Royal College of Emergency Medicine

Best Practice Guideline

Management of Acute Pain in Adults in the Emergency Department

Last revised
September 2024

Summary of recommendations

1. Recognition and alleviation of pain should be a priority when treating the ill and injured. This process should start at triage, be monitored during the patient's time in the ED and continue through to admission or discharge ensuring adequate analgesia is offered at all times, including beyond discharge where appropriate.

2. All emergency departments should ensure patients with moderate and severe pain receive adequate analgesia within 15 minutes of arrival.

3. All emergency departments should ensure patients in severe pain have the effectiveness of their analgesia re-evaluated within 15 minutes of receiving the first dose of analgesia.

4. Encourage the use of simple analgesics and maximise the use of non-pharmacological therapies and adjunctive analgesic options (such as local anaesthetic transdermal patches) where appropriate and safe to do so, and in the absence of contraindications or risk of drug interaction.

5. Only consider the use of opioid therapy for acute pain if the benefits of these are anticipated to outweigh the potential risk on a patient-by-patient basis.

6. All emergency departments should ensure pain severity is measured and documented using a validated numeric or visual analogue rating scale.

7. All emergency departments should audit pain management at least annually. Audits should consider equity of analgesia provision across protected characteristics.

8. Emergency department patient surveys should include specific questions regarding the assessment of pain and the adequacy of its management.

9. Training in the delivery of timely and effective pain management is essential for all staff involved in the delivery of patient care.

10. When discharging patients with opioid medications, avoid the use of modified release and compound analgesic preparations. Ideally use an 'as required' immediate release formulation titrated to a level that aims to restore a level of physical activity and function appropriate and acceptable to the patient.

11. Provide information about the intended benefits and known risks of continuing opioid therapy, explaining to patients this will usually be a single course of treatment and will not automatically become a repeat prescription.

12. The duration of discharge opioid prescriptions for acute pain should ideally be limited to 3-5 days (although may be extended up to 7 days in specific circumstances such as predictable gaps in access to healthcare).

Contents

Scope

This guideline has been developed and reviewed in order to provide clear guidance on the standards for timeliness of provision of analgesia, and to provide an approach to the delivery of analgesia for adult patients presenting to the emergency department (ED) with acute nociceptive pain. The guidance does not specifically cover pain management of children or for palliative care (which is covered in separate RCEM guidance). Although intended to provide recommendations which can be applied in these circumstances, the guidance has not been specifically developed to cover acute or chronic pain, or neuropathic pain conditions.

Reason for development

Pain management is one of the most important components in patient care, which is why it is given such a high priority in the RCEM 'Clinical Standards for EDs and initial assessment processes which may involve early warning systems and triage tools, such as the Manchester Triage Scale [1]. Suboptimal management of pain can lead to chronic pain states, hinder recovery, whilst inappropriate management can cause adverse drug events.

Introduction

Pain is a commonly presenting complaint in EDs and frequently under-recognised, under-treated and under-prioritised [2,3]. Pain cannot be treated if it has not been recognised or assessed. Recognition and alleviation of pain should be a priority when treating the ill and injured. This process should start at triage, be monitored during their time in the ED and continue through to admission or discharge ensuring adequate analgesia is provided at all times, including beyond discharge where appropriate. This is dependent on many factors in the clinical patient pathway associated with processes, culture, and individual prejudices. There is some evidence that pain relief is related to patient satisfaction [4].

Pain Assessment

As part of the initial assessment, pain evaluation is an essential component. Multiple assessment tools are in use and include the visual analogue scale (VAS), the numeric ratings scale (NRS) and the four point verbal categorical rating scale (VRS). None have been validated in the context of an ED environment but are nevertheless satisfactory for the purpose of pain assessment and management. The recording of pain scores is often suboptimal [3]. The experience of the member of staff who first sees a patient will help in estimating the severity of the pain. Staff frequently rely on their experience or intuition when managing pain, particularly when judging the appropriate level of analgesia to prescribe and value this more highly than strict adherence to pain scores [5]. Relying on pain scores alone may be unreliable in isolation, therefore scoring systems should ideally be used for serial assessments and auditing the treatment of pain. Simplifying the pain severity scale into functional domains will also aid consistency and coherency for effective implementation.

The literature suggests that the assessment of pain in the ED is often not as good as it could be [6,7] which is particularly concerning since pain is often the reason for attending. Other clear reasons to ensure adequate analgesia include improved patient assessment, the ability to perform painful or uncomfortable procedures as well as physiological benefits to providing adequate analgesia [7].

Table 1 describes a number of themes that have been identified as potential barriers to adequate pain management in the ED, adapted from Sampson *et al* [8].

Table1. Summary of potential barriers to effective pain management in the ED [8]

Overarching Theme	Narrative
Pain management is not perceived to be one of the organisational priorities for which ED staff are held accountable	● 4hr waiting time target and ambulance handover target perceived as more important ● Little individual feedback about pain management, the concept of excellent pain management infrequently discussed within the ED ● Poor pain management performance not challenged leading staff to believe pain management was being done well ● Failure to challenge individual staff's belief regarding the utility of pain score
Pain Management is not prioritised within ED training and education	● Staff having limiting knowledge of either local or national guidance ● Staff relying on personal experience rather than evidence-based knowledge with regards to pain management ● Inconsistent knowledge of key pain management principles e.g. the peak effect of morphine, pain ladder
Low organisational priority underpinned personal beliefs about the priority of pain management	● Not perceived as a priority – "you can't die of pain" ● Perceived low levels of control in improving pain management e.g. staff shortages, two witnesses for controlled drugs ● Pain is only one priority competing amongst many other for staff's attention
ED processes and structures enable other ED priorities, but can hinder pain management	● Multiple handovers ● Focus on pain management lost amongst other issues e.g. focus on flow and diagnosis ● Departmental layout contributing to barriers e.g. location of analgesics within the ED, poor visibility, difficulty communicating between areas within the ED ● ED processes, including poor documentation, competencies

There have been numerous international studies suggesting that patient ethnicity plays a role in determining how quickly and what type of pain relief a patient receives in the ED. Statistics released by the Care Quality Commission surprisingly suggest this may not be the case in the UK [9].

However, staff need to be mindful of the effect that a patient's ethnicity or different cultural background might have on their own decisions in relation to the provision of rapid and appropriate analgesia. National guidance already exists for the prompt provision of analgesia experienced during painful sickle crises [10] and recently published RCEM guidance [11]. Positive and negative personal biases may also manifest themselves when caring for other patient groups, e.g. obese patients [12], or children [13].

Assessment of Acute Pain in the Emergency Department

A numeric rating or visual analogue score for pain is recommended for those patients presenting to ED. This will correlate with a functional descriptive scale, from "no pain" to "severe pain". Special consideration, however, must take place for those patients with cognitive impairments, who may not be able to express the degree of pain clearly (Appendix 2,3). In these cases, alternative assessment tools should be utilised (e.g. FLACC scale). Category scores must be consistent between whichever tool is used.

Table 2. Methodology of acute pain scoring in the ED

	No Pain	Mild Pain	Moderate Pain	Severe Pain
Descriptive classification	**Comfortable at rest or activity**	**Discomfort not limiting function**	**Constant pain limiting function**	**Pain unbearable despite basic care**
Attributed pain score	**0**	**1 - 3**	**4 - 6**	**≥ 7**
Initial assessment	Within 15 mins of arrival in all cases			
Target for re-evaluation	Within 60 mins of initial assessment	Within 60 mins of analgesia	Within 30 mins of analgesia	Within 15 mins of analgesia

- Using this method of pain scoring it should be possible to adequately assess into one of four categories and treat pain appropriately.
- Once the category has been established, appropriate analgesia may be prescribed according to the acute pain 'pyramid' shown in Figure 1, below.
- Following reassessment, if analgesia is still found to be inadequate, stronger or an increased dose of analgesics should be used along with the use of nonpharmacological measures.
- It is important to re-assess the pain control within 15 - 30 minutes in moderate to severe pain.

How to Manage Pain

Pain scores should be documented in conjunction with any analgesic interventions in order to assess their effectiveness in a measurable and meaningful way. Aligning pain management processes with existing service priorities at a system level may improve overall pain management [8].

Patients in severe pain should be transferred to an area where they can be properly assessed, a working diagnosis formulated and receive analgesic treatment of a form and dose appropriate to their assessed pain severity. Patients in severe pain should have the effectiveness of analgesia re-evaluated within 15 minutes of receiving the first dose of analgesia.

Patients in moderate pain should be offered oral analgesia at the initial assessment. Patients with moderate pain should have the effectiveness of analgesia re-evaluated within 30 minutes of the first dose of analgesia.

The guidance in this document is primarily aimed at ensuring patients receive appropriate analgesia in a timely fashion. When patients first present to the ED the diagnosis may be unclear, and it is important that the lack of diagnosis does not delay administration of appropriate analgesia. Pain relief must not be withheld in the misunderstanding that it will mask signs required to make a diagnosis. It is recognised, however, that there are a number of conditions or presentations in which certain types or combinations analgesics are known to perform particularly well, such as nitrates for angina, or NSAIDs for ureteric colic.

In all cases it is also important to consider the use of non-pharmacological techniques to achieve analgesia, which may include applying cooling measures (e.g. for burns), dressings, or immobilising a limb, etc.

Drug Seeking Behaviours

Emergency physicians are sometimes placed in the very difficult position of having to decide whether a patient's pain is genuine or not (i.e. is the patient displaying 'drug seeking' behaviour?). Careful decision-making is required to balance the risk of not recognising drug seeking behaviours as opposed to denying a patient with genuine pain appropriate and adequate analgesia. Being 'wise after the event' and instituting appropriate measures after the acute episode is likely to be preferable (see separate guidance: "Frequent Attenders in the ED"). The use of alternative behavioural pain assessment methodology (e.g. FLACC scale) may offer further information to aid decision-making.

Prescribing for the Elderly

When prescribing for the elderly it is worth remembering that paracetamol (including intravenous) is a safe first line treatment with a good safety profile. NSAIDs should be used with caution and at the lowest possible dose in older adults in view of gastrointestinal, renal and cardiovascular side effects as well as drug-drug interactions and the effects on other co-morbidities [14]. When using opioid medication in the elderly appropriate dose reduction should be used as well as anticipating any other drug interactions; particularly those acting on the central nervous system which may increase the likelihood of respiratory depression, for example drugs used for procedural sedation.

Prescribing in Pregnancy Including in Pregnancy Loss

In general, the use of medications in pregnancy should be avoided where possible, particularly in the first trimester, although this is not always practical. All pain relief used in pregnancy should follow a careful risk versus benefit assessment and should be prescribed at the lowest possible dose and for the shortest possible duration. Paracetamol is considered safe at any stage of pregnancy. NSAIDs, such as ibuprofen, should not be used if there is PV bleeding or threatened miscarriage and are limited for use up to 20 weeks. If required, opioids such as morphine can be used in all three trimesters and may warrant closer monitoring near to term or during delivery. Maternal use of oral

opioids during breastfeeding can cause infant drowsiness, and newborn infants seem to be particularly sensitive to the effects of even small dosages of narcotic analgesics.

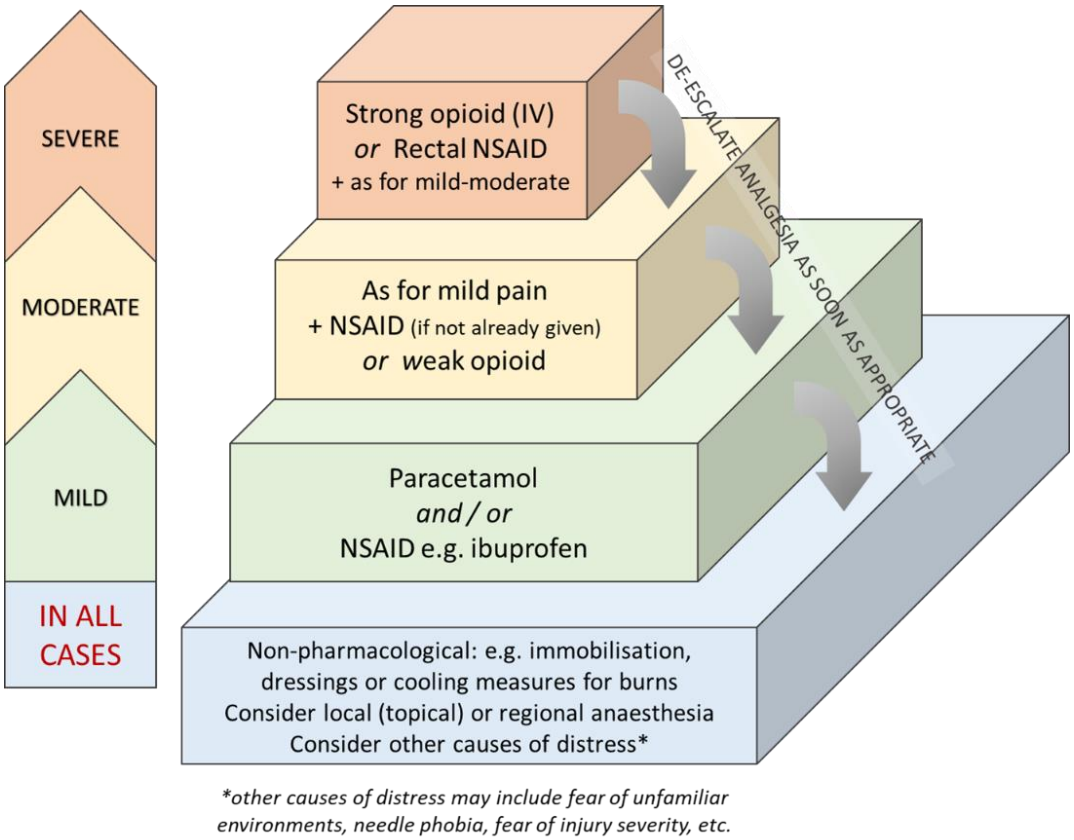
Emotional support and welfare of the patient is essential in situations of inevitable miscarriage. Pain may not appear to be proportional to the gestation of the pregnancy. For threatened miscarriage, an increase in pain should be anticipated and consideration should be given for a supply of medication to manage this [15].

Algorithm for Treatment of Undifferentiated Acute Pain in the ED

Patients should be managed with an analgesic of a strength appropriate to their assessed pain severity. There is no single best 'one size fits all' solution. Guidance should not hold clinical staff to unrealistic or inappropriate analgesic options.
The WHO cancer pain ladder [16] is suggested as an indicative approach, allowing a consistent algorithm to be applied on an individual patient basis without offering prescriptive criteria or specific drug options. Suggested analgesic choices are discussed further below. It is likely that severe pain will require more potent analgesia, and this may include the use of IV opioids.

This approach is illustrated below, in conjunction with pain scoring (*see* ***Table 2***).

Figure 1. The acute pain 'pyramid': modified WHO pain algorithm [16]



Drug Notes

Paracetamol

Available as oral, rectal and intravenous preparations.

- The standard oral and IV dose for adults is 1g qds however when administering the IV preparation the dose must be adjusted for those patients weighing less than 50kg (adults 40-49kg 750mg qds, 35-39kg 500mg qds).
- The IV route is available and is shown to be effective if patients cannot tolerate the oral route [7].
- The rectal preparation is probably best avoided due to variable and slow absorption in adults.

Before prescribing paracetamol, an inquiry must be made regarding previous paracetamol use (including compound preparations such as co-codamol and OTC preparations e.g. cold relief powders as well as paramedic use prior to arrival in the ED).

Non-Steroidal Anti-inflammatory Drugs (NSAIDS)

Available as oral, rectal, intravenous and intra-muscular preparations (although it should be noted IM diclofenac has been associated with sterile abscesses following IM use).

- Ibuprofen 400mg PO tds; fewer side effects than other NSAIDs, good analgesic but relatively weak anti-inflammatory properties.
- Naproxen 500mg PO initially then 250mg every 6-8hrs in acute musculoskeletal disorders; stronger anti-inflammatory properties than ibuprofen but with relatively fewer side-effects compared to other NSAIDs [17].
- Diclofenac 50mg PO tds, 100mg PR; particularly useful for the treatment of renal colic pain via the rectal route. It is contra-indicated in IHD, PVD, CVD and heart failure [18]. Concern has also been raised regarding increased risk of thrombotic events (incl. MI) and Clostridium difficile [19].

Avoid NSAIDS in asthmatics who are known to get worsening bronchospasm with NSAIDS, also avoid in patients with previous or known peptic ulcer disease. NSAIDs should be used with caution in the elderly (risk of peptic ulcer disease) and women who are experiencing fertility issues. It should also be avoided in pregnancy, particularly during the third trimester and for PV bleeding or threatened miscarriage.

Opioids

- Codeine Phosphate is available as oral and IM preparations. The typical adult dose is 30-60mg qds, however, consider lower doses in the elderly (15-30mg qds). Codeine is a prodrug and as such its efficacy is subject to genetic polymorphism. Codeine is not recommended for breastfeeding mothers.
- Dihydrocodeine is a semi-synthetic opioid used to treat moderate pain. The typical oral dose is 30 mg qds. It is an active drug, and its actions are not subject to genetic polymorphism. It can be given to breastfeeding mothers.
- Morphine is available as oral, intravenous and intra-muscular preparations (due to its relatively slow onset of action the oral preparation is not recommended for acute pain control in the ED, unless the patient is already taking the drug in which case this might be a reasonable alternative). Morphine 0.1-0.2mg/kg IV is a typical adult dose, however a titrated dose to provide the desired response is recommended; consider lower doses in the elderly.

Use opioids with caution if there is risk of loss of airway reflexes or cardiorespiratory depression. The routine prescription of an anti-emetic with an opioid is not recommended, and only required if patient is already experiencing nausea / vomiting [20]. It should be noted that the use of opioids in abdominal pain does not hinder the diagnostic process [21]. Laxative co-treatment should also be commenced for anyone initiating strong opioids.

Opioid-seeking behaviour is not uncommon in ED. This is not only in those with active abuse but may also manifest in those with chronic pain disorders. However, if after assessment an opioid is deemed necessary, do not withhold appropriate treatment, but be aware of possible signs of dependency such as repeat attendances, asking for treatment by different doctors, 'losing' prescriptions, and similar reasons.

Although opioids can be good analgesics for acute pain, evidence is limited for longer-term pain management. There is evidence from the USA that opioid prescriptions commenced in the ED may predispose to the development of an opioid use disorder [22].

If pain remains severe despite opioid treatment it suggests that these are less likely to be effective. In such cases, the patient should be reassessed and alternative treatments explored. Side effects are extremely common with opioid therapy, with between 50% and 80% of patients experiencing at least one side effect in clinical trials. Adverse events also frequently lead to discontinuation of opioid therapy. The risk of harm increases substantially at doses above an oral morphine dose equivalent of 120mg/day [23].

Opioid Stewardship

In response to concerns regarding opioid dependency, the Medicines and Healthcare products Regulatory Agency (MHRA) published [24] in September 2020 stating that clinicians should:

- discuss with patients that prolonged use of opioids may lead to drug dependence and addiction, even at therapeutic doses – warnings have also been added to the labels (packaging) of UK opioid medicines to support patient awareness.
- before starting treatment with opioids, agree the treatment strategy with patients and a plan for stopping such treatment.
- explain the risks of tolerance, addiction [25] and potentially fatal unintentional overdose, and counsel patients and caregivers on signs and symptoms of opioid overdose to be aware of (*see Appendix 4*).

The British Pain Society and RCEM have collaborated to share an updated version of this guidance, including appropriate recommendations regarding analgesic discharge medications and the practice of opioid stewardship. Further information is available from the Faculty of Pain Medicine: Opioids Aware.

Other Analgesic Options

Entonox®, a 50% mixture of nitrous oxide and oxygen, is very useful for short term and rapid relief of severe pain and for performing short lasting uncomfortable procedures. It should not be viewed as a definitive analgesic and EDs need mechanisms in place to ensure rapid assessment and institution of appropriate analgesia when paramedics bring patients to the ED who are using Entonox as their sole source of analgesia. Entonox should be avoided in patients with head injuries, chest

injuries, suspected bowel obstruction, middle ear disease, early pregnancy and B12 or folate deficiency [26].

EDs should aim to reduce their use of Entonox® to the bare minimum in view of its environmental impact. The ability of nitrous oxide to trap heat in the atmosphere (known as the global warming potential or GWP) is approximately 298 times that of carbon dioxide. Nitrous oxide is also an ozone depleting gas and has been labelled as one of the most significant ozone depleting gases of the 21st century [27].

Methoxyflurane is volatile anaesthetic (Penthrox™) designed to be self-administered via a "green whistle". It has been shown to be a safe and effective when used for pain relief in adult patients with minor trauma. Following its use in the pre-hospital setting, it has also been introduced into some EDs. It has been shown to offer advantages compared to standard care, specifically time to effective analgesia and efficacy when compared to standard care. Penthrox™ may be a useful addition to the ED formulary for patients with moderate to severe pain particularly in the setting of trauma. Penthrox™ is contra-indicated in patients with known renal or hepatic failure, cardiac insufficiency or respiratory depression, known or suspected susceptibility to malignant hyperthermia [28]. In contrast to Entonox®, the GWP of Methoxyflurane is only 4 [27].

Ketamine is an effective analgesic at sub-anaesthetic doses either as a sole agent or as an adjunct used together with a co-administered opioid. Analgesic doses are generally considered to be 0.1 – 0.3 mg/kg IV (0.5-1.0mg/kg IM); the higher the dose within this range the greater the chance of dissociative effects, these are also more likely in older age groups. Contraindications include schizophrenia, active pulmonary disease or infection, cardiovascular disease, hydrocephalus, globe injury, glaucoma and porphyria.

Non-systemic Drug Treatment of Pain

Oral and intravenous drugs should not be thought of as the only treatment for acute pain for patients presenting to EDs. There are several alternatives that may prove more effective or reduce the need for dose increases or more potent medication.

Relaxation techniques

Relaxation techniques are dependent on appropriately trained members of staff and are particularly helpful in children. There are many techniques available. Typically, some techniques work well for one person and other techniques work better for another. A quiet environment will also help in this regard.

Local and regional anaesthesia

The use of local anaesthetic (LA) agents are an excellent form of pain relief. This may be regionally, such as *fascia iliaca blocks* or locally such as *'ring' blocks*. Use of LA transdermal patches (e.g**. lidocaine 5%**) may also be an effective adjunctive therapy, particularly for chest wall injuries and as an 'opioid-sparing' approach.

Immobilisation

Appropriate immobilisation of fractures produces excellent analgesia. However, in order to immobilise an area, good analgesia may be required initially. Once the area is immobilised the level of analgesia required may be reduced significantly.

Early reduction of fractures and dislocations

As with immobilisation, once a fracture or dislocation is reduced, using appropriate analgesia, ongoing pain relief will decrease.

Discharge Medications

Many patients visiting the ED will have pain as an ongoing symptom and may require more potent analgesic medications to be prescribed at discharge. As well as the guidance provided above, the choice of analgesic should be discussed with individual patients in anticipation of the expected benefits and sharing potential risks.

In general terms, the following principles should be applied:

- Encourage simple analgesic use wherever possible and safe to do so
- Maximise relevant non-pharmacological therapies
- Utilise adjunctive analgesic options, such as LA transdermal patches, as appropriate
- If prescribing opioid analgesics, ensure the risk:benefit balance is considered and use the lowest dose possible aiming to restore physical activity and function
- Avoid prescribing modified release opioids or compound preparations
- Supply of opioid medications should be of limited duration – no more than 3-5 days, unless there is likely to be a predictable gap in access to further primary healthcare.
- Counsel regarding a gradual tapering of opioid dosage as soon as possible.

Patients should be provided with accessible information that reinforces these key messages. For continuity, primary healthcare summaries should include relevant detail regarding the type of analgesic discharge medication, its dose and duration of supply.

Abbreviations

IM	Intramuscular	PO	Oral	PR	Rectal	IV	Intravenous
kg	Kilogram	mg	Milligram				
od	Once a day	bd	Twice a day	tds	Three times a day	qds	Four times a day
NSAID	Non-steroidal anti-inflammatory drug	IHD	Ischaemic heart disease	PVD	Peripheral vascular disease	CVD	Cerebrovascular disease

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Endorsements

None

Review

Usually within three years or sooner if important information becomes available.

Declaration of Interests

None

Disclaimers

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

Research Recommendations

Barriers to prompt and effective provision of analgesia during a patient's stay in the ED.

Audit standards

Each department should have its own agreed policy, resource set and active governance approach to ensure adherence to all of the above recommendations and encourage best practice.

Documentation of patient assessment for pain, during their initial clinical assessment.

Provision of analgesia or lack of, documented in accordance with severity.

Documentation of re-assessment of pain in those requiring any intervention to relieve pain.

Pain management audits should be performed as a minimum annually.

Patient feedback surveys should include specific questions related to the management of pain within the emergency department.

Key words for search

Pain, Analgesia, Opioid stewardship

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Appendix 1: Methodology

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

Evidence Levels

1. Evidence from at least one systematic review of multiple well designed randomised control trials.

2. Evidence from at least one published properly designed randomised control trials of appropriate size and setting.

3. Evidence from well-designed trials without randomisation, single group pre/post, cohort, time series or matched case control studies.

4. Evidence from well-designed nonexperimental studies from more than one centre or research group.

Opinions, respected authority, clinical evidence, descriptive studies or consensus reports.

Appendix 2: PAINAD tool [29]

Example of a pain assessment tool for patients with cognitive impairment.

The total score ranges from 0-10 points. A possible interpretation of the scores are:

- Mild pain 1-3
- Moderate pain 4-6
- Severe pain 7-10

Caution should be used when categorising the score with this tool.

Behavior	0	1	2	Score
Breathing Independent of vocalization	• Normal	• Occasional labored breathing • Short period of hyperventilation	• Noisy labored breathing • Long period of hyperventilation • Cheyne-Stokes respirations	
Negative vocalization	• None	• Occasional moan or groan • Low-level speech with a negative or disapproving quality	• Repeated troubled calling out • Loud moaning or groaning • Crying	
Facial expression	• Smiling or inexpressive	• Sad • Frightened • Frown	• Facial grimacing	
Body language	• Relaxed	• Tense • Distressed pacing • Fidgeting	• Rigid • Fists clenched • Knees pulled up • Pulling or pushing away • Striking out	
Consolability	• No need to console	• Distracted or reassured by voice or touch	• Unable to console, distract, or reassure	
			TOTAL SCORE	

(Warden et al., 2003)

Appendix 3: Abbey Pain Scale [30]

Example of a pain assessment tool for patients with cognitive impairment:

The Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise

How to use scale: While observing the resident, score questions 1 to 6.

Name of resident: .....

Name and designation of person completing the scale: .....

Date: ..... Time: .....

Latest pain relief given was ..... at .....hrs.

Q1. Vocalisation
eg whimpering, groaning, crying
Absent 0 *Mild 1* *Moderate 2* *Severe 3* Q1 ☐

Q2. Facial expression
eg looking tense, frowning, grimacing, looking frightened
Absent 0 *Mild 1* *Moderate 2* *Severe 3* Q2 ☐

Q3. Change in body language
eg fidgeting, rocking, guarding part of body, withdrawn
Absent 0 *Mild 1* *Moderate 2* *Severe 3* Q3 ☐

Q4. Behavioural change
eg increased confusion, refusing to eat, alteration in usual patterns
Absent 0 *Mild 1* *Moderate 2* *Severe 3* Q4 ☐

Q5. Physiological change
eg temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor
Absent 0 *Mild 1* *Moderate 2* *Severe 3* Q5 ☐

Q6. Physical changes
eg skin tears, pressure areas, arthritis, contractures, previous injuries
Absent 0 *Mild 1* *Moderate 2* *Severe 3* Q6 ☐

Add scores for Q1 to Q6 and record here ⇒ Total pain score ☐

Now tick the box that matches the Total pain score ⇒

0–2 No pain	3–7 Mild	8–13 Moderate	14+ Severe

Finally, tick the box which matches the type of pain ⇒

Chronic	Acute	Acute on chronic

Abbey J, De Bellis A, Piller N, Esterman A, Giles L, Parker D, Lowcay B. The Abbey Pain Scale. Funded by the JH & JD Gunn Medical Research Foundation 1998–2002.
(This document may be reproduced with this reference retained.)

Appendix 4: Example of opioid advice leaflet content [31]

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How do opioids work?

Opioids provide pain relief by acting on areas in the spinal cord and brain to block the transmission of pain signals. Opioids are considered to be some of the strongest painkillers available and are used to treat pain after surgery, serious injury and cancer. Opioid drugs can help manage some but not all types of chronic pain.

How are opioids taken?

Opioid medicines come in many different forms, such as injections, tablets, capsules, liquids, and patches.

When should I take my opioid medicines?

For continuous long-term pain you may be given a slow-release tablet or an opioid skin 'patch' which gives a steady level of medicine in the blood that is the best way to manage pain. Your healthcare team will adjust the dose to give you pain relief most of the time, and so you don't get too many side effects. Fast-acting opioid medicines and opioids that can be injected are not very useful for managing continuous pain.

What dose of opioid should I take?

The correct dose of any medicine is the lowest dose that produces a noticeable benefit. It is not usual to get complete relief of pain from opioids. You should always take the correct dose of prescribed medicines. If you feel the dose isn't enough, or if the side effects interfere with your life, you should discuss this with your healthcare team.

How long will it take to work?

This depends on the form that has been prescribed. For long-term pain tablets or skin patches are prescribed most commonly. Fast acting tablets may be used when you first start trying opioid treatment. They may work within an hour and last for around three to four hours. Slow-release tablets or patches take longer, up to two or more days to begin to have any noticeable effect.

What are the possible side effects?

When you first start taking opioids you can get some side effects, which usually stop after a few days. These include:

- feeling dizzy
- feeling sick (nausea)
- being sick (vomiting)
- feeling sleepy
- feeling confused

Sometimes these side effects can go on for longer than a few days. Your healthcare team may give you some other medicines to help, such as anti-sickness tablets. If pain has affected your sleep, opioids may help you to recover your normal pattern of sleep, but they should not make you drowsy in the daytime.

Opioid medicines can cause some problems when you take them for long periods of time. These problems include:

- constipation*

- itching
- weight gain
- lack of sex drive
- difficulty breathing at night**

* This is a common problem when taking opioids and does not tend to go away the longer you take opioid medicines. You may need to try laxatives to treat constipation. If you experience a lot of side effects your team may suggest changing to another opioid drug.

** This is most common if you are overweight and if you snore heavily. If you have a condition called obstructive sleep apnoea it may not be safe for you to take opioids.

Can I drive when I'm taking opioids?
The law in the UK allows you to drive if you are taking prescribed opioid medicines in accordance with the instructions from your prescriber (including what your prescriber advises you about driving safely). You should never drive if you feel unsafe. Your ability to drive may be affected by other medicines you are taking in addition to opioids, whether you feel tired and by your pain. You are responsible for making sure you are safe on each occasion that you drive.

The law on drugs and driving in the UK changed in 2015. If your driving is impaired for any reason, including taking medicines, it is illegal to drive. It is also now illegal to drive when you are taking opioid medicines without them being prescribed, even if you are not impaired. Preparation for the new drug driving laws involved extensive scientific research to investigate what effect opioid drugs have on ability to drive safely. We now know that if a person is taking more than 220mg of morphine a day they are likely to have a blood level of the medicine which impairs them nearly as much as someone who is over the legal limit of alcohol. All opioid medicines have the potential to impair driving and your prescriber will advise whether the dose of opioid you are taking is likely to impair you. If you are taking a high dose of opioid your prescriber will advise you that you are probably not safe to drive and will document this in your medical notes.

The doses of opioid medicine that are likely to affect your driving are quite high and are above the level that we know is safe and effective for pain treatment.

It is unsafe to drive in the first few days after starting an opioid and for a few days after dose change (up or down). Drinking alcohol reduces the amount of opioid medicine you can take and drive safely so do not drive if you have drunk alcohol and taken opioid medicines.

What if I forget or miss a dose?
Take it as soon as you remember. However, if it is almost time for your next dose, skip the missed dose and take your medication as normal. Do not take two doses together.

Can I take this medicine long-term?
While opioids can have a positive benefit for some people living with long-term pain, they can have serious consequences when they are not providing sufficient benefit or are being taken in a manner that was not intended. It is important to consider the risks and benefits of continued opioid therapy with your prescriber on a regular basis. Recent medical literature suggests that the risks to your health increase significantly when prescribing opioids at high doses for a long period of time. If you take opioid drugs for many months or years it can affect your body in a number of ways.
These problems include:

- reduced fertility
- low sex drive
- irregular periods
- erectile dysfunction in men (the inability to keep an erection)
- reduced ability to fight infection
- increased levels of pain

If you are worried about any of these problems, please discuss this with your healthcare team. Your team will be able to tell you whether you are at risk of developing these problems.

Everyone prescribed opioid medicines in the long-term should have them reviewed by their prescriber at regular intervals. If this does not happen ask your General Practitioner.
If you want to try reducing your dose, you should discuss this with your doctor and bring the dose down slowly.

Many people find that after a few months they can reduce their opioid dose without the pain increasing. Many individuals are able to reduce gradually their opioid dose and find that their pain is no worse. As fewer side effects are experienced, quality and enjoyment of life can improve. All of this contributes to greater physical fitness.

Can I drink alcohol?
Alcohol and opioids both can cause sleepiness and poor concentration. You should avoid alcohol completely when you first start on opioids or when your dose has just been increased. If you are taking opioids, you should avoid alcohol if you are going to drive or use tools or machines. When you get on a steady dose of opioid, you should be able to drink modest amounts of alcohol without getting any extra unusual effects.

Will my body get used to opioid medicines?
Opioids can become less effective with time (this is called tolerance) meaning your body has got used to the pain relieving effect of the medicine. You can also become dependent on opioid medicines (dependence). This means that if you stop taking the drug suddenly, or lower the dose too quickly, you can get symptoms of withdrawal.

If you run out of medicine, you can experience the same symptoms that include:
- tiredness
- sweating
- a runny nose
- stomach cramps
- diarrhoea
- aching muscles

What about addiction to opioids?
It is rare for people in pain to become addicted to opioids. People who are addicted to opioids can:
- feel out of control about how much medicine they take or how often they take it
- crave the drug
- continue to take the drug even when it has a negative effect on their physical or mental health

We do not know exactly how many people get addicted when they are taking opioids for pain relief, but it is very uncommon. It is more common if you have been addicted to opioids (including heroin) or to other drugs (or alcohol) before. Addiction may be more common in people with severe depression or anxiety. This does not mean that if you have had an addiction problem before or you are very depressed and anxious you will become addicted. It only means that you are more likely to become addicted than someone who has not had these problems. Most people do not become addicted.
So, if you have had a problem with drug or alcohol addiction in the past this doesn't mean that you cannot take opioid medicines for your pain. However, your healthcare team will need to know about your past or current drug-taking to prescribe opioids safely and to help you watch out for warning signs.

What if I want to stop taking an opioid?
Do not stop taking your opioid suddenly, you may experience withdrawal symptoms. Speak to your healthcare professional (doctor, nurse, pharmacist) who will be able to supervise a gradual reduction.

Is there anything else my prescriber needs to know?

- If you are allergic to any drugs or medicines
- If you are taking any other medicines or herbal medicines
- If you are pregnant or breast feeding, or if you are planning to become pregnant in the future
- If you have a kidney problem
- If you have or have had a history of excessive alcohol use, recreational drug use or addiction to prescribed or over-the-counter medication

Opioids Aware 2016. Faculty of Pain Medicine www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware

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