



The College of Emergency Medicine

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CLINICAL EFFECTIVENESS COMMITTEE Guideline for the management of pain in adults

Summary of recommendations

1. 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 the ED and finish with ensuring adequate analgesia at, and if appropriate, beyond discharge. Level 5 Evidence
2. The CEM Clinical Effectiveness Committee standard of analgesia for moderate & severe pain within 20 minutes of arrival in the ED should be applied to patients in all Emergency Departments. An audit against these standards should be done annually. Level 5 Evidence
3. Pain management should be regularly audited. Level 5 Evidence
4. Training in pain relief for all staff involved in patient care is essential to ensure quality and timely management. Level 5 Evidence

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Scope

This guideline has been developed and reviewed in order to provide clear guidance on the standards for timeliness of provision of analgesia, and to provide an approach to the delivery of analgesia based on available evidence and consensus of the CEM CEC.

Reason for development

Pain management is one of the most important components in patient care, which is why it is given such a high priority in the CEM 'Clinical Standards for Emergency Departments' and the Manchester Triage Scale.⁽¹⁾

Introduction

Pain is commonly under-recognised, under-treated and treatment may be delayed.^(2, 3) 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 the ED and finish with ensuring adequate analgesia at, and if appropriate, beyond discharge. There is some evidence that pain relief is related to patient satisfaction.⁽⁴⁾

Pain Assessment

Pain assessment forms an integral part of the National Triage Scale.⁽¹⁾ Multiple assessment tools are in use. The better known scales have not been validated in the context of an ED environment but are never the less satisfactory for the purpose of pain assessment and management. The recording of pain scores is often suboptimal.⁽³⁾ The experience of the member of staff triaging will help in estimating the severity of the pain.

Assessment of acute pain in the Emergency Department

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

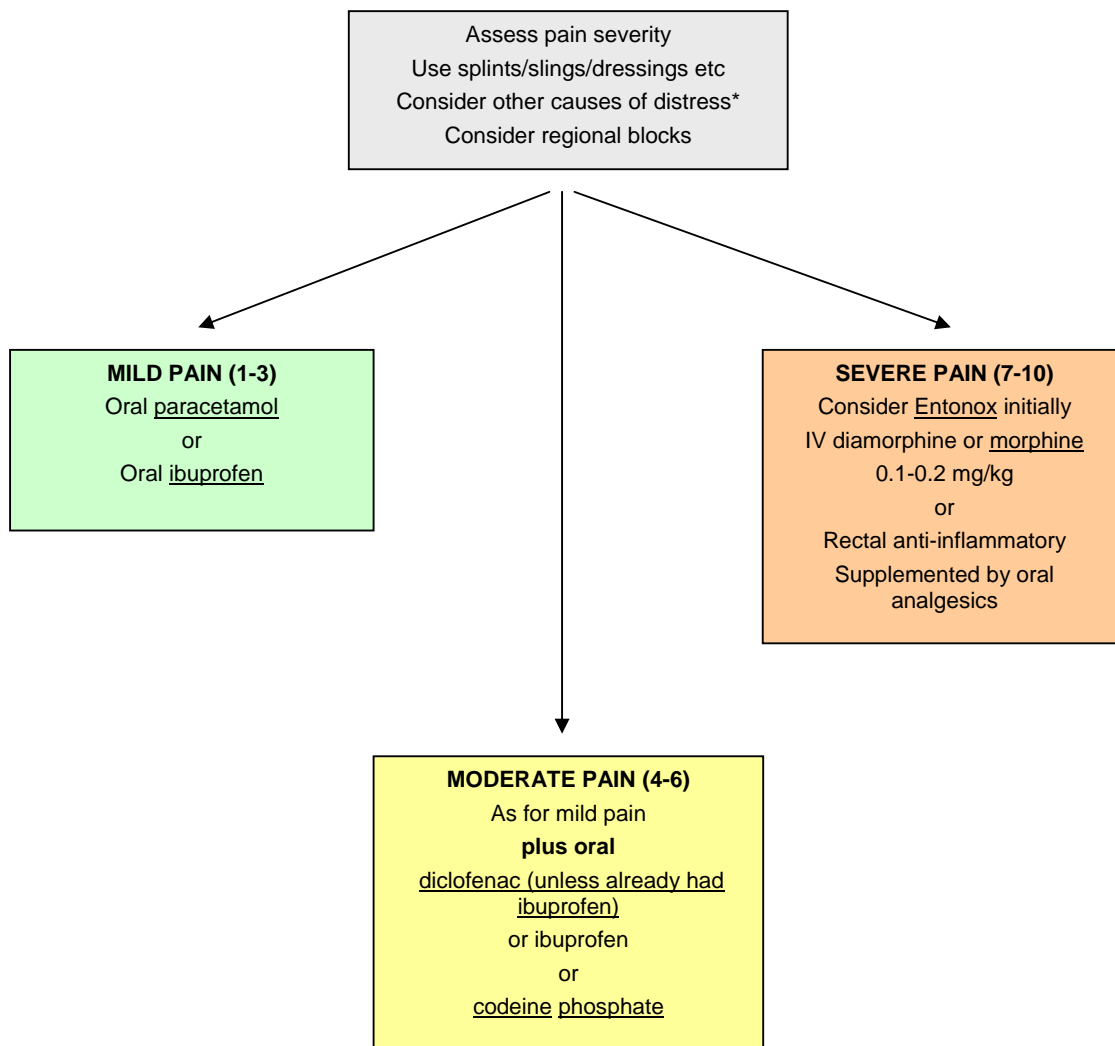
Notes for use

- 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 60 minutes in severe and moderate 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 60 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 analgesia is essential.

Algorithm for treatment of acute pain in the Emergency Department



*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 NSAID's or in moderate or severe asthmatics

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

REFERENCES:

- 1) Emergency Triage, 2nd Ed. BMJ Publishing Group, 2005.
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- 3) Brown J, Klein C, Lewis B et al. Emergency Department analgesia for fracture pain management. Ann Emerg Med 2003;42(2):197-205
- 4) Stahmer SA, Shofer FS, Marino A et al. Do Quantitative Changes in Pain Intensity Correlate with Pain Relief and Satisfaction? Acad Emerg Med 2008; 5(9): 851-7

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Review

2013 or sooner if important information becomes available.

Disclaimers

The College recognises that patients, their situations, Emergency Departments and staff all vary. This guideline cannot cover all possible scenarios. The ultimate responsibility for the interpretation and application of this guideline, the use of current information and a patient's overall care and wellbeing resides with the treating clinician.

Research Recommendations

None identified. Given the high incidence of pain in an ED, and the paucity of evidence in evaluation, difficulties with identification and pain and provision of pain relief in acute settings (especially in paediatrics), and the confounding variables that are known to exist there is a lot of scope for research in this area.

Audit standards

There should be a documentation and audit system in place within a system of clinical governance.

Key words for search

Pain, analgesia

Appendix 1

Methodology

Where possible, appropriate evidence has been sought and appraised using standard appraisal methods. High quality evidence is not always available to inform recommendations. Best Practice Guidelines rely heavily on the consensus of senior emergency physicians and invited experts.

Evidence Levels

1. Evidence from at least one systematic review of multiple well designed randomised control trials
2. Evidence from at least one published properly designed randomised control trials of appropriate size and setting
3. Evidence from well designed trials without randomisation, single group pre/post, cohort, time series or matched case control studies
4. Evidence from well designed non experimental studies from more than one centre or research group
5. Opinions, respected authority, clinical evidence, descriptive studies or consensus reports.