



IAEM Clinical Guideline 1

Emergency Department Analgesia in Adults

Version 1

July 2013

DISCLAIMER

IAEM recognises that patients, their situations, Emergency Departments and staff all vary. These guidelines cannot cover all clinical scenarios. The ultimate responsibility for the interpretation and application of these guidelines, the use of current information and a patient's overall care and wellbeing resides with the treating clinician.



GLOSSARY OF TERMS

Pain: Pain is a subjective experience as described in the formal definition: "An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage" (www.iasp-pain.org). Note: The inability to communicate verbally does not negate the possibility that an individual is experiencing pain and is in need of appropriate pain-relieving treatment.

Analgesic: A drug or non-pharmacological technique that relieves pain.

Non-pharmacological pain management: The management of pain and distress without medications. Methods of non-pharmacological procedural pain management include splintage, sling immobilisation of an injured limb and wound dressing.



Emergency Department Analgesia in Adults

INTRODUCTION

The objective of these guidelines is to outline the principles for the appropriate Emergency Department (ED) assessment and management of pain in adults.

These guidelines have been developed to act as a resource for medical and nursing staff and other members of the multidisciplinary ED team to guide them through the principles associated with achieving optimal pain control in adults. These guidelines are not intended to replace clinical judgement.

PRINCIPLES OF ED PAIN MANAGEMENT IN ADULTS

ABCDE of Pain Assessment and Management

- **A**sk about pain regularly. **A**ssess pain systematically;
- **B**elieve the patient and family in their reports of pain and what relieves it;
- **C**hoose pain control options appropriate for the patient, pain level and setting;
- **D**eliver intervention in timely, logical and coordinated fashion;
- **E**mpower patients and their family. **E**nable them to control their pain to the greatest extent possible.

PAIN ASSESSMENT

- Pain is commonly under-recognised, under-treated and treatment may be delayed;
- The experience of the staff member triaging will help in estimating pain severity;
- The assessment of pain includes a careful history and physical examination;
- Pain assessment should be undertaken in conjunction with assessment of vital signs and should be performed regularly;
- Recognition and alleviation of pain should be a priority when treating ill and injured patients. This process should start at triage, be monitored throughout the patient's ED stay and finish with ensuring adequate analgesia at and, if appropriate, beyond discharge;
- Although the better known pain assessment scales have not been validated in the ED setting, they are nevertheless currently satisfactory for the purpose of ED pain assessment and management.

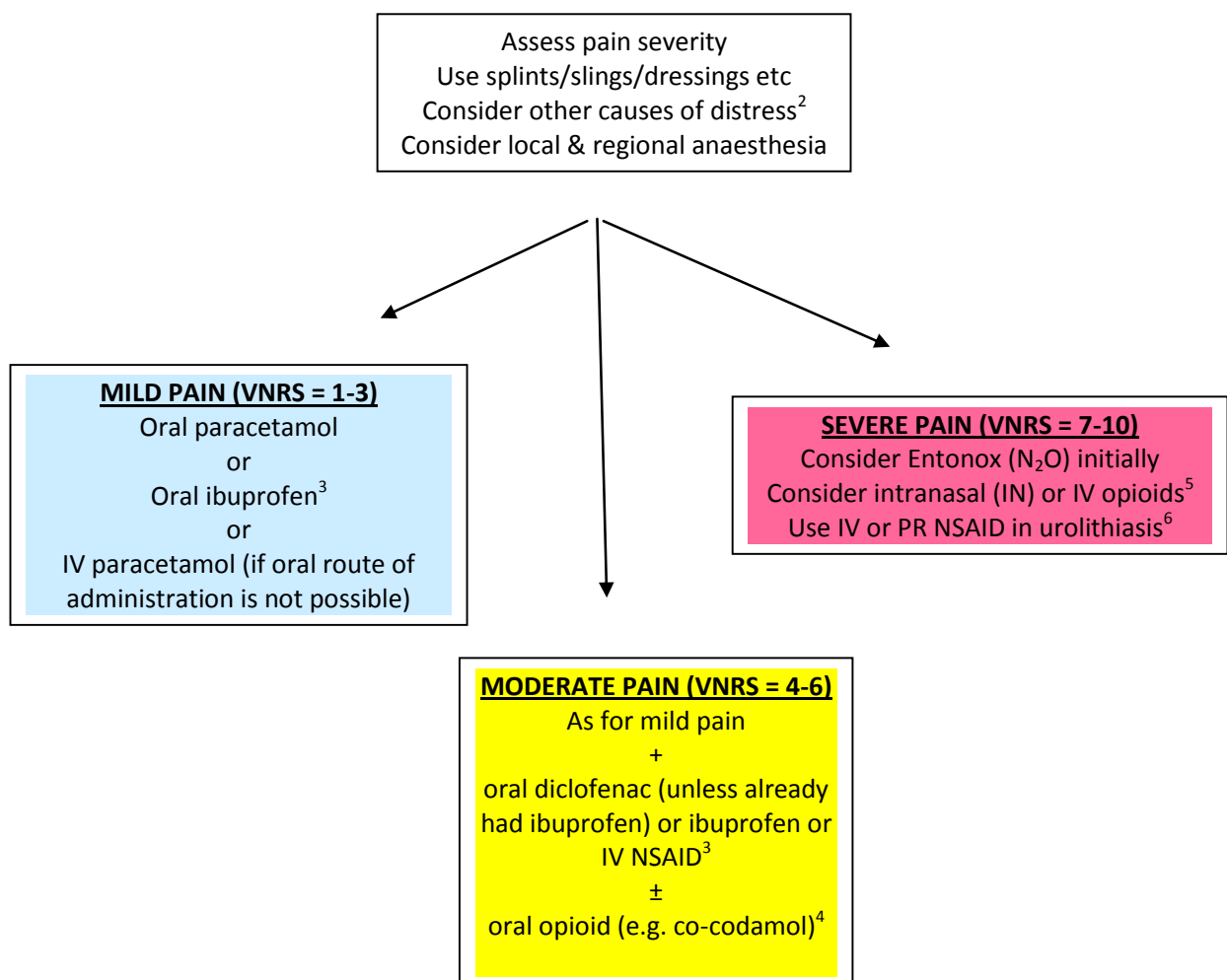
ED assessment of acute pain in adults using the Verbal Numerical Rating Scale (VNRS)

No Pain	Mild Pain	Moderate Pain	Severe Pain
VNRS = 0	VNRS = 1-3	VNRS = 4-6	VNRS = 7-10

- It is important to re-assess the pain control within 30 minutes in severe and moderate pain;
- If analgesia is still found to be inadequate on reassessment, stronger/increased dose of analgesics should be used along with the use of non-pharmacological measures. Simple analgesia, such as Paracetamol, may be used in addition to opiate analgesia in severe pain.

PAIN MANAGEMENT

Algorithm for the ED management of acute pain in adults¹



Notes:

1. Adapted from the College of Emergency Medicine (CEM) Clinical Effectiveness Committee Guideline for the management of pain in adults, June 2010;
2. Other causes of distress include: fear of the unfamiliar environment, needle phobia, fear of injury severity etc.
3. NSAIDs should be avoided or used with caution in the following circumstances: the elderly, allergic disorders (they are contra-indicated in patients with a history of hypersensitivity to aspirin or any other NSAID), coagulation defects (including anticoagulation therapy), cardiac impairment, renal impairment, hepatic impairment, moderate or severe asthma, pregnancy and head injury;
4. Before administering combination drugs (e.g. co-codamol) containing paracetamol, consider the dose of paracetamol the patient has already received to ensure that the total paracetamol dose does not exceed clinically safe limits;
5. Opioids should be used with caution if there is risk of respiratory or cardiovascular depression;
6. In severe pain due to urolithiasis, use IV or PR NSAID as first drug of choice.

- Pain management is a key determinant of patient experience and quality of care;
- Patients in severe pain should be transferred to an area where they can receive appropriate intravenous (IV) or intranasal (IN) or rectal analgesia within 20 minutes of ED arrival;
- Patients in severe pain should have the effectiveness of analgesia re-evaluated within 30 minutes of receiving the first dose of analgesia;
- Patients in moderate pain should be offered oral analgesia at triage/assessment;
- Patients with moderate pain should have the effectiveness of analgesia re-evaluated within 60 minutes of the first dose of analgesia;
- Documentation of the administration of analgesia is essential.