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Best Practice Statement ~ *February 2006*

Management of chronic pain in adults

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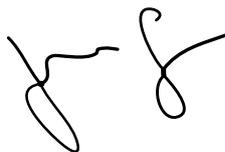
www.nhshealthquality.org

Foreword

Chronic pain is a major health and social care challenge affecting a significant number of people in Scotland, many of whom are cared by nurses and Allied Health Professionals (AHPs) working in primary care and in the community. In order to support these healthcare professionals in their work, NHS Quality Improvement Scotland has, in partnership with patients, carers and clinical experts, developed a Best Practice Statement for the Management of Chronic Pain in Adults.

This best practice statement is aimed at general nursing and AHP staff and does not cover Specialist Pain Services although it is acknowledged that they are a key element in the patient pathway for those with chronic pain.

We hope you find it of use and would welcome any comments you may have.



David R Steel
Chief Executive
NHS Quality Improvement Scotland

Acknowledgements

This best practice statement was developed in partnership with a number of people who live with chronic pain, carers and clinical experts. A list of those involved can be found in Appendix 2.

There are also a number of individuals whose guidance and support has been greatly appreciated. These include:

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Introduction

NHS Quality Improvement Scotland (NHS QIS) was set up by the Scottish Parliament in 2003 to take the lead in improving the quality of care and treatment delivered by NHSScotland.

The purpose of NHS QIS is to improve the quality of healthcare in Scotland by setting standards and monitoring performance, and by providing NHSScotland with advice, guidance and support on effective clinical practice and service improvements.

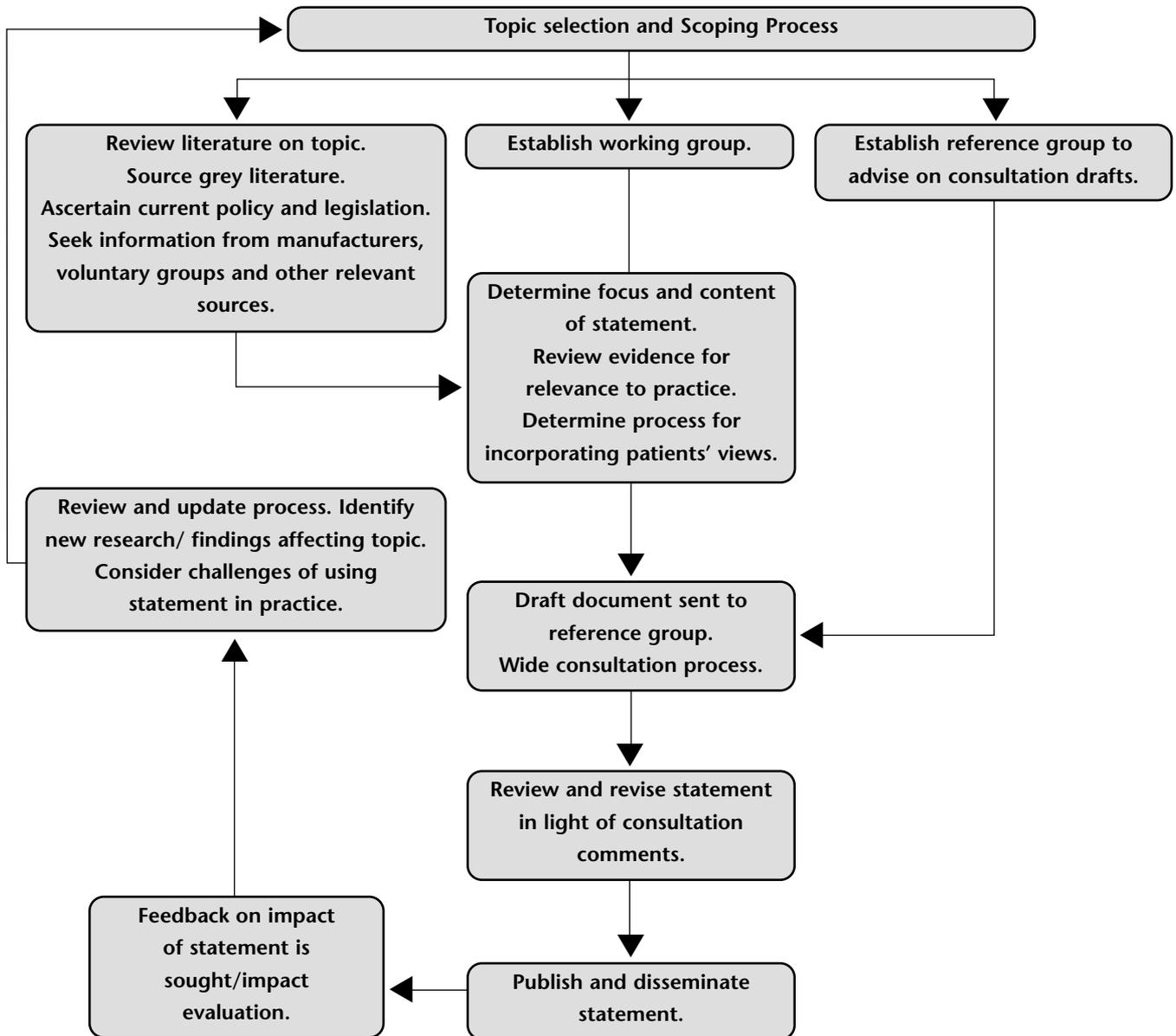
A series of best practice statements has been produced within the Practice Development Unit of NHS QIS, designed to offer guidance on best and achievable practice in a specific area of care. These statements reflect the current emphasis on delivering care that is patient-centred, cost-effective and fair. They reflect the commitment of NHS QIS to sharing local excellence at a national level.

Best practice statements are produced by a systematic process, outlined overleaf, and underpinned by a number of key principles:

- They are intended to guide practice and promote a consistent, cohesive and achievable approach to care. Their aims are realistic but challenging.
- They are primarily intended for use by registered nurses, midwives, allied health professionals, and the staff who support them.
- They are developed where variation in practice exists and seek to establish an agreed approach for practitioners.
- Responsibility for implementation of these statements rests at local level.

Best practice statements are reviewed, and, if necessary, updated after 3 years in order to ensure the statements continue to reflect current thinking with regard to best practice.

Key Stages in the development of best practice statements





Best practice statement on the management of chronic pain in adults

This best practice statement has been developed by a multidisciplinary working group of relevant specialists, which included people living with chronic pain and carers. A multi-professional reference group has advised on and overseen the work of the working group.

Chronic pain is one of the most common reasons people seek medical help and depending on the severity of their pain are thought to use health services up to five times more often than the rest of the population (Von Korff 1991).

Pain is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage (IASP 1986). This definition suggests that chronic pain is linked with severe psychological, social and economic consequences which impact upon the sufferer, their families and healthcare resources (Smith 2001).

Patients and families struggling with chronic pain have different needs than those with acute healthcare problems (Matthews 2002). These needs are unlikely to be met within an acute care culture.

Traditionally chronic pain has been viewed as a symptom or complication of another condition rather than a medical problem in its own right. Consequently, many approaches to pain management have been short-sighted reinforcing the problem of chronicity (Bonica and Loeser 2001).

Chronic pain varies in aetiology (the cause of a disease or condition) and presentation therefore the effects on individuals are often particular to them and can include disruption of employment, family and social functioning. This can lead to depression, withdrawal from social activities, inability to cope and increasing disability. The Pain in Europe Survey (2004) suggested that the prevalence of chronic pain in Scotland is likely to be around 18.1% of the population, with only 3% of people accessing specialist pain services.

Considering the number of people who live with chronic pain, this Best practice statement is intended as a resource to guide the practice of nurses and allied health professionals (AHPs) in acute care and primary care who will undoubtedly care for people with chronic pain.

This Best practice statement refers to the management of chronic pain in adults; it does not address the needs of children who suffer chronic pain. The IASP (International Association for the Study of Pain) taxonomy on chronic pain lists over 600 individual clinical syndromes related to chronic pain. It would be impractical to attempt to produce guidelines on all these individual syndromes. Instead a more generalised approach is taken. Further reference to individual disorders can and should be sought elsewhere.

The analgesic medications referred to in this document are only illustrative examples. The prescription of medicines for the relief of pain should be carried out in accordance with information provided within the British National Formulary (BNF) and according to the Nursing and Midwifery Council (NMC) Guidelines for the Administration of Medicines (2004).

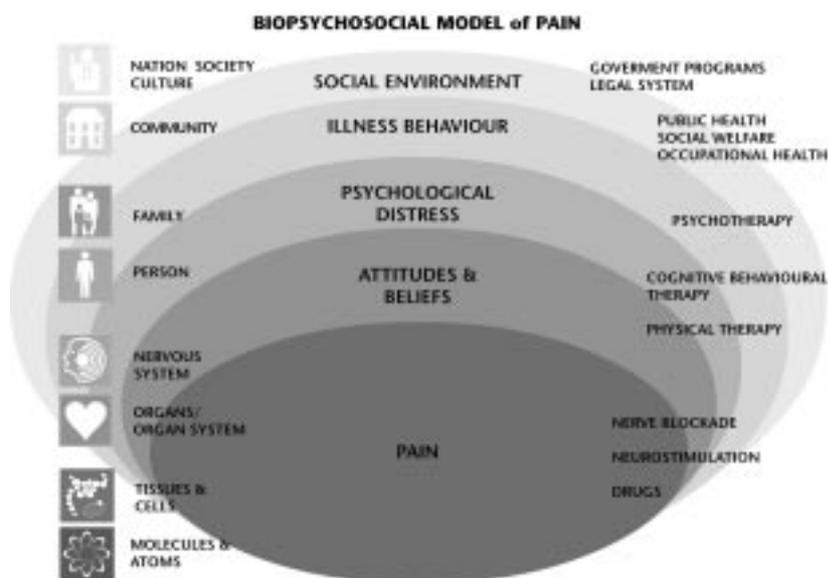
What is chronic pain?

Pain can be defined as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage" (International Association for the Study of Pain 1986). The IASP further define **Chronic Pain** as "pain without apparent biological value that has persisted beyond normal tissue healing time" (usually taken to be 3 months). When pain lasts longer than 3 months or beyond the time when an acute injury would be expected to have healed, the person's presentation becomes more complex. There may be psychological features, including complaints of poor or non-refreshing sleep, tiredness, depression and poor concentration.

Apart from the time characteristics (acute or persistent), pain can be classified clinically as either nociceptive or neuropathic, although in practice these can co-exist. Psychosocial features may play a significant role in the persistence of symptoms.

Because of the complexity of persistent pain, it is essential to make a biopsychosocial assessment (Dysvik et al 2004). By viewing chronic pain in a biopsychosocial manner it enables the practitioner to focus on the individual area which is having the largest impact on the patient's symptoms.

Figure 1 Biopsychosocial model for pain courtesy of Medical Illustrations Department, Glasgow Royal Infirmary, adapted from Waddell et al (1993)



The Scope of the Problem

Chronic pain is a complex, devastating and widespread problem affecting approximately 18.1% of people in Scotland (Breivik et al 2005). It has harmful effects on health, employment and daily life (Smith et al 2001). It is often described as persistent and may not totally resolve even with treatment (Elliott et al 2002).

Nevertheless, management is worth pursuing.

Key points

- Chronic pain is most prevalent in middle aged people. It is more prevalent in women than men (Rustoen et al 2005, Verhaak et al 1998).
- At least 7 million adults in the UK have long-term health problems due to arthritis and related conditions (Arthritis Research Campaign).
- In the UK the prevalence of neuropathic pain is 2.4%-8% of the population (Neuropathy Trust).
- Chronic pain is one of the most common reasons why people seek medical care (Haetzman et al 2003).
- Chronic pain is a major public health problem.
- Chronic pain inflicts tremendous personal suffering.
- Chronic pain can reduce quality of life.
- Chronic pain does not always lead to disability - different people with the same condition or injury often respond differently.
- There are significant health and social economic consequences associated with chronic pain (Pizzi et al 2005, Thomsen 2002).

Resources:

www.neuropathy-trust.org/

www.arc.org.uk/about-arth/astats.htm



Key Principles

The key to successful management is identification of chronic pain, accurate assessment, adequate intervention and frequent evaluation (McCaffery 1999). This will allow the professional to:

- explain the process to the patient
- offer empathy and support having clearly explained the possible limitations of the physical relief of symptoms
- support the patient in a holistic way, in terms of the social and environmental impact
- improve quality of life, where possible
- encourage continuance at work, or return to work, where appropriate and possible
- foster an understanding of these patients within their families and within the general population, including employers.

Factors to consider in patient assessment:

- clinical history
- general personality traits and dispositions
- current level of somatic concern, depression, anger
- report of pain and functional limitations
- preliminary behavioural analysis
- pain coping strategies
- beliefs about injury, pain and treatment outcome
- social, economic and occupational influences on symptom presentation (Keefe and Bonk 1999).

What are the most common causes of chronic pain?

For many people the source of pain is musculoskeletal. Common diagnoses are back pain, arthritis and widespread joint pain. Headache, angina and neuropathic pain are other common causes of pain. It is important to recognise that a significant number of individuals (5-10%) will have chronic pain with no formal diagnosis. This does not mean their pain is imaginary. Pain is what the person says it is and exists whenever the person says it does (McCaffery 1980).

Table 1 Common diagnostic subgroups of chronic pain in the community (based on Elliott et al 1999)

Diagnosis	Male (%)	Female (%)
Back Pain	14.9	17
Arthritis	13.7	17.8
After Injury	7.6	4.3
Angina	4.9	4.1
Gynaecological	0	7.5
Unknown Cause	5.2	3.4

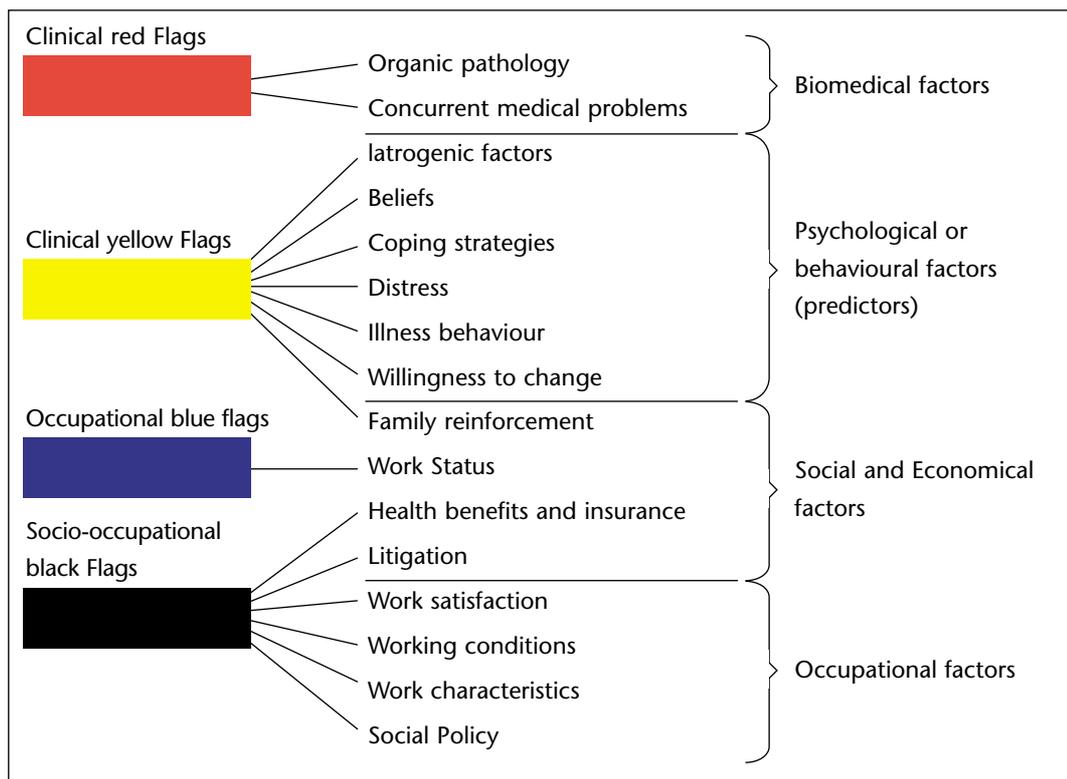
Table 2 Anatomical Site of Pain (based on Gureje et al 1998)

Anatomical site	Subjects reporting pain (%)
Backpain	47.8
Headache	45.2
Joint Pain	41.7
Arm or leg pain	34.3
Chest Pain	28.9
Abdominal Pain	24.9
Pain Elsewhere	11.7
Number of sites	
1	32.1
2	27.5
3	22.8
>4	17.5

Working Model

In relation to **Back Pain** a set of "flags" have been produced to reflect the biopsychosocial phenomenon.

Figure 2 Adapted from Main CJ, Spanswick CC. 2000



A number of psychosocial "yellow flags" can be used during acute episodes and have been found to be useful in predicting failure to return to work after back injury, and also prove useful in predicting which patients will develop prolonged pain in other situations.

These include:

- presence of a belief that the pain is harmful or potentially severely disabling
- fear-avoidance behaviour (avoiding a movement or activity because of a misplaced anticipation of pain), and reduced activity levels
- tendency to low mood and withdrawal from social interaction
- an expectation that passive treatments rather than active participation will help Kendall et al (1997).

Resource: www.nzgg.org.nz

Types of Pain

Nociceptive pain (tissue damage pain) arises from mechanical, chemical or thermal stimulation of nociceptors (eg after surgery, trauma or associated with degenerative processes such as osteoarthritis). It is important to realise that pain may persist long after the nociceptive process has ended and that other factors eg psychosocial features may need to be considered.

Neuropathic pain (nerve damage pain) is initiated or caused by a primary lesion or dysfunction in the nervous system (eg in conditions such as diabetic neuropathy or spinal cord injury). It has quite different clinical features from nociceptive pain. It is less well localised and often is described as burning or shooting. It can occur in areas that are numb and where there is no tissue damage.

Table 3 Types of pain adapted from Nicholson (2003)

Nociceptive (tissue damage) pain	Neuropathic (nerve damage) pain
<ul style="list-style-type: none"> • Well localised • May be more diffuse if visceral structures involved • Sharp • Stabbing • Ache • Gripping <p>Examples of nociceptive pain</p> <ul style="list-style-type: none"> • Arthritis • Trauma • Acute Post Operative 	<ul style="list-style-type: none"> • Persistent • Burning • Paroxysmal/spontaneous • "Electric Shocks" • Pain in the absence of ongoing tissue damage • Allodynia - painful response to stimuli that would not normally cause pain • Hyperalgesia - increased pain in response to pain stimulus • Dysaesthesia - unpleasant abnormal sensations <p>Examples of neuropathic pain</p> <ul style="list-style-type: none"> • Trigeminal neuralgia • Diabetic neuropathy • Post-herpetic neuralgia • Complex regional pain syndromes I & II • Peripheral Neuropathy

Key points

- The above characteristics are typical rather than definitive
- Not **all** the above characteristics will be present
- Both nociceptive and neuropathic pain may co-exist

Psychosocial Features have been shown to be predictors of incidence and duration of chronic pain. It is important to realise that this does not imply that the pain has a psychological basis, only that psychological and social factors may have an implication in the severity and maintenance of pain. This relationship has been firmly established by research.

Patients' fear of pain, their interpretation of what the pain means and its likely effect on their lives, have become important targets for therapy.

Patient Assessment

Comprehensive assessment of pain requires protected time with the person and consideration of the following domains:

- **Physical effects/manifestations**
- **Functional effects**
- **Interference with activities of daily living**
 - Weight gain/loss
 - Sit from standing and vice versa
 - Dress and undress unaided
 - Walk with ease
 - Employment/unemployment
 - Unresolved litigation issues
- **Psychosocial factors**
 - Level of anxiety
 - Mood
 - Cultural influences
 - Fears
 - Effects on interpersonal relationships
 - Factors affecting pain thresholds
- **Spiritual aspects**
 - This relates to the meaning of purpose ie "why am I experiencing such pain"? It does not always include a religious component. (SIGN Guideline 44, 2000)

Section 1: Initial Assessment

Key Points ~

- 1 *People with chronic pain need to have undergone a comprehensive medical assessment to ensure no unknown underlying pathological process accounts for their symptoms. This is essential.*
- 2 *Comprehensive assessment of the person and their pain is necessary to increase the likelihood of successful management.*
- 3 *Chronic pain is a multidimensional phenomenon and management must address all aspects (Rucker et al 1996).*
- 4 *The person's self-report of pain will be considered an accurate account of their pain (Solomon 2001).*

Statement	Reasons for statement	How to demonstrate statement is being achieved
<p>Nurses & AHPs understand the multidimensional nature of chronic pain and its component features.</p> <p>Formalised assessment tools that are appropriate for the individual are used to assess the person and their pain (Bourbonnais et al 2004).</p>	<p>Accurate assessment and individual management of the person with chronic pain (Twycross 2000).</p> <p>Multidimensional assessment tools must reflect the holistic phenomenon of chronic pain (Davies & McVicar 2000).</p> <p>Ongoing assessment will help evaluate treatment interventions (Turk & Burwinkle 2005).</p>	<p>There is evidence of locally agreed multi - dimensional pain assessment tools being used to determine management strategies. Tools should be appropriate for each individual person.</p> <p>See Appendix 1 for example of assessment domains and tools.</p>
<p>Once pain is reported, a comprehensive assessment of the impact of pain on the person is undertaken and a management plan developed.</p>	<p>People with chronic pain may have multiple needs. Successful management depends on comprehensive and accurate assessment and reassessment (deWit et al 1999).</p> <p>Points to consider when taking a patient's pain history</p> <ul style="list-style-type: none"> • The site of pain – Where do you feel the pain? • Where does it radiate to? • Nature of pain – Speed of onset, is it intermittent or persistent? • Characteristics of pain – Describe what the pain feels like, eg, is the pain burning, shooting, dull? • History of pain – Onset and duration, how long have you had this pain? • Alleviating/exacerbating factors – What do you do that makes it better or worse? 	<p>A pain management plan is formulated in partnership with the person. A copy of this plan is held within the person's records.</p>

Statement	Reasons for statement	How to demonstrate statement is being achieved
Nurses & AHPs can differentiate between nociceptive and neuropathic pain	<ul style="list-style-type: none"> • Associated factors? For example, nausea, visceral symptoms, signs of sympathetic dysfunction? • Severity of sleep disturbance – Does the pain wake you up? • Impact on activities of daily living – Does the pain stop you from doing anything? • Previous treatments – What have you already tried to relieve your pain, why did you stop any previous treatment? <p>The physical aspects of a person's pain must be treated in conjunction with the psychological, emotional and social aspects.</p>	
	Chronic pain can be characterised as nociceptive or neuropathic. However, it is often a mixture of the two (Nicholson 2003).	Documentation demonstrates appropriate management strategies have been adopted.

Key Challenges ~

- 1 *Considering the fact that any new complaint of pain could be a result of an underlying pathological process, which may need urgent attention.*
- 2 *Distinguishing neuropathic pain from nociceptive pain as treatment strategies often differ.*
- 3 *Recognising that chronic pain affects many activities of daily living - treat the whole person not just the physical symptoms of pain.*
- 4 *Appropriate assessment of psychosocial factors influencing pattern of pain, presentation, and impact of pain on psychosocial functioning eg family, cultural, sexual issues, Disability Living Allowance (DLA) and ongoing litigation.*
- 5 *Assessing the above factors in a sensitive manner.*

Resource: www.jr2.ox.ac.uk/bandolier/booth/painpag/

Section 2: Pharmacological management of chronic pain

Key Points ~

- 1 *Although nurses may or may not be prescribing it is vital that they are aware of the principles of the administration of medicines (NMC 2004). They should be aware of when it would be appropriate to initiate or discontinue a drug, know the dose range and potential side effects.*
- 2 *The use of pharmacological agents in the management of pain should be tailored to each individual.*
- 3 *Pharmacological management is only one component of the person's management plan.*
- 4 *The World Health Organisation (WHO) analgesic ladder is often used as a theoretical framework to support the pharmacological management of chronic pain.*

Statement	Reasons for statement	How to demonstrate statement is being achieved
<p>The pharmacological management of chronic pain will be individualised to meet the needs of the person, their health and concurrent medications.</p>	<p>Pharmacological management of chronic pain is an important element in multimodal treatment (Oxford Pain Research Trust 2002).</p> <p>Nurses & AHPs must be aware of drug-drug interactions / drug-nutrient interactions (Kaye et al 2002).</p>	<p>Optimal pain relief is reported by the person in balance with tolerable side-effects. Concordance with mutually agreed treatments exists.</p> <p>Side effects to analgesic medicines are recorded, managed and monitored.</p>
<p>The principles of the WHO analgesic ladder are applied to the management of people with chronic pain.</p>	<p>The WHO analgesic ladder was developed and has been validated for cancer pain. (WHO 1996). However, its principles are widely implemented in management of chronic non-cancer pain.</p>	<p>Documentation reflects that the principles of the WHO analgesic stepladder have been applied and that pain medication has been discussed and agreed with the person.</p>
<p>People who have difficulty managing pain will be referred to a specialist pain clinic.</p>	<p>The reduction of pain after treatment at a multidisciplinary pain centre is reported to be statistically significant (Flor et al 1992).</p>	<p>Evidence exists in the person's records that appropriate referral to a specialist pain clinic has been made.</p>

Key Challenges ~

- 1 *Misconceptions exist regarding the pharmacological treatments of chronic pain, which can be a barrier to successful management.*
- 2 *Informing people of the indications, side effects and benefits of their medication in a way that is clearly understood.*
- 3 *Analgesic medicines are often used outwith licensed indications and appropriate information about risks and benefits for patients and healthcare professionals requires to be made available. Licensed products should be used where possible.*
- 4 *To ensure the patient progresses up the ladder to the appropriate level. (British Pain Society 2004).*
- 5 *Recognising that other interventions may cause a reduction in analgesics needed.*

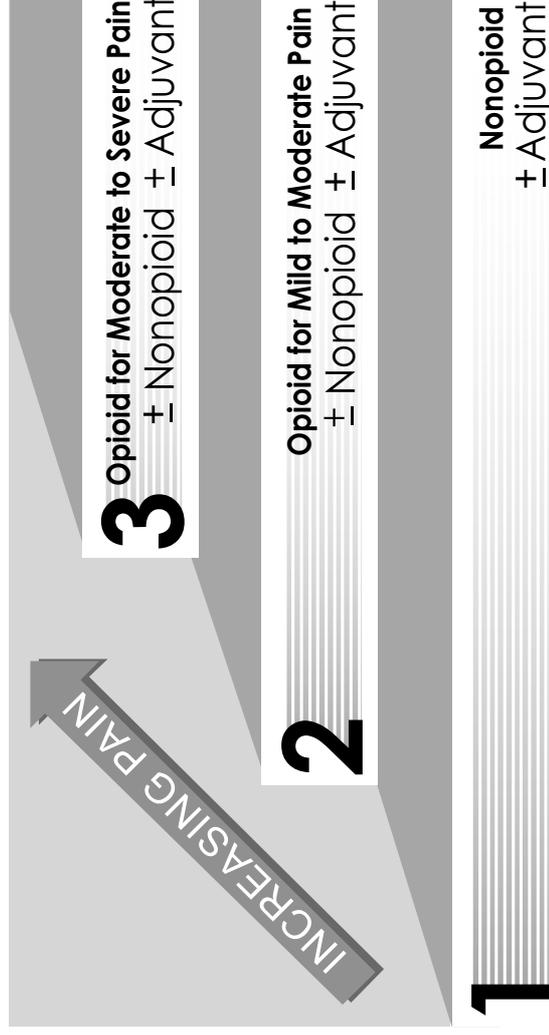


Figure 3 Adapted from WHO 1996

Section 3: Unconventional analgesics (Adjuvants)

These are drugs, which are not normally considered analgesics, but they have a primary role in other conditions. They are used as adjuvant treatments in the management of pain (McQuay et al 1996).

Key Points ~

- 1 *A trial of unconventional analgesics should be considered if the patient describes difficulty in managing pain.*
- 2 *Neuropathic pain can be treated by unconventional analgesics eg antidepressants, anticonvulsants as well as conventional medications eg opioids.*
- 3 *Tricyclic antidepressants are the preferred initial therapy in neuropathic pain.*
- 4 *Unconventional analgesics may be effective at doses which may be lower than those used for their primary indication.*

Table 1 First-line medications for neuropathic pain adapted from Dworkin et al 2003

Medication	Evidence	Comments
Tricyclic antidepressants should be considered for neuropathic pain.	Tricyclic antidepressants are thought to be effective treatment for neuropathic pain. The best available evidence is for amitriptyline (Saarto & Wiffen 2005).	Starting dose 10 – 25mgs every night. Duration of adequate trial 6 – 8 weeks at maximum tolerated dosage (Dworkin et al 2003).
Anticonvulsants should be considered for neuropathic pain.	Gabapentin is thought to be effective in chronic neuropathic pain (Wiffen et al 2005).	Starting dose 100 – 300mgs every night or 100 – 300mgs 3 times a day. Increase by 100 – 300mgs every 1 – 7 days as tolerated. Duration of adequate trial 3 – 8 weeks for titration plus 1 – 2 weeks at maximum tolerated dosage (Dworkin et al 2003).
Tramadol should be considered for neuropathic pain.	Tramadol is thought to have a therapeutic effect on paraesthesiae, allodynia and touch evoked pain. It is considered an effective treatment for neuropathic pain (Duhmke et al 2005).	Starting dose 50mgs once or twice daily. Increased by 50 – 100mgs in divided doses every 3 – 7 days as tolerated. Duration of adequate trial 4 weeks (Dworkin et al 2003).

Unconventional analgesics (Adjuvants)

Statement	Reasons for statement	How to demonstrate statement is being achieved
Nurses and AHPs understand the reasons for using unconventional analgesic in pain states eg neuropathic pain.	There is strong evidence that both antidepressants and anticonvulsants are effective in pain states (Saarto & Wiffen 2005, Wiffen et al 2005).	<p>There is evidence in the person's record to show that these unconventional analgesics have been considered in a systematic way.</p> <p>Optimal pain relief is reported by the person in balance with tolerable side-effects. Concordance with mutually agreed treatments exists.</p> <p>Side effects to analgesic medicines are recorded, managed and monitored.</p>

Key Challenges ~

- 1 *Informing patients of the indications, side effects and benefits of their medication in an accessible format.*
- 2 *Understanding the risks benefit ratios associated with medications eg anticonvulsants.*
- 3 *Unconventional analgesic medicines are often used outwith licensed indications, and appropriate information about risks and benefits for patients and healthcare professionals requires to be made available. Licensed products should be used where possible.*
- 4 *Chronic pain may be an unlicensed indication for most of these medicines and the patient information leaflet, which is issued at the point of dispensing, may not contain relevant information for the condition being treated. The information provided may be confusing.*

Section 4: The use of opioids in the management of chronic non-malignant pain

Key Points ~

- 1 Opioid medication may not be suitable or effective for some people with chronic pain.
- 2 The choice of opioid medication depends on clinical circumstances.

Statement	Reasons for statement	How to demonstrate statement is being achieved
A physical, psychological and social assessment is undertaken before starting the person on long-term opioid medication.	Some people with chronic pain can attain favourable outcomes for prolonged periods using opioid medicines (Portenoy 1996).	Documentation reflects appropriate prescribing and evaluation of treatment.
The person with chronic pain will be fully informed of their treatment plan before commencing opioid therapy.	To assist the patient to make as informed a choice as possible about benefits and risks (British Pain society 2005).	The person is concordant with treatment.
People with chronic pain receiving opioid medication are closely monitored during dose titration.	Please refer to the Recommendations for the appropriate use of opioids for persistent non-cancer pain. The British Pain Society 2004 www.britishtainsociety.org/pdf/Pub_Final_opioid_marc_h%202005.pdf	There is evidence that the use of opioids and potential side-effects have been discussed and agreed between the person and the health professional.

Key Challenges ~

- 1 Ensuring patients are informed that injectable opioids are rarely appropriate for persistent non-cancer pain (British Pain Society 2004).

Section 5: The multidisciplinary approach to pain management in primary care

Key Points ~

- 1 *People with chronic pain often have multiple factors that contribute to pain.*
- 2 *A multidisciplinary approach may be necessary for people with complex needs.*
- 3 *Not all patients with chronic pain require full multidisciplinary care.*

Medical Practitioner	The role involves taking a detailed history, medical examination, assessing, co-ordinating the appropriate management strategy for patients with referral to other members of the team or other specialists; agreeing and reviewing clinical management plans.
Nurse	The nurse's role involves a nursing assessment, running nurse led clinics, TENS, acupuncture, sleep management, following up on medication regimens, education, counselling, collecting and organising patient data.
Physiotherapist	The management plan includes reassessment and education; advice on pacing and goal setting; and facilitation of movement and exercise with the aim of optimising physical fitness, activity and participation.
Psychologist	Poorly managed chronic pain can generate feelings of distress, hopelessness and despair, psychological interventions have been demonstrated to be effective (Morely et al 1999).
Pharmacist	As part of the multidisciplinary team pharmacists can evaluate medication regimens to guard against drug interactions, adverse effects and duplication in therapy. Pharmacists can also discuss preconceived fears associated with analgesic, assessing compliance and advising on appropriate compliance aids.
Occupational Therapist	Assessment and treatment is focused on enabling occupation, which in turn can lead to an improvement in quality of life.
Psychiatric Services	Anxiety and depression is common in chronic pain patients, and can be dealt with by psychology. Psychiatric opinion should be sought particularly in relation to management of suicide risk and resistant severe medical depression.

Key Challenges ~

- 1 *There is no commonly accepted standard multidisciplinary approach to chronic pain.*
- 2 *All practices may not have access to all disciplines, therefore, although not ideal, some roles may be interchangeable.*
- 3 *Ensuring a unified approach.*
- 4 *Understanding the limitations of each role in the team.*

Section 5 (i) Role of the Nurse

Key Points ~

- 1 Nurses undertake a variety of roles which should be viewed within the context of the multidisciplinary team. These can vary from running a Transcutaneous electrical nerve stimulator (TENS) clinic to clinical assessment, medication review and cognitive behavioural therapy.
- 2 Nurses require knowledge of both pharmacologic and non-pharmacologic interventions and the application of this knowledge through such activities as assessment, teaching, monitoring, patient self-management and co-ordinating care among health care providers.
- 3 Nurses are in an ideal position to focus on interventions that help the person take an active role in their care and maintain as much independence as possible.

Statement	Reasons for statement	How to demonstrate statement is being achieved
Nurses understand the need for regular pain assessment and reassessment, and have an awareness of the professional/legal responsibilities related to pain management.	Nurses routinely perform assessment of pain intensity and administration of analgesics. (McCaffery et al 2000, NMC 2004).	The nurse demonstrates clinical and interpersonal skills to assess and relieve pain and measures outcomes by clinical audit.
Nurses can implement a clinical management plan/care plan for the relief of pain in partnership with the patient and within the context of the multidisciplinary team.	Effective pain management is inextricably linked to decisions nurses are required to make in daily practice (Van Niekerk and Martin 2003, Pellino et al 2002).	There is evidence that an action plan/care plan has been formulated, implemented and evaluated.
Nurses demonstrate an ability to liaise successfully with other agencies.	Communication, collaboration and patient advocacy are fundamental nursing activities (NMC 2004).	The documentation reflects that the necessary agencies have been involved.

Key Challenges ~

- 1 *Understanding the breadth and limitations of the skills required to be an effective practitioner.*
- 2 *Providing sufficient time to spend with the person to undertake comprehensive assessment.*

Section 5 (ii) Role of physiotherapy

Key Points ~

- 1 *People with chronic pain often have problems with physical fitness.*
- 2 *Activity limitation (problems with the capacity to carry out tasks or actions), is often a problem for people with chronic pain.*
- 3 *Participation restriction (problems with performance or involvement in social situations), is often a problem for people with chronic pain.*
- 4 *Promotion of movement and exercise can maintain and improve physical fitness, activity and participation for people with chronic pain.*
- 5 *As independent practitioners, physiotherapists have an important role in assessing and managing patients with pain.*
- 6 *People with acute pain or chronic pain will routinely be referred to outpatient physiotherapy services in acute sites and community settings.*

Statement	Reasons for statement	How to demonstrate statement is being achieved
<p>Assessment of the impact of pain on function (physical fitness, activity and participation) is undertaken to assist with formulation of a management plan.</p> <p>The management plan includes reassessment and education; advice on pacing and goal setting; and facilitation of movement and exercise with the aim of optimising physical fitness, activity and participation.</p> <p>The person with chronic pain is involved in formulating the management plan to ensure that it is relevant to their needs.</p>	<p>Assessment of physical function is a crucial element in the formulation of an accurate diagnosis and effective treatment plan (Stroud et al 2004).</p>	<p>Documentation reflects that pain-related physical disability has been measured and used to influence the treatment plan.</p>

Key Challenges ~

- 1 *Physiotherapists need to apply a biopsychosocial approach to the management of chronic pain.*

"Increasingly in Scotland, patients can self-refer directly to physiotherapy without GP referral. Self-referral brings with it a responsibility to triage patients safely and efficiently. A key responsibility is to classify the nature of the patient's pain and instigate immediate appropriate management. For example, in Glasgow, 700 new patients present to physiotherapy each month with low back pain. Some of these patients will have neuropathic pain which requires specific medication and management. Physiotherapists can identify this condition and arrange appropriate medication via the GP often resulting in dramatic reduction in pain symptoms and minimising the chance of chronic pain developing".

Mr. M. McMenemy, Glasgow Backpain Service

Section 5 (iii): Role of psychology in the management of chronic pain

Key Points ~

- 1 *Psychological factors affect the neurophysiological and biochemical aspects of the pain experience (Price 1999) and can adversely affect the efficacy of established treatments (Wasan et al 2005).*
- 2 *Psychological approaches to the management of chronic pain include different interventions aimed at enabling an individual to develop strategies to manage their thinking, behaviour and emotion in response to pain.*
- 3 *Psychological approaches can be on three levels (Mowbray 1989).*
 - Level one - (all clinicians)*
basic understanding of psychological principles, skills eg good therapeutic relationship, listening skills.
 - Level two (specifically trained clinicians)*
application of psychological techniques described by protocol (can be to high level) eg relaxation, Cognitive Behavioural Therapy (CBT) principles, Pain Management Programme (PMP) training to agreed competency essential and ongoing supervision from psychologist to ensure continuing competence.
 - Level three (clinical and applied psychologists)*
application of psychological principles and theories. Discretionary component in decisions as to what to use and when.
Complex cases, individual, group and group processes, training others.
Complex issues such as severe depression, post-traumatic stress response, vulnerability due to previous life experiences, will influence pain experience and should only be dealt with by someone working at level 3.

Statement	Reasons for statement	How to demonstrate statement is being achieved
Psychological interventions can be provided by individuals at specified levels of competence with appropriate supervision, to enable an individual to develop their thinking, behaviour and emotion in response to chronic pain.	Poorly managed chronic pain can generate feelings of distress, hopelessness and despair, psychological interventions have been demonstrated to be effective (Morely et al 1999).	There is documented evidence that the patient has been offered evidence-based psychological intervention.
Patients receive cognitive behavioural treatments to help them cope with pain-related psychosocial problems.	Cognitive behavioural strategies can restore a sense of control and improve coping ability for people with chronic pain (Vlaeyen & Morley 2005, Morley et al 1999).	Documented evidence suggests cognitive behavioural strategies have been considered.

Statement	Reasons for statement	How to demonstrate statement is being achieved
Complex psychological presentations eg suicidal ideation, post traumatic stress disorder, influence of previous abuse, is managed by clinical psychologist within pain team, or referred to appropriate mental health service.	These factors will have a significant impact on outcomes and pain experience, and require appropriate training in order to provide safe treatment. (D.O.H. 2001, Treatment choice in psychological therapies and counselling)	Documented evidence of referral to appropriately qualified person/service.

Key Challenges ~

- 1 *Providing appropriate training and supervision for those working with psychological principles (level 2).*
- 2 *Accessing adequate resources for psychological services locally and timeously (level 3).*
- 3 *Adapting cognitive behavioural strategies to meet the needs of people with cognitive impairments.*
- 4 *Dealing with patients who are not ready to embrace a psychological approach to pain management.*

Section 5 (iv): Role of Occupational Therapy

Key Points ~

- 1 *The focus of intervention is the promotion of occupation. Occupation is defined as 'daily activities that reflect cultural values, provide structure to living and meaning to individuals; these activities meet human needs for self-care, enjoyment and participation in society' (COT2 2004).*
- 2 *Assessment of the person's occupational performance should be undertaken within any assessment.*
- 3 *A treatment plan should be identified with joint goal-setting*
- 4 *The person should be educated on goal-setting principles and pacing techniques as tools to participation in occupations relevant to his/her life.*

Statement	Reasons for statement	How to demonstrate statement is being achieved
Assessment and treatment is focused on enabling occupation, which can lead to an improvement in quality of life.	An occupational behavioural model provides a holistic picture of the person with chronic pain. A rehabilitative approach to be taken with emphasis on re-establishing order in the occupational functioning of the individual patient (Strong 1996).	The person's progress is documented and performance monitored with regular review. Appropriate outcome measures are completed before and after occupational therapy (Law et al 1991).
Intervention is undertaken within the framework of a multidisciplinary approach to pain management.	A multidisciplinary team approach to chronic pain is cost effective (Waddell 1996).	The occupational therapist has read and complies with the National Occupational Therapy Pain Association Guidelines on the Role of Occupational Therapy and Minimum Requirements for Practice (Pain Society, 2001).

Key Challenges ~

- 1 *The provision of equipment and adaptations must promote functional ability and not reinforce functional disability.*
- 2 *Addressing social barriers (physical, organisational, cultural and attitudinal) to occupational performance.*
- 3 *Considering the management of risk when promoting occupational performance.*

Section 5 (v): Psychiatric Services

Key Points ~

- 1 Anxiety and depression are common in chronic pain patients, and can be addressed by psychology services. Psychiatric opinion should be sought, particularly, in relation to management of suicide risk and resistant severe medical depression.*
- 2 Illness behaviour can affect pain patients' clinical presentation.*
- 3 Somatoform Disorder can present in a pain clinic.*

Key Challenges ~

- 1 Assessing patients in a sensitive and non-confrontational manner where patients may be defensive about psychiatric contact.*

Section 6: Pain management programmes

Key Points ~

- 1 *People with chronic pain need the knowledge and skills to be actively involved in self-management of their condition.*
- 2 *Family support can be an important factor in the rehabilitation of people with chronic pain.*
- 3 *Pain management programmes require close interdisciplinary working with all staff engaging the principles of cognitive behavioural therapy.*
- 4 *The aims of pain management programmes are to:*
 - *improve people's understanding of chronic pain and the relationship between pain, emotion and behaviour*
 - *improve people's level of physical, social, practical and emotional functioning and confidence*
 - *reduce fear of movement*
 - *provide coping strategies for dealing with their disability and distress*
 - *promote autonomy and independence*
 - *reduce or modify the person's future use of healthcare resources eg GP appointments, medication.*

Statement	Reasons for statement	How to demonstrate statement is being achieved
Pain management programmes include all aspects of pain, the treatment of pain, pain perception, psychological and social factors.	Pain management education programmes have been shown to reduce pain, anxiety, depression, improve treatment adherence and facilitate return to work (Olason 2004).	Pre and post-programme assessments are completed.
Carers or family members are actively involved in the management of chronic pain and the person's rehabilitation.	Chronic pain affects important basic relationships including emotional and physical intimacy (Smith 2003).	The patient and the family/carer report improved quality of life.

Key Challenges ~

- 1 *Ensuring pain management programmes meet the desirable criteria set by the British Pain Society, (1997, currently under review), including minimum staffing*
- 2 *Ensuring pain management programmes are accessible to all who require them via referral to specialist pain management clinic (McEwen Report 2004).*
- 3 *Ensuring appropriate patient selection.*
- 4 *Accessing pain management programmes.*

Resource: www.britishpainsociety.org/pdf/desirable.pdf

Section 7: Self-management/support groups

Key Points ~

- 1 *Some self-management groups offering self-management and training can promote ways of coping with chronic pain and improve self-efficacy (Lorig et al 1999).*
- 2 *Mutual support and group encouragement can improve the person's coping abilities.*
- 3 *Self-management/support groups can reduce social isolation.*
- 4 *Self-management/support groups can complement statutory services by offering support between appointments and by offering long-term follow-up support.*

Statement	Reasons for statement	How to demonstrate statement is being achieved
<p>People with chronic pain will be informed of any local self-management/support groups or organisations to facilitate their coping skills and access ongoing support.</p>	<p>People with chronic pain who choose to join self-management/support groups report the benefits as:</p> <ul style="list-style-type: none"> • an opportunity to receive information • an opportunity to get a deeper, different sort of understanding that can be obtained from friends, family and health professionals • overcoming a sense of isolation • learning from others with chronic pain • helping others and socialising (Subramaniam et al 1999). 	<p>There is evidence that the patient and the carer have received information on how to access self-management /support groups.</p> <p>There is evidence of an up to date directory of self management groups/support groups available in the area.</p>

Key Challenges ~

- 1 *Self-management/support groups require active leadership.*
- 2 *Health professional involvement in self-management/support groups can influence the direction of the group.*
- 3 *Ensuring successful integration with the health care team.*

Resources:

www.painassociation.com
www.painconcern.org.uk

Section 8: Chronic pain ‘flare-ups’/exacerbations

Key Points ~

- 1 *People with chronic pain will experience fluctuations in their pain intensity.*
- 2 *Chronic pain ‘flare-ups’ can last for varying periods of time from a few seconds to several hours.*

Statement	Reasons for statement	How to demonstrate statement is being achieved
People with chronic pain are aware that they may experience occasional periods of fluctuation in pain intensity.	Patients with persistent non-cancer pain may present with acute exacerbations of pain (British Pain Society 2004).	People with chronic pain demonstrate effective coping mechanisms during fluctuations in pain intensity.
The possibility of ‘flare-ups’ is included in patient education sessions.	Peripheral and/or central sensitisation may play a role in many cases of breakthrough pain in chronic non-malignant pain (Svensden et al 2005).	People with chronic pain are aware of their own pain-activating triggers.
People with chronic pain have sufficient knowledge to manage their analgesic medicines and employ personal coping strategies to manage fluctuations of pain intensity.		

Key Challenges ~

- 1 *Recognising and diagnosis of an episode of ‘flare-up’.*
- 2 *People with chronic pain who experience a ‘flare-up’ may avoid physical activity.*
- 3 *People who are experiencing a ‘flare-up’ may adopt negative thoughts.*
- 4 *Ensuring awareness that ‘flare-ups’ may be influenced by behavioural activity patterns.*
- 5 *There is patient-led demand for an action plan for the management of flare-ups.*
- 6 *There is a need for research into the value of an action plan in the management of ‘flare-ups’ of pain.*

Section 9: Specific challenges (i): chronic pain and the older adult

Key Points ~

- 1 *Chronic pain is highly prevalent in older people (Gagliese & Melzack 2003, Elliott et al 1999).*
- 2 *Pain is poorly managed in older people (Proctor & Hirdes 2001, Bernabei et al 1998, Closs 1994).*
- 3 *Pain is often a part of a complex picture including concurrent medical conditions.*

Statement	Reasons for statement	How to demonstrate statement is being achieved
Older people who report pain are routinely assessed using a formalised pain assessment tool as part of initial evaluation following referral to any healthcare professional.	Chronic pain is not an inevitable consequence of ageing, however, pain may be a consequence of other chronic conditions (American Geriatric Society 1998).	Formalised pain assessment tools are available for use by all health professionals.
Any pain reported is recognised as a problem.	Pain in the older adult is poorly assessed and managed (Proctor & Hirdes 2001, Closs 1994).	There is evidence of pain assessment within the patients' records.

Key Challenges ~

- 1 *Ensuring sufficient time to undertake accurate assessment.*
- 2 *An older person may be unwilling to acknowledge pain due to misconceptions that pain is a part of ageing (Closs 2004).*
- 3 *Overcoming communication difficulties. Repeating or rephrasing questions can improve response (Closs et al 2004).*
- 4 *Unqualified staff provide direct care to elderly residents in nursing homes. They may not be educationally prepared to undertake many complex tasks including those involved in pain management (Horgas & Dunn 2001, Higgins et al 2004).*

Specific challenges (ii): chronic pain and the person with learning disabilities including cognitive impairment

Key Points ~

- 1 *People with profound learning disabilities may be unable to communicate verbally therefore pain assessment tools that rely on self-report using language are inadequate (Davis & Evans 2001).*
- 2 *Psychological distress can occur if pain is not acknowledged.*
- 3 *The caring relationship with the client is important for the identification of behavioural changes associated with pain (Donovan 2002).*
- 4 *Use of non-verbal communication methods and non-traditional methods require specialist skills, patience and interpretation.*

Statement	Reasons for statement	How to demonstrate statement is being achieved
People with learning disabilities have the right to have their pain managed.	Deficiencies have been highlighted in the treatment of pain in people with learning disabilities (CSAG 1999).	Local practice guidelines for the management of pain in people with learning disabilities exist.
Locally agreed tools to assist in the assessment of pain in people with learning disabilities are available and used.	Pain assessment for this care group relies on behavioural indicators and facial expression (McGrath et al 1998).	There is evidence that referral advice has been sought from learning disabilities services.

Key Challenges ~

- 1 *Behaviour that indicates pain in the general population may be inconsistent and difficult to interpret in those with profound learning disabilities (McGrath et al 1998).*
- 2 *Ensuring practitioners do not make assumptions about the causes of pain.*
- 3 *Acknowledging that people with learning disabilities often experience ongoing pain from a variety of other disabilities.*

Specific challenges (iii): management of sleep in people with chronic pain

Key Points ~

- 1 70% of people with chronic pain report impaired sleep (Morin et al 1998).
- 2 Pain causes lighter/disturbed sleep and can interfere with the ability to initiate or maintain sleep.
- 3 Poor sleep may be a contributing factor to the perception of pain intensity.

Statement	Reasons for statement	How to demonstrate statement is being achieved
<p>Patients with chronic pain who report sleep disturbance undergo accurate evaluation of the reported symptoms.</p> <p>Advice is given to people with chronic pain on how to address problems with sleep disturbance.</p>	<p>25% of people with chronic pain report that pain disrupts their sleep at least 10 nights per month (Lamberg 1999).</p>	<p>The patient demonstrates skill in techniques that enhance restful sleep.</p>

Key Challenges ~

- 1 *Managing sleep disturbance which may be a consequence of and a contributing factor to chronic pain.*
- 2 *Treating depression which can be associated with sleep disturbance.*
- 3 *Optimising analgesic medication and managing side-effects that can interfere with sleep.*
- 4 *Accessing cognitive behavioural interventions that specifically target insomnia (Smith et al 2000).*

Specific challenges (iv): spiritual needs associated with chronic pain

Key Points ~

- 1 *Spirituality is a basic human phenomenon that allows the creation of a meaning and purpose in life.*
- 2 *Chronic pain may be associated with endless, meaningless suffering*
- 3 *The person's spiritual beliefs can influence their health beliefs and sense of well-being*

Statement	Reasons for statement	How to demonstrate statement is being achieved
Emotional, psychological, social and spiritual aspects of chronic pain are addressed.	Uncontrolled pain can cause suffering and loss of self-esteem (Chapman & Gavrin 1999, Bullington et al 2003).	The person's spiritual needs form part of the overall management plan and are assessed sensitively.
Spiritual care is given in a one-to-one relationship, is completely person-centred and makes no assumptions about personal conviction or life orientation (NHS HDL 2002 76).	Spiritual issues related to the suffering of chronic pain can involve a reaction between emotions such as fear, guilt, anger, loss and despair. It may appear inseparable from physical pain and can influence the way pain is expressed. The NHS must offer both spiritual and religious care with equal skill and enthusiasm (NHS HDL 2002 76).	Local resources for spiritual support are accessed with the person's permission. The person displays the desire and ability to get on with life.

Key Challenges ~

- 1 *The concept of spiritual pain requires practitioners to go beyond the bounds of clinical treatments and be prepared to devote the time required to give supportive and understanding care.*
- 2 *Including the spiritual aspects of pain in the holistic assessment.*
- 3 *Spiritual care is not necessarily religious. Religious care, at its best, should always be spiritual (NHS HDL 2002 76).*

Resource: http://www.show.scot.nhs.uk/sehd/mels/HDL2002_76.pdf

Specific Challenges (v): chronic pain and sexuality

Key Points ~

- 1 *People who experience chronic pain may report a deterioration or cessation of sexual activity.*
- 2 *People with chronic pain may fear an exacerbation of pain during sexual activity.*
- 3 *Pharmacological agents commonly used in the treatment of pain can diminish libido and inhibit sexual function.*
- 4 *Depression commonly linked with chronic pain can contribute to loss of libido.*
- 5 *Time should be allocated to discuss this aspect of care in private.*

Statement	Reasons for statement	How to demonstrate statement is being achieved
Assessment of sexual function is included in the multidimensional assessment of people with chronic pain.	There is a high incidence of sexual dysfunction reported by people living with chronic pain (Ambler et al 2001).	Multidimensional assessment including sexual function has been carried out if necessary.
When starting new pharmacological agents for the treatment of chronic pain the patient is informed of potential effects of the medicines.	Many medicines used to treat chronic pain are known to inhibit sexual function (Paice 2003).	People with chronic pain receive information on the drug treatments initiated and are educated on the potential side-effects. There is evidence to show that any sexual dysfunction has been addressed.

Key Challenges ~

- 1 *Avoiding the assumption that the identification of sexual difficulties means that the individual wishes to access help.*
- 2 *Recognising that physiological changes can alter sexuality in people with chronic pain.*
- 3 *Acknowledging patients and professionals are often uncomfortable discussing sexual issues.*

Specific Challenges (vi): chronic pain and the workplace

Key Points ~

- 1 *People with chronic pain are at increased risk of work loss and disability, and the longer they are absent from work, the less likely they are to return (Waddell 1998).*
- 2 *People living in areas of social deprivation, where unemployment may be higher, are more likely to suffer chronic pain.*
- 3 *Information on the Disability Discrimination Act (2005) can be obtained from <http://www.disability.gov.uk/dda/employers/employers.asp>*

Key Challenges ~

- 1 *If chronic pain is linked to a work-related injury there may be ongoing compensation issues.*
- 2 *People may be reluctant to return to work as they may lose financial support.*
- 3 *A staged approach for return to work may need to be negotiated with the employer.*
- 4 *To liaise with occupational health departments to facilitate return to work.*

Section 10: Use of complementary therapies in the management of chronic pain

Key Points ~

- 1 *Many people with chronic pain source complementary therapies.*
- 2 *Various definitions of complementary therapies exist.*
- 3 *There has been an increase in the use of complementary therapies for pain-related problems (Rao et al 1999, Haetzmann et al 2003).*
- 4 *Non-pharmacological interventions must not be seen as a substitute for pharmacological agents.*
- 5 *The interaction between the patient and healthcare professional may be an important mediator in treatment outcome.*
- 6 *Transcutaneous Electrical Nerve Stimulation (TENS) and acupuncture are commonly used for the relief of chronic pain.*

Statement	Reasons for statement	How to demonstrate statement is being achieved
Assessment of patients' use of complementary therapies is included in the comprehensive assessment.	There is evidence to suggest that some complementary therapies have a positive effect on chronic pain (Snyder & Wieland 2003, Stephenson & Dalton 2003).	Documentation reflects that consideration of complementary therapies has been included in the patient's assessment.
Assessment of the patient's suitability and a trial of TENS should be considered in managing chronic pain.	The use of TENS has been shown to be effective in the management of chronic pain if used correctly and for a sufficient duration (Johnson 2000). Patient education can influence the success of TENS therapy (Mitchell & Kafai 1997).	A trial of TENS is offered to the patient. The patient demonstrates an understanding of the TENS machine.

Key Challenges ~

- 1 *Ensuring a balanced attitude towards the use of complementary therapies is conveyed.*
- 2 *Recognising that some complementary therapies may be unsuitable for people with chronic pain who are considered psychologically unstable.*
- 3 *Ensuring patients understand how a TENS machine works to maximise the benefit.*

NB: TENS and acupuncture can be provided by healthcare professionals but it must be acknowledged that people may access these treatments from other sources.

Section 11: Chronic pain and culture

Key Points ~

- 1 Pain has both personal and cultural interpretations.
- 2 Verbal and non-verbal communications differ between cultures.

Statement	Reasons for statement	How to demonstrate statement is being achieved
Health professionals demonstrate sensitivity to the influence of culture on pain perceptions and pain behaviours.	Cross-cultural differences in the meaning of and coping with pain have been reported (Cleland et al 2005, Callister 2003, Lasch 2000).	Patient assessment and management reflects culturally appropriate care.

Key Challenges ~

- 1 Ensuring health professionals are sensitive to the influence of a person's cultural background on pain perceptions and behaviours, and are aware that there are differences in the pain experience between individuals in cultural groups

Section 12: Education for Healthcare Professionals

Key Points ~

- 1 *Healthcare professionals should be prepared to meet patients' desire for information about chronic pain and its management.*
- 2 *Lack of knowledge by healthcare professionals is one reason for the inappropriate treatment of chronic pain.*
- 3 *Education should reflect that chronic pain is a multidimensional phenomenon, which cuts across professional boundaries.*

Statement	Reasons for statement	How to demonstrate statement is being achieved
The principles of chronic pain assessment and management are included in educational programmes for health professionals at pre and post registration levels.	Chronic pain is a multidimensional phenomenon, which cuts across all professional boundaries. There is an educational gap relating to care for people with chronic pain (Jones et al 2001).	A record of healthcare professionals who attend pain management education is available. Healthcare professionals are equipped with the knowledge to care for people with chronic pain.
Education programmes reflect the multidimensional nature of chronic pain.	Healthcare professionals must be prepared for practice (Sohn & Cook 2002).	As a minimum requirement changes in knowledge and/or skills are assessed; attempts are made to assess changes in attitudes and beliefs; ideally changes in patient/client outcomes are addressed.

Key Challenges ~

- 1 *Ensuring education addresses the knowledge, skills and confidence required to deliver effective pain management in a multiprofessional environment.*
- 2 *Professionals' attitudes and beliefs, and organisational barriers may hamper pain management practice independently of professionals' knowledge.*
- 3 *Ensuring the educational needs of social care professionals who come into contact with people with chronic pain are addressed.*

Additional Information

Integration of Pain Services

Situations where acute pain services and chronic pain management services will overlap

Key Points ~

- 1 *Specific analgesic interventions may reduce the incidents of chronic pain after surgery.*
- 2 *Chronic post-surgical pain is common, may be severe and lead to significant disability.*
- 3 *Risk factors which are predisposed to chronic post-surgical pain include the severity of pre or post-operative pain, intraoperative nerve injury and psychological vulnerability.*
- 4 *Many patients suffering from chronic pain relate this to an acute incident.*
- 5 *Chronic severe pain is common after surgery (Macrae 2001). Such pain may have a neuropathic element which may appear early in the post-operative period.*
- 6 *Chronic pain patients requiring treatment for acute pain present a special challenge.*

Incidence of Chronic Pain after Surgery

Type of operation	Incidence %
Amputation	30 - 85
Thoracotomy	5 - 67
Mastectomy	11 - 57
Cholecystectomy	3 - 56
Inguinal hernia	0 - 63
Vasectomy	0 - 37

Adapted from Macrae 2001, Perkins and Kehlet 2000

Palliative care and chronic pain

Situations where chronic pain and palliative care will overlap

Key Points ~

- 1 The principles underlying the management of chronic pain and the palliative care of patients with cancer have much in common (SIGN Guideline 44, NHS QIS 2000).*
- 2 This includes the palliative management of non-malignant disease where pain may be a major issue eg HIV, multiple sclerosis.*
- 3 The best results are likely to be achieved where there are good local links between palliative care, pain management services and the local community.*
- 4 A significant number of cancer patients will not achieve optimal pain relief with the WHO guidelines either due to the drug or unacceptable side-effects.*
- 5 For patients where standard treatments have failed, interventional techniques may be required and referral to a pain management service for advice would be appropriate (SIGN Guideline 44).*

Key Challenges ~

- 1 To ensure that health professionals looking after such patients are aware of the range of techniques available and when these are appropriate.*
- 2 To achieve adequate rapid access to specialist pain services (McEwen 2004).*

Determining pain in people who have difficulty communicating and may be cognitively impaired: behavioural signs

Categories	<p>Behavioural signs <i>Behaviours are unique to each individual; knowledge of the person's 'baseline' behaviour is helpful and can assist in recognising behaviour which indicates the person is experiencing pain.</i></p>
Vocal signs	A specific sound or vocalisation for pain – a cry or word, eg moaning, whining, whimpering, crying, screaming.
Eating/sleeping	Eats less. Not interested in food. Increase in sleep. Decrease in sleep.
Social/personality	Not co-operating. Irritable. Unhappy. Less interaction. Withdrawn. Seeks comfort. Seeks physical closeness. Difficult to distract. Cannot be satisfied or pacified.
Facial expressions	Crying, grimacing has furrowed brow. Eyes closed tight, eyes open wide, frowning. Mouth turned down, not smiling, tight pout or quiver, clenches teeth, grinds teeth, chews, thrusts tongue.
Activity	Not moving, less active, quiet, jumping around, fidgety, agitated.
Body and limbs	Floppy, stiff, tense, has spasticity or rigidity, gestures to or touches part of body that hurts, projects, favours or guards part of body that hurts, flinches or moves body part away, sensitive to touch, moves body in a specific way – curls up, head back or arms may be down.
Physiological	Shivering, changes in colour, pallor, sweating, tears, sharp intake of breath, gasping, breath-holding.

Adapted from McGrath et al (1998).

Examples of unconventional analgesics (Adjuvants)

Type of Drug	Example	Prescribing notes/Patient information	Monitoring notes
Tricyclic antidepressants should be considered for Neuropathic pain.	Amitypyline Imipramine Nortrypyline	<ul style="list-style-type: none"> <input type="checkbox"/> Start with a low dose and gradually increase. <input type="checkbox"/> The analgesic effect appears within the first few days of therapy. <input type="checkbox"/> There is a dose-response curve to analgesic effects of tricyclic antidepressants. 	There may be a reduction in opioid requirement reported.
Selective Serotonin Re-uptake inhibitors (SSRIs)	Citalopram	<ul style="list-style-type: none"> <input type="checkbox"/> Chronic pain may be an unlicensed indication for most of these medicines and the patient information leaflet, which is issued at the point of dispensing, may not contain relevant information for the condition being treated. <p>The information provided may be confusing.</p>	
Serotonin Noradrenaline Re-uptake inhibitors (SNRIs)	Venlafaxine		
Anticonvulsants should be considered for neuropathic pain.	Carbamazepine Gabapentin	<ul style="list-style-type: none"> <input type="checkbox"/> Antidepressants and anticonvulsants have a similar efficacy in the treatment of neuropathic pain. Choice is based on patient factors and concurrent medication. <input type="checkbox"/> Different anticonvulsants have different mechanisms of action. If one is ineffective it may be worth considering trial of another. 	<p>When the patient has sustained pain relief for 3 months, a slow dose reduction should be attempted to see if the anticonvulsant could be discontinued.</p> <p>Liver function should remain within normal limits whilst receiving anticonvulsant therapy.</p>

SSRIs are thought to be less effective for the relief of neuropathic pain than tricyclic antidepressants or SNRIs (Sindrup et al 2005).

Use of opioids in the management of chronic non-malignant pain

Key Issues ~

- 1 Strong opioids should *not* be considered as first line treatments for chronic pain.
 - 2 Some people with chronic non-malignant pain can benefit from the use of oral opioids.
 - 3 Thorough attention to diagnosis and patient history must precede any decision to prescribe opioids.
 - 4 Patients should be deemed psychologically stable with specific regard to addiction issues.
 - 5 The person with chronic pain and their doctor should agree beforehand on how to assess the outcome of therapy.
 - 6 Sustained release opioid preparations are the drug of choice
 - 7 An immediate release preparation may be required to manage breakthrough/flare-up pain.
 - 8 A trial of therapy, with goals and endpoint agreed between the person with chronic pain and their doctor, should precede any decision to prescribe opioids in the long term.
-

Informed consent should:

- stress that oral opioids are only one part of the treatment plan, and that data is lacking on the long-term effects of medically prescribed opioids.
- clearly define specific goals of the treatment program.
- warn of the potential for cognitive impairment which may affect driving ability, especially while commencing opioid therapy and around the time of dose escalation.
- point out the increased likelihood of sedation if benzodiazepines and/or alcohol are used in conjunction with opioid therapy.
- stress that patients must accept responsibility for:
 - o ensuring their supply of medication does not run out after hours;
 - o security of their medication;
 - o keeping review appointments;
 - o using only one doctor to supply this medication.

- *explain the consequences of aberrant behaviour as clearly as possible.*
- *explain the indications for ceasing treatment with opioids:*
 - o *lack of improvement in function, or evidence of deterioration in function;*
 - o *unsanctioned dose escalation and requests for early repeat prescriptions;*
 - o *losing prescriptions;*
 - o *unapproved use of the drug to treat other symptoms.*
- *discuss side-effects and their management (eg constipation, nausea, sedation, dry mouth, urinary hesitancy, and depression of sex hormones, with associated risk of osteoporosis with long-term use).*
- *the possibility (for women) of physical dependence in children born to them if they continue to take opioids in late pregnancy.*

Specialist Services: The Pain Management Clinic

Key Points ~

- 1 *Referral to a pain clinic should be considered after appropriate treatment strategies have proved unsuccessful.*
- 2 *When the patient has difficult-to-control pain.*
- 3 *When there are complex psychosocial influences in the pain presentation.*
- 4 *Professional roles in pain management clinics may vary.*

At a pain clinic, patients will usually be seen by a pain medicine specialist and be offered a more comprehensive and specialised assessment that is likely to be multi-disciplinary. Disciplines represented vary, but may include specialist nursing, specialist pain physiotherapist, pain medicine specialist, occupational therapist, pharmacist and clinical pain psychologist (level 3). Professional roles in these clinics may vary.

The key to effective management, namely appropriate assessment, functional restoration and a biopsychosocial approach, underpin any pharmacological or invasive therapies undertaken. **The key to success is patient involvement.**

A multidisciplinary management plan should be developed for appropriate patients. Medication review is an important part, considering the appropriateness of existing medicines, withdrawing or reducing or introducing new medicines. This may be complemented with non-invasive therapies.

The management plan may include interventional therapies, but rarely in isolation. Good resources for information about these include:

- An evidence based resource for interventional pain management www.wacc.co.nz/ipm
- The British Pain Society www.britishpainsociety.org

Key Challenges ~

- 1 *The patient understands why they are being referred to the pain clinic.*
- 2 *An appropriate medical assessment should have taken place.*
- 3 *A **complete** referral letter should be sent (SIGN Guideline 31).*
- 4 *Realistic expectations should be encouraged.*
- 5 *Treatment at a pain clinic should be limited with discharge back to primary care with community support where appropriate.*

Common interventional procedures

Summary of common interventional procedures in specialist pain management clinics

Procedure	Indication	Comment
Muscle trigger spots Localised intramuscular injection	For localised myofascial pain Painful muscle spasm	Local anaesthetic with or without steroid. Botulinum toxin is sometimes used
Neuroma or scar infiltration	Post-operative or post trauma pain	Local anaesthetic with or without steroid. Rarely cryo-analgesia
Peripheral nerve blocks	Greater occipital nerve for headaches Intercostal nerve for chest wall pain Numerous other limb and trunk blocks	Local anaesthetic with or without steroid
Joint injections	Facet joints for backpain Intra articular hip injections for osteoarthritis	Local anaesthetic with or without steroid With or without opioid
Regional blocks	Epidural steroid injections for radicular referred pain, usually leg pain	Local anaesthetic with or without steroid
Sympathetic blocks	Stellate ganglion injection for angina, Coeliac Plexus Block for abdominal pain, eg pancreatic malignancy	Local anaesthetic
	Blocks for Complex Regional Pain Syndrome	Local anaesthetic with or without guanethidine

Less common procedures:

Procedure	Indication	Comment
Epidural or intrathecal drug delivery systems via short or long-term catheter. These can be administered via external pumps or by internalised reservoirs.	More commonly used in the management of cancer pain or severe muscle spasm	Local anaesthetic Opioid Lioresal

Appendix 1 Examples of tools and assessment domains

Sample 1: Doloplus-2 Scale

NAME :		Christian Name :	Unit :	DATES			
Behavioural Records							
SOMATIC REACTIONS							
1 • Somatic complaints	• no complaints	0	0	0	0		
	• complaints expressed upon inquiry only	1	1	1	1		
	• occasional involuntary complaints	2	2	2	2		
	• continuous involuntary complaints	3	3	3	3		
2 • Protective body postures adopted at rest	• no protective body posture	0	0	0	0		
	• the patient occasionally avoids certain positions	1	1	1	1		
	• protective postures continuously and effectively sought	2	2	2	2		
	• protective postures continuously sought, without success	3	3	3	3		
3 • Protection of sore areas	• no protective action taken	0	0	0	0		
	• protective actions attempted without interfering against any investigation or nursing	1	1	1	1		
	• protective actions against any investigation or nursing	2	2	2	2		
	• protective actions taken at rest, even when not approached	3	3	3	3		
4 • Expression	• usual expression	0	0	0	0		
	• expression showing pain when approached	1	1	1	1		
	• expression showing pain even without being approached	2	2	2	2		
	• permanent and unusually blank look (voiceless, staring, looking blank)	3	3	3	3		
5 • Sleep pattern	• normal sleep	0	0	0	0		
	• difficult to go to sleep	1	1	1	1		
	• frequent waking (restlessness)	2	2	2	2		
	• insomnia affecting waking times	3	3	3	3		
PSYCHOMOTOR REACTIONS							
6 • washing &/or dressing	• usual abilities unaffected	0	0	0	0		
	• usual abilities slightly affected (careful but thorough)	1	1	1	1		
	• usual abilities highly impaired, washing &/or dressing is laborious and incomplete	2	2	2	2		
	• washing &/or dressing rendered impossible as the patient resists any attempt	3	3	3	3		
7 • Mobility	• usual abilities & activities remain unaffected	0	0	0	0		
	• usual activities are reduced (the patient avoids certain movements and reduces his/her walking distance)	1	1	1	1		
	• usual activities and abilities reduced (even with help, the patient cuts down on his/her movements)	2	2	2	2		
	• any movement is impossible, the patient resists all persuasion	3	3	3	3		
PSYCHOSOCIAL REACTIONS							
8 • Communication	• unchanged	0	0	0	0		
	• heightened (the patient demands attention in an unusual manner)	1	1	1	1		
	• lessened (the patient cuts him/herself off)	2	2	2	2		
	• absence or refusal of any form of communication	3	3	3	3		
9 • Social life	• participates normally in every activity (meals, entertainment, therapy workshop)	0	0	0	0		
	• participates in activities when asked to do so only	1	1	1	1		
	• sometimes refuses to participate in any activity	2	2	2	2		
	• refuses to participate in anything	3	3	3	3		
10 • Problems of behaviour	• normal behaviour	0	0	0	0		
	• problems of repetitive reactive behaviour	1	1	1	1		
	• problems of permanent reactive behaviour	2	2	2	2		
	• permanent behaviour problems (without any external stimulus)	3	3	3	3		
COPYRIGHT				SCORE			



DOLOPLUS-2 SCALE : LEXICON

Somatic complaints

The patients expresses pain by word, gesture, cries, tears or moans.

Protective body postures adopted at rest

Unusual body positions intended to avoid or relieve pain.

Protection of sore areas

The patient protects one or several areas of his/her body by a defensive attitude or gestures.

Expression

The facial expression appears to express pain (grimaces, drawn, atonic) as does the gaze (fixed gaze, empty gaze, absent, tears).

Investigation

Any investigation whatsoever (approach of a caregiver, mobilization, care procedure, etc.).

Washing/dressing

Pain assessment during washing and/or dressing, alone or with assistance.

Mobility

Evaluation of pain in movement: change of position, transfer, walking alone or with assistance.

Communication

Verbal or non-verbal.

Social life

Meals, events, activities, therapeutic workshops, visits, etc.

Problems of behaviour

Aggressiveness, agitation, confusion, indifference, lapsing, regression, asking for euthanasia, etc.

DOLOPLUS-2 SCALE : INSTRUCTIONS FOR USE

1 • Scale use requires learning

As is the case with any new instrument, it is judicious to test it before circulating it. Scale scoring time decreases with experience (at most a few minutes). Where possible, it is of value to appoint a reference person in a given care structure.

2 • Pluridisciplinary team scoring

Irrespective of the health-care, social-care or home structure, scoring by several caregivers is preferable (physician, nurse, nursing assistant, etc.). At home, the family and other persons can contribute using a liaison notebook, telephone or even a bedside meeting. The scale should be included in the 'care' or 'liaison notebook' file.

3 • Do not score if the item is inappropriate

It is not necessary to have a response for all the items on the scale, particularly given an unknown patient on whom one does not yet have all the data, particularly at psychosocial level. Similarly, in the event of coma, scoring will be mainly based on the somatic items.

4 • Compile score kinetics

Re-assessment should be twice daily until the pain is sedated, then at longer intervals, depending on the situation. Compile score kinetics and show the kinetics on the care chart (like temperature or blood pressure). The scale will thus become an essential argument in the management of the symptom and in treatment initiation.

5 • Do not compare scores on different patients

Pain is a subjective and personal sensation and emotion. It is therefore of no value to compare scores between patients. Only the time course of the scores in a given patient is of interest.

6 • If in doubt, do not hesitate to conduct a test treatment with an appropriate analgesic

It is now accepted that a score greater than or equal to 5/30 is a sign of pain. However, for borderline scores, the patient should be given the benefit of the doubt. If the patient's behavior changes following analgesic administration, pain is indeed involved.

7 • The scale scores pain and not depression, dependence or cognitive functions

Numerous instruments are available for each situation. It is of primary importance to understand that the scale is used to detect changes in behavior related to potential pain. Thus, for items 6 and 7, we are not evaluating dependence or independence but pain.

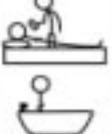
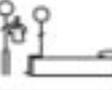
8 • Do not use the DOLOPLUS 2 scale systematically

When the elderly patient is communicative and cooperative, it is logical to use the self-assessment instruments. When pain is patent, it is more urgent to relieve it than to assess it ... However, if there is the slightest doubt, hetero-assessment will avoid underestimation.

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Sample 2: NoPain - Non-Communicative Patient's Pain Assessment Instrument

NOPPAIN (Non-Communicative Patient's Pain Assessment Instrument) Activity Chart Check List				Name of Evaluator _____ Name of Resident: _____ Date: _____ Time: _____			
DIRECTIONS: Nursing assistant should complete at least 5 minutes of daily care activities for the resident while observing for pain behaviors. This form should be completed immediately following care activities							
		Did you do this? <small>(Check Yes or No)</small>	Did you see pain when you did this? <small>(Check Yes or No)</small>			Did you do this? <small>(Check Yes or No)</small>	Did you see pain when you did this? <small>(Check Yes or No)</small>
(a) Put resident in bed OR saw resident lying down		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	(f) Fed resident		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
(b) Turned resident in bed		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	(g) Helped resident stand OR saw resident stand		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
(c) Transferred resident (bed to chair, chair to bed, standing or wheelchair to toilet)		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	(h) Helped resident walk OR saw resident walk		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
(d) Sat resident up (bed or chair) OR saw resident sitting		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	(i) Bathed resident OR gave resident sponge bath		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
(e) Dressed resident		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	REMEMBER: Make sure to ASK THE PATIENT if he/she is in pain!			

Pain Response/Responsibility (What did you see and hear?)

Pain Words? • "That hurts!" • "Ouch!" • Cursing • "Stop that!"  <input type="checkbox"/> YES <input type="checkbox"/> NO How intense were the pain words? 0 1 2 3 4 5 <small>Lowest Possible Intensity Highest Possible Intensity</small>	Pain Faces? • grimaces • winces • furrowed brow  <input type="checkbox"/> YES <input type="checkbox"/> NO How intense were the pain faces? 0 1 2 3 4 5 <small>Lowest Possible Intensity Highest Possible Intensity</small>	Bracing? • rigidity • holding • guarding (especially during movement)  <input type="checkbox"/> YES <input type="checkbox"/> NO How intense was the bracing? 0 1 2 3 4 5 <small>Lowest Possible Intensity Highest Possible Intensity</small>
Pain Noises? • moans • groans • grunts • cries • gasps • sighs  <input type="checkbox"/> YES <input type="checkbox"/> NO How intense were the pain noises? 0 1 2 3 4 5 <small>Lowest Possible Intensity Highest Possible Intensity</small>	Rubbing? • massaging affected area  <input type="checkbox"/> YES <input type="checkbox"/> NO How intense was the rubbing? 0 1 2 3 4 5 <small>Lowest Possible Intensity Highest Possible Intensity</small>	Restlessness? • frequent shifting • rocking • inability to stay still  <input type="checkbox"/> YES <input type="checkbox"/> NO How intense was the restlessness? 0 1 2 3 4 5 <small>Lowest Possible Intensity Highest Possible Intensity</small>

Locate Problem Areas

Please "X" the site of any pain
Please "O" the site of any skin problems



Snow AL, O'Walley K, Kunik M, Cody M, Bruera E, Beck C, Ashton C. Developed with support from the U.S. Veterans Affairs Health Services Research & Development Service and the National Institute of Mental Health. For more information, contact Dr. Snow at asnow@bcm.tmc.edu. (This document may be reproduced)



Sample 3: McCaffery and Pasero Initial Assessment Tool

Initial Pain Assessment Tool

Date: _____

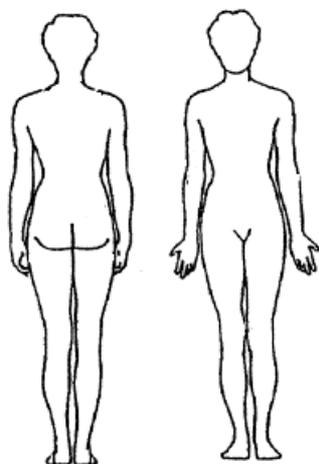
Patient's name: _____ Age: _____

Diagnosis: _____

Physician: _____

Nurse: _____

I. Location: Patient or nurse marks drawing



II. Intensity: Patient rates the pain. Scale used: _____

Present: _____

Worst pain gets: _____

Best pain gets: _____

Acceptable level of pain: _____

III. Quality: (Use patient's own words, e.g., prick, ache, burn, throb, pull, sharp)

IV. Onset, duration, variations, rhythms:

V. Manner of expressing pain:

VI. What relieves the pain?

VII. What causes or increases the pain?

VIII. Effects of pain: (Note decreased function, decreased quality of life.)

Accompanying symptoms (e.g., nausea) _____

Sleep _____

Appetite _____

Physical activity _____

Relationship with others (e.g., irritability) _____

Emotions (e.g., anger, suicidal, crying) _____

Concentration _____

Other _____



IX. Other comments: _____

X. Plan: _____

Note: May be duplicated and used in clinical practice Source: McCaffery and Beebe, 1989. Used with permission.

Sample 4: Patient Comfort Assessment Guide

Patient Comfort Assessment Guide

Name: _____ Date: _____

1. Where is your pain? _____

2. Circle the words that describe your pain.

aching	sharp	penetrating
throbbing	tender	nagging
shooting	burning	numb
stabbing	exhausting	miserable
gnawing	tiring	unbearable

Circle One occasional continuous

What time of day is your pain the worst?

morning afternoon evening nighttime

3. Rate your pain by circling the number that best describes your pain at its worst in the last month.

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

4. Rate your pain by circling the number that best describes your pain at its least in the last month.

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

5. Rate your pain by circling the number that best describes your pain on average in the last month.

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

6. Rate your pain by circling the number that best describes your pain right now.

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

7. What makes your pain better? _____

8. What makes your pain worse? _____

9. What treatments or medicines are you receiving for your pain? Circle the number to describe the amount of relief the treatment or medicine provide(s) you.

a) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

b) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

c) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

d) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

10. What side effects or symptoms are you having? Circle the number that best describes your experience during the past week.

a. Nausea	Barely Noticeable	0 1 2 3 4 5 6 7 8 9 10	Severe Enough to Stop Medicine
b. Vomiting	Barely Noticeable	0 1 2 3 4 5 6 7 8 9 10	Severe Enough to Stop Medicine
c. Constipation	Barely Noticeable	0 1 2 3 4 5 6 7 8 9 10	Severe Enough to Stop Medicine
d. Lack of Appetite	Barely Noticeable	0 1 2 3 4 5 6 7 8 9 10	Severe Enough to Stop Medicine
e. Tired	Barely Noticeable	0 1 2 3 4 5 6 7 8 9 10	Severe Enough to Stop Medicine
f. Itching	Barely Noticeable	0 1 2 3 4 5 6 7 8 9 10	Severe Enough to Stop Medicine
g. Nightmares	Barely Noticeable	0 1 2 3 4 5 6 7 8 9 10	Severe Enough to Stop Medicine
h. Sweating	Barely Noticeable	0 1 2 3 4 5 6 7 8 9 10	Severe Enough to Stop Medicine
i. Difficulty Thinking	Barely Noticeable	0 1 2 3 4 5 6 7 8 9 10	Severe Enough to Stop Medicine
j. Insomnia	Barely Noticeable	0 1 2 3 4 5 6 7 8 9 10	Severe Enough to Stop Medicine

11. Circle the one number that describes how during the past week pain has interfered with your:

a. General Activity	Does Not Interfere	0 1 2 3 4 5 6 7 8 9 10	Completely Interferes
b. Mood	Does Not Interfere	0 1 2 3 4 5 6 7 8 9 10	Completely Interferes
c. Normal Work	Does Not Interfere	0 1 2 3 4 5 6 7 8 9 10	Completely Interferes
d. Sleep	Does Not Interfere	0 1 2 3 4 5 6 7 8 9 10	Completely Interferes
e. Enjoyment of Life	Does Not Interfere	0 1 2 3 4 5 6 7 8 9 10	Completely Interferes
f. Ability to Concentrate	Does Not Interfere	0 1 2 3 4 5 6 7 8 9 10	Completely Interferes
g. Relations with Other People	Does Not Interfere	0 1 2 3 4 5 6 7 8 9 10	Completely Interferes



Sample 5: Short Form McGill Pain Questionnaire

Appendix IV (i)

SHORT FORM MCGILL PAIN QUESTIONNAIRE and PAIN DIAGRAM

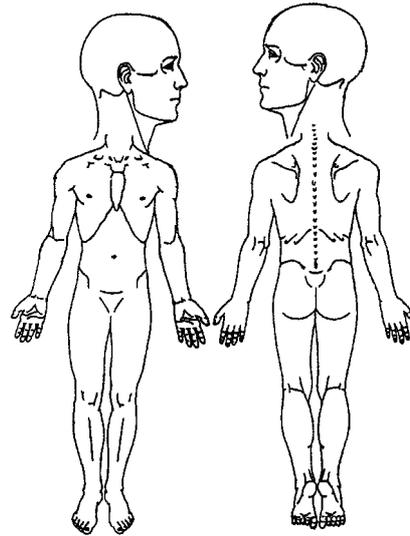
(Reproduced with permission of author © Dr. Ron Melzack, for publication and distribution)

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
---	-----	---	-----	-----	-----

Sample 6: Brief Pain Inventory

STUDY ID# _____ HOSPITAL # _____

DO NOT WRITE ABOVE THIS LINE

Brief Pain Inventory (Short Form)

Date: ____/____/____ Time: ____

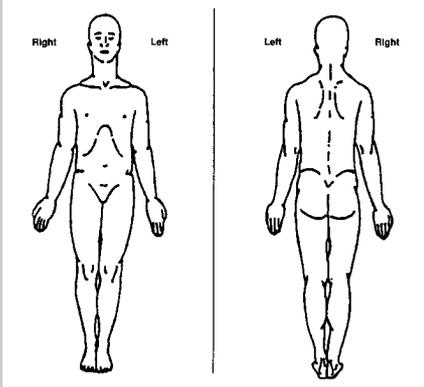
Name: _____

Last First 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 last 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 last 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 the **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 last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
No Complete
Relief 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 Completely
Interfere Interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10
Does not Completely
Interfere Interferes

C. Walking Ability

0 1 2 3 4 5 6 7 8 9 10
Does not Completely
Interfere 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 Completely
Interfere Interferes

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10
Does not Completely
Interfere Interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10
Does not Completely
Interfere Interferes

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10
Does not Completely
Interfere Interferes

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Pain Research Group
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Sample 7: Oswestry Disability Questionnaire

Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking one box in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

Section 1: Pain Intensity

- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

Section 2: Personal Care (eg. washing, dressing)

- I can look after myself normally without causing extra pain
- I can look after myself normally but it causes extra pain
- It is painful to look after myself and I am slow and careful
- I need some help but can manage most of my personal care
- I need help every day in most aspects of self-care
- I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives me extra pain
- Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed eg. on a table
- Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights
- I cannot lift or carry anything

Section 4: Walking*

- Pain does not prevent me walking any distance
- Pain prevents me from walking more than 2 kilometres
- Pain prevents me from walking more than 1 kilometre
- Pain prevents me from walking more than 500 metres
- I can only walk using a stick or crutches
- I am in bed most of the time

Section 5: Sitting

- I can sit in any chair as long as I like
- I can only sit in my favourite chair as long as I like
- Pain prevents me sitting more than one hour
- Pain prevents me from sitting more than 30 minutes
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all

Section 6: Standing

- I can stand as long as I want without extra pain
- I can stand as long as I want but it gives me extra pain
- Pain prevents me from standing for more than 1 hour
- Pain prevents me from standing for more than 30 minutes
- Pain prevents me from standing for more than 10 minutes
- Pain prevents me from standing at all

Section 7: Sleeping

- My sleep is never disturbed by pain
- My sleep is occasionally disturbed by pain
- Because of pain I have less than 6 hours sleep
- Because of pain I have less than 4 hours sleep
- Because of pain I have less than 2 hours sleep
- Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

- My sex life is normal and causes no extra pain
- My sex life is normal but causes some extra pain
- My sex life is nearly normal but is very painful
- My sex life is severely restricted by pain
- My sex life is nearly absent because of pain
- Pain prevents any sex life at all

Section 9: Social Life

- My social life is normal and gives me no extra pain
- My social life is normal but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- Pain has restricted my social life and I do not go out as often
- Pain has restricted my social life to my home
- I have no social life because of pain

Section 10: Travelling

- I can travel anywhere without pain
- I can travel anywhere but it gives me extra pain
- Pain is bad but I manage journeys over two hours
- Pain restricts me to journeys of less than one hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from travelling except to receive treatment

Score: / x 100 = %

Scoring: For each section the total possible score is 5: if the first statement is marked the section score = 0, if the last statement is marked it = 5. If all ten sections are completed the score is calculated as follows:

Example: $\frac{16 \text{ (total scored)}}{50 \text{ (total possible score)}} \times 100 = 32\%$

If one section is missed or not applicable the score is calculated: $\frac{16 \text{ (total scored)}}{45 \text{ (total possible score)}} \times 100 = 35.5\%$

Minimum Detectable Change (90% confidence): 10%points (Change of less than this may be attributable to error in the measurement)

Source: Fairbank JCT & Pynsent, PB (2000) The Oswestry Disability Index. Spine, 25(22):2940-2953.
Davidson M & Keating J (2001) A comparison of five low back disability questionnaires: reliability and responsiveness. Physical Therapy 2002;82:8-24.

*Note: Distances of 1 mile, ½ mile and 100 yards have been replaced by metric distances in the Walking section.

Appendix 2

Who was Involved in Developing the Statement?

Working Group

Janette Barrie	Practice Development Project Co-ordinator	NHS QIS
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Drummond Taylor	Carer	Pain Association Scotland
Jenny Williamson	Clinical Nurse Specialist Pain Management	NHS Lothian

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Glossary of Terms

AHP	Allied Health Professions
acute pain	Related to injury and resolves during an appropriate healing period.
addiction	The compulsive use of opioids or other agent to the detriment of the user's physical and/or psychological health and/or social function. Signs of compulsive use include preoccupation with obtaining opioids, apparently impaired control over their use, and reports of craving. These signs of compulsive use are well established where opioids are taken not primarily for pain relief but for effects on mood and thinking (The Pain Society 2004).
allodynia	Pain due to a stimulus which does not normally provoke pain (IASP)
analgesia	Absence of pain or suppression of pain
analgesic	Substance or technique that reduces pain
BNF	British National Formulary
chronic pain	Pain that persists for more than 3 months or that outlasts the healing process.
complementary therapy	Any range of medical treatments that fall beyond the scope of scientific medicine
dysaesthesia	An unpleasant abnormal sensation, whether spontaneous or evoked (IASP)
hyperalgesia	Increased sensitivity to pain or noxious stimulation
hyperaesthesia	Increased sensitivity to stimulation
IASP	International Association for the Study of Pain
NMC	Nursing and Midwifery Council
neuralgia	Pain in the distribution of a nerve
neuropathic pain	Pain initiated or caused by a primary lesion or dysfunction in the nervous system (IASP)
NHS QIS	NHS Quality Improvement Scotland
nociceptive Pain	Pain due to tissue damage i.e. skin, muscle, bone, viscera
opioid	A broad term that applies to any substance which produces its effects by binding opioid receptors and which is stereospecifically antagonised by naloxone (Shug & Cardwell 2003)

pain	An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage (IASP 1994)
paraesthesia	An abnormal sensation, whether spontaneous or evoked.
physical dependence	Is the physiological adaptation of the body to the presence of an opioid
pruritis	Where irritation of sensory nerve endings leads to localised or more general itching
sensitisation	Elevated spontaneous activity in neurones, lowered activation thresholds, and increased response to stimuli
tolerance	State of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time. Increased doses are then needed to get the same effect.
unconventional/ adjuvant analgesics	Diverse group of drugs that have a primary indication other than pain, but are used to enhance analgesia in specific circumstances (WHO 2002)
WHO	World Health Organization
withdrawal	usually occurs when pharmacological agents eg opioids are stopped suddenly, or an antagonist such as naloxone or naltrexone is administered. Withdrawal is easily avoided by gradual reduction of opioid dose (The Pain Society 2004).

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