how the person usually communicates may lead to a misinterpretation of facial expressions, head and body movements and verbalisations. Distress signs or behaviours may be easily ignored or misinterpreted as a challenging behaviour. (40% of all people with a severe learning disability have challenging behaviours). Thus, getting to know the person very well is essential to the intuitive recognition and contextual interpretation of non-verbal, communicative behaviours and subtle changes in such behaviour. (examples of non-verbal behaviours are shown on the next page)

## H-2-2 Behavioural indicators caregivers use to determine pain in non-verbal, cognitively impaired individuals

Categories	Behavioural indicators
<b>Vocal</b>	Moaning, whining, whimpering (fairly soft), crying (moderately loud), screaming/yelling (very loud), a specific sound or vocalization for pain, a word, cry, type of laugh
<b>Eating /sleeping</b>	Eats less, not interested in food, increase in sleep, decrease in sleep
<b>Social /personality</b>	Not cooperating, cranky, irritable, unhappy, less interaction, withdrawn, seeks comfort or physical closeness, difficult to distract, not able to satisfy or pacify
<b>Facial expression of pain</b>	Crying, grimace, furrowed brow, change in eyes, including eyes closed tight, eyes opened wide, eyes as if frowning, turn down of mouth, not smiling, lips pucker up, tight pout or quiver, clenches teeth, grinds teeth, chews, thrusts tongue
<b>Activity</b>	Not moving, less active, quiet, jumping around, agitated, fidgety
<b>Body and limbs</b>	Floppy, stiff, spastic, tense, rigid, gestures to or touches part of body that hurts, protects, favours, or guards part of body that hurts, flinches or moves body part away, sensitive to touch, moves body in a specific way to show pain (eg. head back, arms down, curls up)
<b>Physiological</b>	Shivering, changes in colour, pallor, sweating, perspiring, tears, sharp intake of breath, gasping, breath-holding

(Source: McGrath et al (1998) *Dev Med Child Neurol* 40: 340-3)

## H-2-3 Use of Pain Assessment Tools

Although some people suggest that the use of pain scoring tools with this client group is questionable, other healthcare professionals have recommended either the Dis-DAT (Distress Assessment Tool) developed by Dr Claud Regnard and colleagues (from Northgate & Prudhoe NHS Trust Palliative Care Team) originally to support people with learning disabilities who were terminally ill, but suitable for wider use, or the new Paediatric Pain Profile (PPP) which operates in a similar way to the Dis-DAT, and although designed for use with children, can be used for people with a learning disability. (see <http://www.pppprofile.org.uk>) The basis of these tools is that a group of relatives/carers who know the individual very well meet to pool and record information about how that particular person demonstrates contentment or distress. This enables carers to monitor distress over time, suggest likely causes of the distress, and take action to make things better.

## H-2-4 References

Davies & Evans (2001)	Assessing pain in people with profound learning difficulties. <i>British Journal of Nursing</i> v10, n8, p513 - 516.
Regnard et al (2003)	Difficulties in identifying distress and its causes in people with severe communication problems. <i>International Journal of Palliative Nursing</i> , 2003, vol 9, No 4, pp173176.

**H-3 Opiate dependent adults**

Not every person who uses heroin or other opiates regularly is necessarily addicted. However, when dependence on opiates is diagnosed the nature and severity of the dependence may indicate different modes of treatment from detoxification to symptomatic treatment to maintenance / substitute prescribing of opiates eg. methadone.

Patients maintained on methadone because of their opiate addiction may require additional analgesia for pain depending on their medical condition or procedure. If indicated, opiate analgesia can be given and the patient carefully observed for signs of over-sedation. However, the following drugs should be avoided, due to their mixed agonist / antagonist affects.

- Pentazocine (not currently used in NHS)
- Buprenorphine (Subutex)
- Butorphanol (used in the USA)
- Nalbuphine (not currently used in NHS)

**H-3-1 Pre and Post Operative Pain Relief**

For pre- and post-operative pain relief methadone may be given as per the patient's usual maintenance requirements up to 3 hours before surgery. Post-operatively methadone should be continued at the same dose (IM – intramuscular - in split doses if necessary). For post-operative pain relief the emphasis for this group of patients should be the optimisation of non-opiate analgesia. However, for moderate to severe post-operative pain other opiates can be prescribed for analgesia as if the patient was opiate naïve and the dose titrated according to the need for pain relief.

**H-3-2 Patients Prescribed High Dose Buprenorphine (Subutex)**

Patients maintained on high dose Buprenorphine have a reduced response to opiate analgesia and may require larger doses of opiate analgesics than patients not on Buprenorphine treatment. If opiates are required for pain relief a temporary increase in Buprenorphine dose may provide sufficient analgesia. If opiates such as morphine are clinically indicated then the dose will need to be closely monitored especially if Buprenorphine is stopped, as there is a risk of overdose.

Pain relief should be carried out as directed in these Guidelines. The Centre for Pain Medicine can be contacted for advice if necessary on **01482 624093**.

## **SECTION I     CONTACTS & FURTHER RESOURCES**

*(Principal author = Mrs Jenny Walker)*

### **I-1            CONTACTS & RESOURCES FOR STAFF**

- I-1-1     Hospital & hospice services
- I-1-2     Specialist pain management services
  - I-1-2.1   Centre for Pain Medicine, Castle Hill Hospital
  - I-1-2.2   Primary Care Chronic Pain Management Service
- I-1-3     Hospital Macmillan palliative care nurses
- I-1-4     Community Macmillan nurses in Hull
- I-1-5     Community Macmillan nurses in the East Riding of Yorkshire
- I-1-6     Oncology Health Centres
- I-1-7     Community Pharmacies holding palliative care drug stocks
- I-1-8     Out Of Hours (OOH) palliative care contacts
- I-1-9     Hull and East Riding district nursing contacts
  - I-1-9.1   Hull district nursing contacts
  - I-1-9.2   East Riding district nursing contacts
- I-1-10   Pain & palliative care education
- I-1-11   Translated resources

### **I-2            CONTACTS & RESOURCES FOR PATIENTS**

- I-2-1     Spiritual and religious support
- I-2-2     Oncology Health Centre
- I-2-3     The Expert Patients Programme
- I-2-4     Dove House Hospice – psychosocial help
- I-2-5     Support groups

### **I-3            CONTACTS & RESOURCES FOR CARERS**

- I-3-1     Local resources
- I-3-2     National resources

### **I-4            INFORMATION RESOURCES**

- I-4-1     Books
- I-4-2     Booklets & online resources

**I-1 CONTACTS & RESOURCES FOR STAFF****I-1-1 Hospital & Hospice Services (for Hull and East Riding PCTs)****Hospitals:**

<b>Address</b>	<b>Services available</b>
Macmillan Wolds GP Unit Bridlington DGH Bessingby Road Bridlington YO16 5QP Tel: 01262 423456	Consultant in Palliative Medicine Outpatients Macmillan Palliative Day Care Complementary Therapies Access to Macmillan Clinical Nurse Specialist Team Palliative Care Beds x 2
Alfred Bean Hospital Bridlington Road Driffield YO25 5JR Tel: 01377 241124	Access to Macmillan Clinical Nurse Specialist Team Macmillan Palliative Day Care Advice from Consultants in Palliative Medicine Palliative Care Beds x 3
Withernsea Community Hospital Queen Street Withernsea HU19 2QB Tel: 01964 614666	Access to Macmillan Clinical Nurse Specialist Cover
Hornsea Cottage Hospital Eastgate Hornsea HU18 1LP Tel: 01964 533146	Access to Macmillan Clinical Nurse Specialist Cover
Beverley Westwood Hospital Woodlands, Beverley HU17 8BU Tel: 01482 886600	Palliative Care Bed x 1 Access to Macmillan Clinical Nurse Specialist Cover
Hull Royal Infirmary Anlaby Road Hull HU3 2JZ Tel: 01482 328541	Macmillan Clinical Nurse Specialist Team
Princess Royal Hospital Saltshouse Road Hull HU8 9HE Tel: 01482 701151	Macmillan Clinical Nurse Specialist Team Oncology Health Centre
Castle Hill Hospital Castle Road Cottingham HU16 5JQ Tel: 01482 875875	Macmillan Clinical Nurse Specialist Team The Centre for Pain Medicine

**Hospices:**

Dove House Hospice Chamberlain Road Hull HU8 8DH Tel: 01482 784343 Fax: 01482 701433 <a href="http://www.dovehouse.org.uk">http://www.dovehouse.org.uk</a>	Bereavement Support Service Palliative Day Care Inpatients Complementary Therapies
St Catherines Hospice Throxenby Lane Scarborough North Yorkshire YO12 5RE Tel: 01723 351421 Fax: 01723 501714 <a href="http://www.stcatherineshospice-nyorks.org">http://www.stcatherineshospice-nyorks.org</a>	Community Macmillan Nurse Specialist Team Palliative service Neurology services Complementary Therapies Lymphoedema Services Bereavement Support Service Inpatient Unit Medical Consultant Outpatients
York St Leonards Hospice 185 Tadcaster Road York YO24 1GL Tel. 01904 708553 Fax. 01904 704337 <a href="http://www.stleonardshospice.org.uk">http://www.stleonardshospice.org.uk</a>	Day hospice Inpatient palliative care (20 beds) Bereavement service Lymphoedema clinic Physiotherapy and occupational therapy Chaplaincy and social work services Research & education

**I-1-2 Specialist Pain Management Services****I-1-2.1 The Centre for Pain Medicine, Castle Hill Hospital**

Centre for Pain Medicine

Castle Hill Hospital

Castle Road, Cottingham

HU16 5JQ

Tel: 01482 624093

Fax: 01482 622376

The ethos of the Centre is to champion the understanding of chronic pain and its consequences amongst patients, their friends and relatives and healthcare professionals, and to offer advice and certain therapies based on the understanding of chronic pain processes.

*Referrals*

Written referrals are accepted from GPs, hospital consultants and healthcare professionals. The patient's GP should know that such a referral has been made.

*The patient experience*

- 1) The first appointment with a pain management consultant is organised through the HEYHT Call Centre, or occasionally via the secretaries. A patient needs to confirm that the appointment is suitable for them, or agree an alternative appointment.  
A pre-consultation questionnaire is sent to the patient together with a stamped addressed envelope.
- 2) The first consultation involves an assessment of the chronic pains within the context of the patient's medical and psychosocial history.  
An evaluation of the factors and processes involved in the generation and maintenance of the chronic pain is made and shared with the patient and accompanying others.
- 3) A management plan is devised, tailored to the *needs* of the patient, and to the *preferences* of the patient when reasonable and appropriate.
- 4) Onward referrals may be made as appropriate, eg.
  - To hospital specialists for an opinion, investigation etc.
  - To specialist therapy services
  - To the Expert Patients Programme
- 5) Certain therapies and interventions are available at the Centre, such as
  - education about pain and related issues
  - relaxation training and self hypnosis
  - physiotherapy based on the cognitive behavioural approach
  - transcutaneous electrical nerve stimulation (TENS)
  - acupuncture
  - advice about appropriate drug therapies, both immediate and long term
  - trigger point injections
  - nerve blockade
  - radiofrequency lesioning
  - drug infusions and delivery systems
- 6) Continuing support is available
  - by telephone
  - outpatient appointment
  - by liaison with the patient's primary care team
  - referral to Primary Care Pain Management Team (currently Eastern Hull only)

*NB. Telephone advice*

concerning chronic pain is available for healthcare professionals:

- Mondays to Fridays 9am to 5pm (01482 624093)
- other times via HEYHT switchboard to one of the pain consultants (01482 328541)



### *Continuing Education*

for healthcare professionals is available via:

- monthly team meetings (2nd Friday afternoons)
- library with a growing collection of books and articles on pain
- access to *Pain* journal from Volume 1

Healthcare professionals from all local Trusts are encouraged to attend clinics, but please telephone first.

### *Centre for Pain Medicine Staff (not all full time)*

- secretaries (3)
- consultants in pain management (3)
- chronic pain specialist nurses (2)
- senior registered nurse (1)
- auxiliary nurses (3)
- health psychologist (1)
- physiotherapist (1)

### **I-1-2.2 Primary Care Chronic Pain Management Service**

The local community chronic pain management service operates from:

Marfleet Primary Healthcare Centre, Preston Rd, Hull

(Monday-Friday, Tel: 01482 344294)

led by a GP with input from a specialist nurse and 2 pharmacists, with future plans to employ a psychologist, physiotherapist and occupational therapist.

Currently the majority of referrals are from Eastern Hull, although it is anticipated that after the formation of the single Hull PCT the community chronic pain management service will expand.

The primary care chronic pain management service offers a detailed assessment followed by a recommendation to attend individual sessions with a clinical psychologist, a medication use review (MUR) with a pharmacist, and/or attendance at a pain management group programme (incorporating relaxation, overcoming sleep problems, reducing medication, pacing and goal setting, challenging negative thoughts, using attention and distraction etc).

### **I-1-3 Hospital Macmillan Specialist Palliative Care Nurses**

The Hospital Macmillan Specialist Palliative Care Nurses will

- See patients at any stage of their illness whilst an in-patient;
- Provide expert knowledge in the management of patients with specialist palliative care needs
- Provide specialist nursing advice
- Pain and symptom control advice for patients and staff.
- Provide support for patients, family and staff

- Give patients and carers the opportunity to talk through information they have been given.
- Give further information and help patients/ carers find the information they need.

The team also provides a rapid response palliative care clinic for outpatients each Friday morning at The Oncology Outpatients Dept at Princess Royal Hospital. Patients can be booked onto this clinic by telephoning 01482 676625.

The Hull and East Yorkshire Hospitals Palliative Care Team is based at:  
The Sutton Centre, The Princess Royal Hospital  
Saltshouse Road  
Hull HU8 9HE.

The team has 5 members who can be contacted on 01482 676739.

All referrals should be faxed on 01482 676588.

Team members can also be contacted on their mobiles via the PRH switchboard on 01482 701151.

#### **I-1-4 Community Macmillan Nurses in Hull**

Hull Community Macmillan Team  
Rank Ward, Princess Royal Hospital  
Hull HU8 9HE

Telephone / fax / answer machine: 01482 336523

N.B. All new referrals for any patient from any GP surgery in Hull should be posted or faxed to the above address and fax number.

Availability: MONDAY - FRIDAY 09.00 - 17.00 hrs (not bank holidays)

#### **I-1-5 Community Macmillan Nurses in the East Riding of Yorkshire**

Macmillan Team	Telephone
Cottingham Clinic King Street, Cottingham	01482 335161
Alfred Bean Hospital Bridlington Road, Driffeld	01377 208758

The Macmillan teams are available, 9am - 5pm Monday to Friday (not bank holidays).

**I-1-6      Oncology Health Centres – a resource for staff**

<b>Oncology Health Centre</b> Princess Royal Hospital Saltshouse Road Hull, HU8 9HE  Tel: 01482 676708	<b>Oncology Health Centre</b> Castle Hill Hospital Entrance 2 Castle Road Cottingham Hull, HU16 5JQ  Tel: 01482 622031	Professor L G Walker Director Institute of Rehabilitation and Oncology Health Centres 215 Anlaby Road Hull, HU3 2PG  Email: <a href="mailto:l.g.walker@hull.ac.uk">l.g.walker@hull.ac.uk</a> Tel: 01482 675046 Fax: 01482 675636
--	---	---

An Oncology Health Centre was established in January 2000 at the Princess Royal Hospital (Eastern Hull), and a second Centre opened in 2002 at Castle Hill Hospital (West Hull). Based on research carried out in Aberdeen, these Centres offer drop-in facilities for local patients with cancer and their relatives. In addition, healthcare professionals can refer patients and relatives who are experiencing clinically significant difficulties in coping with the diagnosis and/or the treatment of cancer. A key feature is that the Centres are fully integrated functionally with medical and surgical oncology.

Psychological pain management can be offered as an adjunct or an alternative to pharmacological therapies for chronic pain. Patients who are experiencing a clinically significant difficulty (eg. an adjustment disorder, depression, a fear of needles, medical procedures or hospitals, or inadequately controlled side effects) are seen by a clinical psychologist or a specialist behavioural oncology nurse. A range of evidence-based psychotherapeutic interventions is used, including adjunctive psychological therapy and hypnotherapy. Full assessments are provided by the oncology health centres, 9am – 5pm Monday to Friday.

The aims of the Oncology Health Centres are:

- to prevent psychological distress,
- to improve quality of life,
- to deliver evidence-based psychological interventions equitably for patients in Hull, the East Riding of Yorkshire and North Lincolnshire,
- to provide support and supervision for staff,
- to offer local and national training programmes, and
- to create an infrastructure for research. (Current RCTs include the evaluation of the effects of complementary interventions eg. reflexology on quality of life.)

The Centres offer information, support, practical help (including welfare rights) and the opportunity to discuss any matter of concern. In addition, patients are given the opportunity to learn various evidence-based, self-help techniques, for example cue-controlled relaxation and visualisation, in order to minimise treatment side effects and to enjoy as good a quality of life as possible during and after cancer treatment. Further enquiries regarding the work of the Oncology Health Centres may be made to the Director, Professor Walker (see details above).

**I-1-7 Community pharmacies holding palliative care drug stocks**

NB. These do not offer a 24hr service.

Pharmacy	Tel/Fax	Opening Times	Pharmacist Specialist Training
Newland Community Pharmacy 59-61 Newland Ave Hull HU5 3BG	342872	Mon-Fri 9am-12.30pm and 1.30pm – 6pm Sat 9am -12.30pm and 1.30pm to 5.30pm. Closed for lunch 12.30pm to 1.30pm.	Yes
Keiths Chemist 404 Cottingham Road Hull HU6 8QE	342194	Mon-Fri 9am-6pm Sat 9am – 1pm	Yes
Lloyds Pharmacy 253 Anlaby Road Hull, HU3 2SE	211121 Fax - 214145	Mon-Sat 9am-10pm Sun – 9am-8pm	
Brocklehurst Chemist 801 Hotham Road South Hull HU5 5JX	502882	Mon-Fri 9am-6pm Sat 9am-1pm	Yes
Superdrug Stores PLC, 23-25 Toll Gavel, Beverley, East Yorkshire, HU17 9AA	01482 881344 (Tel & Fax)	Mon- Sat 8.30am to 5.30pm.	

**I-1-8 Out Of Hours (OOH) Palliative Care Contacts****Community Out of Hours Palliative Care Service (Hull)**

This is a point of contact for all aspects of Out of Hours Community Palliative care for staff, patients and carers.

Tel: 01482 335495 (17.00 - 22.30 HRS)

Tel: 01482 336505 (21.30 – 08.00 HRS)

**HEYHT Out of Hours Palliative Care Telephone Advice Line**

This service is available for patients, families and all healthcare professionals. Anyone who needs advice or information specific to palliative care is able to access this service.

The advice line is integral to the Cancer and Oncology Division at HEYHT and is staffed by Senior Registered Nurses, all of whom have experience in cancer and oncology care and have attended a robust training programme. This service is accessed by paging the staff member on the following number:

Tel: 07659 134008

Callers will be asked by the paging service to leave a name, contact number and short message. The nurse will then call back as quickly as possible and ask for some basic information in order to be able to assess the situation and give appropriate advice and information. The nurse will also complete a 'contact' form so that information and advice given to any patients/families can be fed back to the patient's Doctor and Macmillan Nurse (where appropriate) the following working day. This will help promote seamless and cohesive patient care across hospital and community boundaries.

### **Dove House Hospice**

Specialist palliative care advice is available 24 hours a day from Dove House Hospice (this includes other life limiting conditions as well as cancer) on 01482 784343 for healthcare professionals, patients and carers. Nursing teams will respond initially and defer to medical or social work teams as necessary.

### **I-1-9 District Nursing Contacts**

The following services are provided by District Nursing Teams in both Hull and the East Riding of Yorkshire.

- Available 365 days per year
- Qualified District Nurses and Community Staff Nurses
- Auxiliary Nurses / Healthcare Support Workers
- Provide all aspects of practical nursing care for patients in their own home
- Provide support for patients and carers, eg. accessing sitters
- Liaise with GPs and surgeries over prescriptions
- Facilitate the provision and use of equipment to use in the patient's home eg. syringe drivers
- Liaise with all other agencies to provide a suitable package of care
- Provide information regarding welfare benefits available
- The District Nurses manage their role in conjunction with the Macmillan Nurses and GPs through the Gold Standard Pathway.

**NB.** The District Nursing Teams also co-ordinate the 'End of Life Care Pathway' for the last 48hrs of life.

### **Referrals:**

- District nurses will provide services for all patients requiring palliative and terminal care in their own homes
- Referrals will be accepted from anyone requiring community nursing care and any healthcare professional
- District Nursing Staff can be contacted via GP surgeries or the following contact numbers (all have answer machines):

**I-1-9.1 Hull District Nursing Contacts**

Locality	Phone (01482)	Fax (01482)
Bransholme HC	386046	336524
Bilton Grange (Rank Ward)	336539	335469
Newington/Marmaduke HCs	344215	344225
Clarendon HC	617884	322211
Orchard Park HC	855247	336929
Morrill Street HC	335893	336925

**I-1-9.2 East Riding District Nursing Contacts**

In the East Riding of Yorkshire there are specific referral telephone numbers for all District Nursing requests:

Goole	01405 764755
Hessle	01482 335166
Beverley	01482 861802
Bridlington	01262 423114
Driffield	01377 208759
Pocklington	01759 304652
Holme-On-Spalding Moor	01430 861314
Market Weighton	01430 873986
Withernsea	01964 613425
Hedon (Rosedale)	01482 344450
Hornsea (switchboard)	01964 533146

**I-1-10 Pain & Palliative Care Education**

Information, education and training on pain and palliative care can be sought from:

**I-1-10.1 Macmillan GP Facilitators**

The Macmillan GP Facilitators arrange educational workshops, site specific seminars and study days in cancer and palliative care for all healthcare professionals and facilitate the Certificate in Professional Development for GPs which includes pain control. They are happy to arrange practice-based events for primary care. The Macmillan GP Facilitators: Dr Ruth Hunter, Dr Helen Bowden, Dr Ronald Clarke and Dr Emma Dawber can all be contacted via:

Lesley Alcan  
Macmillan Training Development Co-ordinator  
Room SC45, Trust Headquarters  
Willerby Hill  
Beverley Road, Willerby  
East Yorkshire HU10 6ED

Email: [lesley.alcan@humber.nhs.uk](mailto:lesley.alcan@humber.nhs.uk)

Tel: 01482 335825 Fax: 01482 335798

### **I-1-10.2 Community and Hospital Macmillan Nurses**

Contact the relevant Macmillan Nurse who will be happy to facilitate a session or to advise on suitable speakers (contact details can be found in [sections I-1-3 to I-1-5](#) or through the hospital switchboard for site specific cancer specialist nurses).

### **I-1-10.3 Hospital Macmillan Specialist Palliative Care Team**

The HEYHT team, based at Princess Royal Hospital, provides a great deal of palliative care education throughout the Cancer Network area and can be contacted on 01482 676739.

### **I-1-10.4 Independent Palliative Care Education Facilitator**

Please contact:

Sally-Ann Spencer Grey

Independent Lecturer and Consultant

Tel: 0845 686 0211

Email : [sally@saspencergrey.co.uk](mailto:sally@saspencergrey.co.uk)

Website : <http://www.saspencergrey.co.uk>

(NB. Sally-Ann currently has a short-term contract as the Palliative Care Education Facilitator with the Humber and Yorkshire Coast Cancer Network).

### **I-1-10.5 Dove House Hospice Information and Education Centre**

Dove House Hospice provides short courses (day and evening), study days and lectures for Healthcare Professionals, to help them provide appropriate palliative care. It also provides an Information Centre, Courses and Study Days for carers and the general public, (both at the Hospice and in the wider community) recognising the importance of relevant information in helping them cope better with their situation.

Please contact:

Nic Macmanus  
Information & Education Manager  
Dove House Hospice  
Chamberlain Road  
Hull, HU8 8DH

Tel: 01482 784383

Or see their website at <http://www.dovehouse.org.uk/courses.asp>

### **I-1-10.6 St Catherine's Hospice**

The Education Department  
St Catherine's Hospice  
Throxenby Lane  
Scarborough  
North Yorkshire, YO12 5RE

Tel: 01723 356022 Fax: 01723 356033

Email: [trish.Atkinson@st-catherineshospice.org.uk](mailto:trish.Atkinson@st-catherineshospice.org.uk)

Or see the Education page on the website at <http://www.stcatherineshospice-nyorks.org/>

### **I-1-10.7 Educational Co-ordinator – Hull and East Yorkshire Hospitals Trust**

For information on cancer and palliative care education across Hull and East Yorkshire Hospitals Trust, please contact:

Janis Hostad  
Princess Royal Hospital  
Saltshouse Road  
Sutton, Hull  
HU8 9HE

Tel: 01482 676555

Email: [Janis.Hostad@hey.nhs.uk](mailto:Janis.Hostad@hey.nhs.uk)

For education about pain in non-malignant conditions contact the hospices, The Centre for Pain Medicine or the relevant specialist nurses or consultant.

### **I-1-10.8 The Oncology Health Centres**

Conferences, study days, and occasional lectures on various aspects of psychosocial aspects of cancer are organised from time to time under the auspices of the Institute of Rehabilitation.

- Members of the Oncology Health Centres staff contribute to various undergraduate and postgraduate programmes.
- Two MRC students, funded by the Medical Research Council, are currently associated with the Centres.
- Attachments are offered to Specialist Registrars in various specialties, including Medical Oncology, Palliative Medicine and Liaison Psychiatry.
- Students from various disciplines, including nursing and clinical psychology, spend periods of time on clinical placement.
- Regular clinical supervision is offered to local Macmillan Nurses, specialist nurses and others.

Further enquiries may be made to the Director, Institute of Rehabilitation and Oncology Health Centres, Professor Walker (for contact details see [Section I-1-6](#)).

### **I-1-10.9 Centre for Pain Medicine (Castle Hill)**

The Centre for Pain Medicine also offers Pain and Palliative Care education to healthcare professionals (see [Section I-1-2.1](#)).

### **I-1-11 Translated Resources**

#### **I-1-11.1 Pain scales in multiple languages – British Pain Society**

The British Pain Society has produced a series of pain scales to assist in the assessment of people for whom English is not their first language. The scales are intended to be used by GPs and Accident and Emergency staff but may be useful in a wider range of situations in which the communication of pain is necessary.



The Pain Scales can be downloaded and printed free whenever needed from  
[http://www.britishpainsociety.org/pain\\_scales.html](http://www.britishpainsociety.org/pain_scales.html)



Please note that all scales consist of the foreign language scale followed by the English language translation.  
The following languages are available.

- |                         |              |
|-------------------------|--------------|
| ▪ Albanian              | ▪ Polish     |
| ▪ Arabic                | ▪ Punjabi    |
| ▪ Bengali               | ▪ Somali     |
| ▪ Chinese (Simplified)  | ▪ Swahili    |
| ▪ Chinese (Traditional) | ▪ Turkish    |
| ▪ Greek                 | ▪ Urdu       |
| ▪ Gujarati              | ▪ Vietnamese |
| ▪ Hindi                 | ▪ Welsh      |

#### **I-1-11.2 Translated Appointment Card**



This interactive tool from <http://www.communicate-health.org.uk> allows an appointment card to be written in English and a translated version to be printed off at the same time from a choice of 30 languages.

## **I-2 CONTACTS & RESOURCES FOR PATIENTS**

### **I-2-1 Religious & Spiritual Support**

The Hull and East Yorkshire Hospitals Trust includes a Chaplaincy Team, providing a multi-faith and holistic service to patients, relatives and Trust staff, offering a friendly ear to anyone in need of religious or spiritual support. The team covers the Trust's three sites – HRI, Castle Hill or Princess Royal - and is made up of priests and ministers from a number of mainstream Christian denominations, who also have excellent contacts with many local religious leaders from Christian and other faiths.

In addition to the religious and spiritual support services the team also provides training for staff through the Trust's Training Department, on such topics as 'Letting Go - coming to terms with a loss', 'Privacy and Dignity' and 'Spirituality in Health Care'.

The Chaplaincy Team operates a 24/7 emergency call-out service, with one of the chaplains always available. The quickest way to access this service is through the switchboard where you can ask for a Chaplain to be paged.

For less urgent matters the chaplains can be contacted by telephone on either  
01482 674427 (Hull Royal Infirmary)  
or 01482 623091 (Castle Hill Hospital),  
or through the hospital switchboard on 01482 328541 (HRI) or 01482 875875 (CHH).

### **Prayer Rooms**

Multi-faith Prayer Rooms are always open and are provided at various locations across the Trust. These rooms are available for use by patients, relatives and staff of all religions and denominations.

*Hull Royal Infirmary:* A suite of rooms can be found on the ground floor at Hull Royal Infirmary, behind the new Patients' Lounge. These rooms comprise two multi-faith prayer areas, a Chaplains' office and washing facilities. The prayer rooms are always open for prayer and reflection. There is an ecumenical service of Christian worship (including Holy Communion) on a Sunday morning at 9.30am in the prayer room.

*Castle Hill Hospital:* A multi-faith prayer room and the Chaplains' office can be found on the main corridor leading to Wards 8, 9, 10 and 11. The prayer room is always open for prayer and reflection. A Holy Communion service is held every Wednesday lunch-time at 1pm in the prayer room. While there is currently no Sunday worship service at Castle Hill, a Chaplain will always visit patients on request.

*Princess Royal Hospital:* A multi-faith prayer room and the Chaplains' office are located near to the main reception at Princess Royal. The prayer room is always open for prayer and reflection.

Chaplains will visit patients on request.

## I-2-2 The Oncology Health Centres – a resource for local patients and carers

<p><b>Oncology Health Centre</b>  Princess Royal Hospital  Saltshouse Road  Hull, HU8 9HE  Tel: 01482 676708</p>	<p><b>Oncology Health Centre</b>  Castle Hill Hospital  Entrance 2  Castle Road  Cottingham  Hull, HU16 5JQ  Tel: 01482 622031</p>
--	--

Patients who are receiving, or who have received, treatment for cancer locally are welcome to use the Centres, as are their relatives. They can drop in to the Centres Monday-Friday (9am-5pm) or attend by appointment. The atmosphere in the Centres is relaxing and friendly.

In conjunction with other members of the multi-disciplinary teams, the OHCs aims are:

- To help patients achieve the best possible health and quality of life during treatment and afterwards.
- To discuss any matter of concern.
- To offer support and practical help (including welfare rights advice).
- To provide patients/carers with information they feel would be helpful.
- To help patients learn various "self-help" skills such as special types of relaxation and visualisation.

The Oncology Health Centre at the Princess Royal Hospital is next to the Clinical Oncology Department. Please enter via the main Oncology Outpatient Department and ask for directions at the Reception Desk. The Oncology Health Centre at Castle Hill Hospital is immediately on your right at Entrance 2 to the Hospital.

Currently approximately 250 patients and relatives attend every week, and many more access the services by telephone. The Centres are open 9.00am to 5.00pm, Monday to Friday.

The Oncology Health Centres received commendations in the Northern and Yorkshire Modernisation Awards 2001, and in the National Health and Social Care Awards 2002.

For further information, and a copy of our leaflet about the Centres, please pop in to see us or telephone 01482 676708.

## I-2-3 The Expert Patients Programme

The Expert Patients Programme is a generic, time-limited course suitable for people who have any long-term condition. They are usually 6 weekly sessions of 2.5 hours involving between 10 and 16 people with varying conditions. Courses involve easy to learn ways of dealing with symptoms such as fatigue and pain, as well as ways to improve general health and well-being. All PCTs (Primary Care Trusts) in England participated in a national EPP pilot lasting 20 months which came to an end in January 2005. Two salaried EPP Trainers were assigned to each Strategic Health Authority to assist PCTs in the recruitment, accreditation and ongoing support of lay Volunteer Tutors to deliver the programme locally. Volunteer Tutors are themselves living

with a long-term condition and may or may not have attended an EPP course. Tutors use a detailed scripted manual, underpinned by ongoing research. The NHS Improvement Plan (2004) announced a roll out of the Expert Patients Programme, led by PCTs, with an expectation that the Programme will be widely available by 2008. The 'Our Health, Our Care, Our Say' 2006 White Paper resolved to increase the capacity of EPP and support its transition to a social enterprise organisation to market and deliver self-management courses. EPP Trainers will continue to be available as support via the Strategic Health Authorities in the future.

#### *Expert Patients Programme in Hull and the East Riding*

There is currently a pool of seven Volunteer Tutors who work across the whole patch, two of whom are accredited. Additional tutors work with the PCTs. The two Hull PCTs have some future courses planned. There are currently no plans for courses in the East Riding and the North Lincolnshire areas.

The six PCTs on the North and South banks of the Humber are working together in a partnership which they hope will enable EPP to be embedded into mainstream activity across this area by 2008.

#### ***EPP Contacts for East Riding and Hull\****

<b>East Hull PCT</b> Andy Coyne, EPP Co-ordinator	<a href="mailto:andy.coyne@ehpct.nhs.uk">andy.coyne@ehpct.nhs.uk</a>
<b>East Yorkshire PCT and Yorkshire Wolds &amp; Coast PCT</b> Deon Falcon, Patient Involvement Manager	<a href="mailto:deon.falcon@eypct.nhs.uk">deon.falcon@eypct.nhs.uk</a>
<b>EPP Trainers (Strategic Health Authority patch team)</b> Jenny Poulter Liz Powell Janine Cooper	<a href="mailto:jenny.poulter@sypct.nhs.uk">jenny.poulter@sypct.nhs.uk</a> <a href="mailto:liz.powell@sypct.nhs.uk">liz.powell@sypct.nhs.uk</a> <a href="mailto:janine.cooper@sypct.nhs.uk">janine.cooper@sypct.nhs.uk</a>

*\*NB – due to planned PCT mergers, these contact details may change during 2005/6.*

#### **I-2-4 Dove House Hospice – Psychosocial Services**



The Psychosocial Team consists of qualified social workers, support workers and a chaplain. They can be contacted by patients, families, visitors and staff who are associated with the Hospice and offer advice on religious, spiritual, emotional, social, practical and financial issues. The Bereavement Service offer help and advice (from Social Workers and a team of trained voluntary support workers) both during the illness and after the bereavement.

The Psychosocial Services at Dove House Hospice aim to preserve the dignity of patients and those who care about them, respecting their individuality and right to confidentiality. Anyone can make a request for these services but it must be done with the consent of the person needing the service. GP permission is not required.

Members of the Psychosocial team can be contacted directly or via any member of staff at any time. (Contact details are below or visit the website at <http://www.dovehouse.org.uk>)

Psychosocial Services

(Social Work, Bereavement and Chaplaincy Services)

Dove House Hospice

Chamberlain Road

Hull HU8 8DH

Tel: 01482 784343

Fax: 01482 701433

Email: [hospice@dovehouse.org.uk](mailto:hospice@dovehouse.org.uk)

#### **I-2-5 Support Groups**

##### *Cancer*

For details of local cancer support groups in Yorkshire and Humber, contact:

Humber and Yorkshire Coast Cancer Network

Sledmere House

Willerby Hill

Beverley Road, Willerby

East Yorkshire HU10 6ED

Telephone: (01482) 336270

Fax: (01482) 336288

Or see a list of groups on the Patient Involvement Group website at <http://www.pig.org.uk>

*Other local support groups may be contacted via the Patient Advice & Liaison Service (PALS) representatives:*

PALS provides a confidential, on-the-spot advice and support service, to help to sort out any concerns that patients, relatives, carers, or users of health services may have.

You can contact PALS at Hull & East Yorkshire Hospitals Trust via:

Tel: 01482 623065  
Fax: 01482 622252  
Email: [pals.hey@hey.nhs.uk](mailto:pals.hey@hey.nhs.uk)

### **I-3 CONTACTS & RESOURCES FOR CARERS**

#### **I-3-1 LOCAL RESOURCES**

##### **The Carer's Centre Hull**

Unit 5, The Shirethorn Centre  
37 - 42 Prospect Street  
Hull, HU2 8PX

Tel: 01482 225078  
Fax: 01482 609613  
Email: [information@carerscentrehull.org.uk](mailto:information@carerscentrehull.org.uk)  
Website: <http://www.carerscentrehull.org.uk>

##### **East Riding Carers Support Service**

East Riding of Yorkshire Social Services  
65 Keldgate, Beverley  
East Riding of Yorkshire  
HU17 8HU

Freephone 0800 917 68 44 for advice and emotional support

<http://www.eastriding.gov.uk/socialservices/socialservices/carers/carerssupportservice.html>

Provides information on:

Welfare benefits

Health related issues

Other organisations and services

Your rights as a carer.

### **Home from Hospital Carer support scheme for those with terminal illness**

The Carers Support Scheme is a new service under the umbrella of Hull Churches Home from Hospital Service, which has been providing free vital support to patients discharged from hospital since 1992. This scheme provides short-term support to carers of a partner, relative, friend or neighbour with a life threatening illness living in Hull.

Hull Churches Home From Hospital Service  
1st Floor, 82 Princes Avenue  
Hull  
HU5 3QJ

Tel: 01482 475265

Email: [carerssupport@hfhp.karoo.co.uk](mailto:carerssupport@hfhp.karoo.co.uk)

Website: <http://www.hullchurcheshomefromhospital.org.uk/>

### **Age Concern Hull**

Age Concern Hull offers a range of services to anyone over the age of 55, both from their central office and from advice centres and insurance outlets in the community. The central office provides a range of activities throughout the week and also offers the Pop-In Restaurant. Age Concern also co-ordinate the Ageing Well Project that aims to promote better health in later life.

Age Concern  
Bradbury House,  
Porter Street,  
Hull, HU1 2RH

Tel: 01482 324644

Email: [info@ageconcernhull.org](mailto:info@ageconcernhull.org)

Website: <http://www.ageconcernhull.org>

## **I-3-2 NATIONAL RESOURCES**

### **Carers UK**

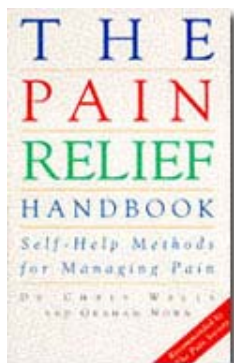
Website: <http://www.carersuk.org>

Carers UK offers benefits and rights information to carers. CarersLine can be contacted on 0808 808 7777. Both the website and CarersLine can put you in touch with a network of around 800 local carers' groups.

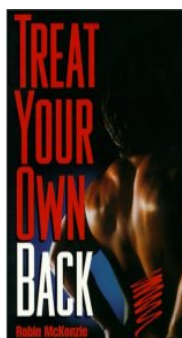
## I-4 INFORMATION RESOURCES

### I-4-1 Books

***Books recommended by The British Pain Society:***



**The Pain Relief Handbook** by Chris Wells and Graham Nown  
(1993) London: Optima.  
ISBN 0-091-81371-9



**Treat Your Own Back** by R McKenzie  
Orthopaedic Physical Therapy Products, Spinal Publications Ltd.  
ISBN 0-959774661.

**Defeating Pain. The War Against A Silent Epidemic** by Wall PD & Jones M  
(1991) Plenum Press, New York. ISBN 0-306-43964-6

**Living With Back Pain** by Helen Parker and Chris Main  
(1993) Manchester: Manchester University Press. ISBN 0-719-03069-2

**Mastering Pain** by Richard A Sternbach.  
(1987) ISBN 0-345-35428-1

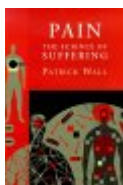
***Other books you may find useful***

*(Source: The list below is reproduced with kind permission from <http://www.channel4.com>)*



***Cancer Pain Management*** by Karen Simpson





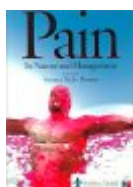
***Pain: The science of suffering*** by Patrick Wall



***Coping Successfully with Pain*** by Neville Shone



***Handbook for Pain Management*** by Ruth Kingdon et al



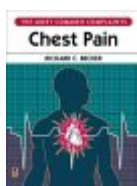
***Pain – Its Nature and Management*** by Nicky Thomas



***A Referred Pain: Reflections on family life and cancer*** by Penny Snow



***Prolo Your Pain Away*** by Ross and Marion Hauser



***Chest Pain*** by Richard Becker

***Reader's Digest Health and Healing the Natural Way:  
Managing pain***

***Healing Back Pain Naturally*** by Art Brownstein

***Overcome Neck and Back Pain*** by Kit Laughlin

***Massage for Pain Relief*** by Peijian Chen

## **I-4-2 Booklets and online resources**



### **Action on Pain**

<http://www.action-on-pain.co.uk>

AOP is a national charity providing support for people affected by chronic pain, either as a sufferer or a carer/relative.

Tel: Painline 0845 603 1593

- Booklets include:
  - About living with chronic pain;
  - About Pain Management;
  - Have Pain will Travel;
  - Plan to Start Exercising;
  - Pacing;
  - Relaxation.

All available from <http://www.action-on-pain.co.uk/publications.htm>

### **Arthritis Research Campaign**

<http://www.arc.org.uk/>

Various leaflets are available eg. back pain and the painful shoulder, as well as information leaflets about drugs eg. NSAIDs and rheumatology drugs, and lifestyle issues.

### **The Back Book - The Best Way to deal with Back Pain.**

This is a short booklet of 21 pages, well researched, carefully worded in an easy-to-read style, and full of accurate, effective information.

Available from The Stationery Office shop at <http://www.tsoshop.co.uk>

### **BackCare**

<http://www.backcare.org.uk>

This site has information about how to prevent back pain by caring for your back, how to live with back pain and also lists practitioners by postcode who are concerned with reducing the impact of back pain. You can email or call for information. Factsheets and books are available plus links to further useful sites.

Tel: 020 8977 5474

### **British Pain Society**

<http://www.britishpainsociety.org>

The British Pain Society, a registered charity, is the representative body for all professionals involved in the management and understanding of pain in the United Kingdom. The Society will endeavour to increase both

professional and public awareness of the prevalence of pain and the facilities that are available for its management.

Tel: 020 7631 8870

- **Understanding and Managing Pain – Information for Patients**  
16 page booklet - The Pain Society (Aug 2004) or can be printed off from:  
[http://www.britishpainsociety.org/pdf/info\\_patients.pdf](http://www.britishpainsociety.org/pdf/info_patients.pdf)
- **Opioid Medication for persistent pain – Information for Patients**  
11 page leaflet - The Pain Society (March 2004) or can be printed off from:  
[http://www.britishpainsociety.org/pdf/opioids\\_doc\\_info\\_for\\_patients\\_2004.pdf](http://www.britishpainsociety.org/pdf/opioids_doc_info_for_patients_2004.pdf)

### **Cancerbackup**

<http://www.cancerbackup.org>

Advice, information and support services about cancer.

Tel: 0808 800 1234

### **Cancer Macmillan Relief**

<http://www.macmillan.org.uk>

UK wide charity providing support mainly for those diagnosed with cancer and their families. Works towards ensuring people with the possible diagnosis of cancer get equal access to services. Produces many leaflets and campaign materials which can be viewed and downloaded from the website.

Macmillan Information Line      Tel: 0808 808 2020

### **Control pain live life**

23-page booklet from NAPP pharmaceuticals endorsed by the Pain Association (Feb 2004)

Available from: Medical Information, Napp Pharmaceuticals, Cambridge Science Park, Milton Road, Cambridge CB4 0GW

Tel: 01223 424444

### **Diabetes UK**

<http://www.diabetes.org.uk>

1 in 4 people with diabetes suffer neuropathic nerve pain. This site has information, factsheets and up to date research information. There is a section for healthcare professionals, and plenty of information about managing diabetes including sections for teenagers, parents and pregnant mums. You can search the site easily for the information you want and can contact the regional office to find out about local support groups.

Tel: 0207323 1531

### **DIPEX Chronic Pain website**

<http://www.dipex.org/chronicpain>

Launched in March 2005, the website offers support, guidance and information to chronic pain sufferers and their families / carers through a combination of patient experiences and evidence-based information.

Visitors to the site can download video and audio clips and read the personal experiences of 47 people with chronic pain about their initial diagnosis through to managing and treating the condition as part of their daily life. DIPEX also has an active online forum where people can interact and seek opinions etc. about pain experiences. There are also Q&A and resource sections that contain useful information on support groups, helplines and further reading.

### **Directory of UK complementary practitioners**

<http://www.drfooster.co.uk/cam/>

The Dr Foster website includes a directory of complementary practitioners in the UK. The directory covers complementary practitioners who are members of appropriate registration bodies in the fields of acupuncture, homeopathy, osteopathy, chiropractic, and herbal medicine including western herbal medicine, Chinese herbal medicine and Ayurvedic medicine.

### **Doctoronline**

<http://www.doctoronline.nhs.uk>

Includes patient information leaflets on pain conditions and medicines

### **Fibromyalgia Association UK**

<http://www.fibromyalgia-associationuk.org>

This site has a wealth of information for sufferers of Fibromyalgia, their carers and healthcare professionals, including details of local support groups and helplines.

Tel: 0870 2201232

### **Macmillan Cancer Relief**

<http://www.macmillan.org.uk>

UK charity supporting people with cancer and their families, with specialist information, treatment and care.

### **Marie Curie Cancer Care**

<http://www.mariecurie.org.uk>

Marie Curie nurses care for seriously ill cancer patients in their own homes and should be accessed through the district nurse or GP.

### **Neuropathy Trust**

<http://www.neuropathy-trust.org/>

Booklets on 'Peripheral Neuropathy & Neuropathic Pain Under the Spotlight' (28 pages) and 'Diabetic Neuropathy Under the Spotlight' (28 pages) are available from the Neuropathy Trust

### **NHSDirect**

<http://www.nhsdirect.nhs.uk>

Information about health conditions and local health services.

Tel: 0845 4647

### **The Oxford pain site**

<http://www.jr2.ox.ac.uk/bandolier/booth/painpag/>

A large resource for anyone with a professional or personal interest in pain and analgesia. The site has comprehensive sections on general pain topics, analgesics and chronic and acute pain.

### **Pain Concern**

<http://www.painconcern.org.uk>

UK charity offering information and support. Free leaflets can be ordered online and the website has details of a helpline on 01620 822572.

### **Pain.com**

<http://www.pain.com>

Lots of information and articles on pain and pain management.

### **Pain Relief Foundation**

<http://www.painrelieffoundation.org.uk>

The Pain Relief Foundation is a UK charity which funds research into the causes and treatment of human chronic pain and is concerned with education of doctors and nurses in pain management.

Tel: 0151 529 5820

### **Pain Support**

<http://www.painsupport.co.uk>

The author of "Natural Pain Relief" promotes a multi-disciplinary approach, where conventional medicine and complimentary therapies work side-by-side. The site contains useful information for patients, their families and friends.

### **Pain Web**

<http://www.thepainweb.com>

For healthcare professionals concerned with research, assessment and treatment of pain. The site includes articles as well as information on drug therapies.

### **Patient UK**

<http://www.patient.co.uk>

This large resource includes leaflets on health and disease, patient support and self help groups, information on medicines, useful books by UK authors and much more.

### **Patients Association**

<http://www.patients-association.com>

The Patients Association operates a helpline, a database of support groups and campaigns on patient issues.

Tel: 0845 6084455

### **Physiotherapy Pain Association**

<http://www.ppaonline.co.uk>

The PPA is a membership organisation for Chartered Physiotherapists and other practitioners involved in the treatment of patients with acute or chronic pain.