

Optimising analgesia for adult inpatients with acute pain

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1. Recognise and Assess Pain

Ask the patient to describe their pain using a pain assessment tool. Pain should be assessed at rest and on moving/function (unless in too much pain to move). Document worst pain score on the flowsheet. Any more than mild pain requires action. It may be necessary for owning medical team to review patient and investigate the cause of the patient's pain or increase in pain.

2. Treat pain

Consider options

Find out what the patient normally does to relieve their pain both physically and pharmacologically and implement these measures where possible. Utilise a combination of analgesic medications depending on the patient's allergies, physiology, and comorbidities. Increased activity such as physiotherapy may require more analgesia. [Frail and/or older patients](#) require significantly less opioid to achieve the same level of analgesia. Initial doses should be reduced to 25-50% of the doses used in young healthy patients. **Δ Think Kidney:** These medications and their metabolites may also accumulate, especially in patients with renal impairment (eGFR <60) necessitating an increase in the dosing interval. In the older person with frailty (because of low muscle mass) eGFR may over-estimate renal function. Remember: codeine is broken down to morphine. Always refer to current BNF for specific drug and dose information². For severe episodic or procedural pain, providing it is not contraindicated, consider Pentrox[®] or short-term use of Entonox[®].

For trauma patients, regional analgesia should be considered especially where patient has fractured femur or fractured ribs

Implementing multimodal analgesia (read cautions above first):

- Prescribe and give REGULAR PARACETAMOL. (Refer to paracetamol dosing table)

	Adult 30-40kg	Adult 41-49kg	Adult 50kg and above
Oral and iv maximum dose	500mg three times a day	500mg four times a day	1g four times a day
Maximum daily dose	1.5g	2g	4g (reduce to 3g if risk factors for hepatotoxicity)
Irrespective of weight where the patient's eGFR is < 30 interval between dosing must be minimum of 6 hours			

- For moderate pain, add a REGULAR non-steroidal anti-inflammatory drug NSAID (if not contraindicated). Use rectal formulations if necessary and if route is available. Consider the need for gastro protection with NSAID therapy. Give these simple REGULAR analgesics even if the patient is requiring opioids¹.
- For moderate to severe pain add a REGULAR weak opioid such as CODEINE PHOSPHATE (up to 60mg QDS²) **or** DIHYDROCODEINE (up to 30 mg QDS²) TRAMADOL (up to 100mg QDS²). **Plus**, for breakthrough pain: morphine sulfate immediate release oral solution 10 to 20 mgs 4 hourly when required (PRN)^{1,2}. **Reduce this dose or consider swap to immediate release oxycodone liquid for [older and/or frail patients](#), or those with renal, hepatic or respiratory impairment.**
- Consider increasing breakthrough dose for those on existing opioid therapy.
- Manage side effects such as nausea and constipation proactively utilising appropriate antiemetics and aperients/laxatives.¹

3. **Management of severe pain in patients 'nil-by-mouth' or unable to absorb oral fluids and diet**
 - Parenteral (Intramuscular, subcutaneous or intravenous) injections of strong opioids are usually essential for crisis resolution but are not a sustainable or sensible medium or long-term solution.
 - Advanced analgesic techniques such as [Patient Controlled Analgesia \(PCA\)](#) or [Regional Analgesia \(RA\)](#) or [Continuous Epidural Analgesia \(CEA\)](#) may be appropriate and should be considered for a patient who has unrelieved pain despite more than 2-3 consecutive parenteral opioid injections.
 - Opioid patches are unsuitable and unlicensed for acute pain.
 - Any patient receiving parenteral opioids is at risk of respiratory depression. **The first clinical indicator of respiratory depression is increasing sedation.** Vigilant monitoring of sedation score and respiratory rate is mandatory for all patients receiving parenteral opioids.
4. **Using opioids with post-operative patients**
 - Long-acting (modified release) opioids should not be used routinely for acute postoperative pain³.
 - Provision of opioid analgesia should be guided by functional outcomes, rather than unidimensional pain scores alone³.
 - Contact the Inpatient/Acute Pain Team for advice before escalating to modified release opioids.
 - If patient started on strong opioids during hospital admission, or opioids have been escalated, this MUST be communicated to GP on discharge and appropriate advice given on opioid tapering.
5. **Patients with fractured ribs**
 - Follow [Trust guidelines](#) ensuring analgesia facilitates deep breathing and coughing.
 - Refer to tertiary centre for consideration of fixation in those with multiple fractures.
 - Refer to pain team/anaesthetist for consideration of regional analgesia.
 - If skin over fractures is intact: Consult [Trust guidelines](#) and consider use of lidocaine 5% plasters, 12 hours on painful area 12 hours off, for up to 14 days in those unable to have a block or those for whom block fails.

Who to call for help?

Inpatient/Acute Pain Service: available in normal working hours Aim to:

- Review inpatients with advanced analgesic techniques: Regional Analgesia (RA) especially Continuous Epidural Analgesia (CEA), and non-standard Patient Controlled Analgesia (PCA)
- Respond to inpatients with complex pain issues such as chronic pain

Refer via EPIC orders or Contact Inpatient Pain Nurse on:

- FPH - Bleep 5252 or ext 134571 (Monday to Saturday 08:30-16:30)
- WPH - Bleep 4820 or ext 154435 (Monday to Friday 08:30-16:30)
- HWD – 07776633562 (or bleep 4820 if no response) (Tuesday to Saturday 08:30-16:30)

Out of hours for urgent advice the on-call medical team can contact the on-call anaesthetist on: **FPH Bleep 5002** **WPH and HWD 07768463877**

References

1. McCaffery, M. and Pasero, C. (1999) *Pain: Clinical Manual*, (2nd edition), St Louis, Mosby. pp.108-128.
2. Joint Formulary Committee (2024) 'Codeine phosphate', in *British National Formulary*. Available at: <https://www.medicinescomplete.com/#/content/bnf/500221934> (Accessed: 4 November 2024).
3. Levy, N. et al. (2021) 'An international multidisciplinary consensus statement on the prevention of opioid-related harm in adult surgical patients', *Anaesthesia*, 76(4), pp. 520-536. Available at: <https://associationofanaesthetists-publications.onlinelibrary.wiley.com/doi/10.1111/anae.15262> (Accessed: 4 November 2024).

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This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.

This guideline is for use in Frimley Health Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version History

Version	Date	Guideline Lead(s)	Status	Comment
1	Oct 2018	K Cannons, C Roques, M Peterson	Final	First trust-wide guideline
2	Dec 2021	K Cannons, C Roques, M Peterson	Final	Scheduled review.
2.1	April 2023	H Say	Interim	Contact details updated.
2.2	Oct 2024	H Say	Draft	Scheduled review
3	Jan 2025	K Cannons	Final	Approved for publication.

Related Documents

Trust Guideline	Acute Pain in Older Patients and/or Those With Frailty
Trust Guideline	Management of Teenage and Adult Patients with Patient Controlled Analgesia (PCA)
Trust Guideline	Regional Analgesia Infusion (Excluding Epidurals) in Adult Inpatients
Trust Guideline	Management of Adult Non-Obstetric Patients with Continuous Epidural Analgesia (CEA)
Trust Guideline	Rib Fracture (Summary Flowchart)