NHS
Greater Glasgow and Clyde

CLINICAL GUIDELINE

Assessment and monitoring of acute pain, Acute Pain Service, Royal Alexandra Hospital

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The online version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

NHS Greater Glasgow and Clyde	NHS Greater Glasgow & Clyde Royal Alexandra Hospital	Pages	1 - 4
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	Acute Pain Service Guidelines (Adult/Surgical)	Review Date	October 2027
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Assessment of pain

Assessment of pain is the essential prerequisite for successful pain management. It is unrealistic to expect that patients will be pain free. The aim of pain management is to optimise analgesia to enable functionality and cope with pain.

Basic elements of a pain assessment

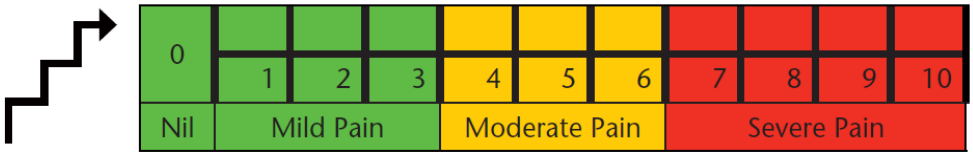
Site of pain	Where? Localised or generalised? Is this an expected or new location? Does pain radiate elsewhere?
Description of the pain	Write down words used to describe pain e.g. sharp, dull, colicky, throbbing, aching, burnings or shooting. This may help to determine the nature of pain and help decide the correct intervention.
Intensity of the pain	Score the intensity by using the pain scales below.
Function (see function score below)	Assess ability to perform a task appropriate to their painful injury or operation. For example: deep breathing, coughing, turning in bed or walking to the toilet.
Pain history of pain	Obtain a baseline pain score to determine what pain score patient normally functions

	with. Does the patient normally take any analgesia? Does the patient have any persistent pains?

Assessment Tools

There are several pain scoring tools available to use:

Numerical Rating Scale (NRS) and Verbal Descriptors Scale (VDS)



Pain scores in multiple languages are available from the Acute Pain Nurses or can be accessed at www.britishpainsociety.org/british-pain-society-publications/pain-scales-in-multiple-languages

Abbey Pain Scale

Behavioural tools are advocated for those patients who are cognitively impaired and unable to report pain verbally. Often a carer, friend or staff member who knows the patient well can help with the pain assessment.

Abbey Pain Scale

Pain assessment for patients unable to self report pain.

Staff should perform the pain assessment while the patient is being moved e.g. during pressure area care, while showering etc. An evaluation should be conducted one hour after any intervention taken, to determine the effectiveness of any pain-relieving intervention or further action required.

Affix ID Label

What type is the pain? (Circle as appropriate) Chronic Acute Acute on Chronic

Score: 0 = Absent; 1 = Mild; 2 = Moderate; 3 = Severe	Date _____ Time _____ Score	Date _____ Time _____ Score	Date _____ Time _____ Score	Date _____ Time _____ Score
Vocalisation e.g. whimpering, groaning, crying				
Facial expression e.g. looking tense, frowning, grimacing, looking frightened				
Change in body language e.g. fidgeting, rocking, guarding part of body, withdrawn				
Behavioural change e.g. increased confusion, refusing to eat, alteration in usual patterns				
Physiological change e.g. temperature, pulse or blood pressure outside the normal limits, perspiring, flushing or pallor				
Physical changes e.g. skin tears, pressure areas, arthritis, contractures, previous injuries				
Pain Score Total				
Print name of assessor				

Remember: Consider if any Non Pharmacological interventions will support the pain management plan.

Score 0 – 2 No Pain	**Score 3 – 7 Mild Pain**	**Score 8 – 13 Moderate Pain**	**Score 14+ Severe Pain**
Continue to assess. Ensure analgesia prescribed PRN according to local analgesic guidelines.	Administer prescribed analgesia according to local analgesic guidelines. Continue to assess.	Administer prescribed analgesia according to local analgesic guidelines. Continue to assess. Seek medical advice if pain is not responding to treatment.	Administer prescribed analgesia according to local analgesic guidelines. Continue to assess. Seek medical advice if pain is not responding to treatment.

This document has been reproduced with the kind permission of the authors. Abbey J, De Bellis A, Piller N, Esterman A, Giles L, Parker D, Lowcay B. The Abbey Pain Scale.
Funded by the JH & JD Gunn Medical Re-search Foundation 1998-2002.

Function Score

Measurement of pain is only a part of the assessment of pain and efficacy of analgesia. The assessment of function ability for example the ability to deep breath, cough, mobilise and sleep after surgery) gives a good indication of the effectiveness of analgesia.

A	No limitation, activity unrestricted by pain or settles quickly
B	Mild limitation, mild activity restriction
C	Moderate limitation, attempts activity but reluctant to continue because of pain **SEEK ADVICE**
D	Severe limitation, unable or refuses to perform activity because of pain **URGENT REVIEW REQUIRED**

Please document pain and functions scores on NEWS2 or PCA/BD Pain Manager/IT chart when recording routine vital signs.

Assessment of adverse effects

To individualise treatment and maximise patient safety there needs to be ongoing assessment of any adverse effects of pain management therapies. These include signs of excessive opioid doses such as sedation, respiratory depression (respiratory rate of <8 breaths per minute), nausea and vomiting. Scoring tools for sedation and nausea and vomiting are shown below.

Sedation Scoting Tool

S	= Sleep	Normal sleep; easy to rouse
A	= Alert	Patient Alert
V	= Verbal	Occasionally drowsy; easy to rouse; responds to verbal stimuli
P	= Pain	Frequently drowsy; easy to rouse; responds to painful stimuli SEEK ADVICE
U	= Unconscious	Somnolent; difficult to rouse URGENT REVIEW REQUIRED

Postoperative Nausea and Vomiting Scoring Tool

0	= None	No treatment required.
1	= Mild Nausea	Not distressing; no retching / no vomiting CONSIDER TREATMENT
2	= Moderate Nausea	Troublesome; occasional retching / vomiting TREATMENT REQUIRED
3	= Severe	Distressing; frequent retching / vomiting URGENT REVIEW REQUIRED

Please document pain, function, sedaiton and nausea/vomiting scores on NEWS2 or PCA/BD Pain Manager/IT chart when recording routine vital signs.

Refrences

1. Abbey J, Piller N, De Bellis A et al (2004) The Abbey pain scale: a 1 minute numerical indicator for people with end stage dementia. Int J Palliat Nurse 10(1): 6 – 13

2. Macintyre PE, Schug SA, Scott DA, Visser EJ, Walker SM; APM:SE Working Group of the Austrainial and New Zealand College of Anaesthetists and Faculty of Pain Medicine (2015), Acute Pain Management: Scientific Evidence (3rd edition), ANZCA & FPM, Melbourn

3. Macintyre PE, Schung S (2015) Acute Pain Management A practicle guide (4th edition), CRC Press

4. Royal College of Physicians, British Geriatric Society & British Pain Society (2018). The assessment of pain in older people: UK national guidelines. Age and Ageing, Volume 47

5. www.britishpainsociety.org/british-pain-society-publications/pain-scales-in-multiple-languages/