SESLHD PROCEDURE COVER SHEET

Health
South Eastern Sydney
Local Health District

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FUNCTIONAL GROUP(S)	Infection Control, Surgery, Perioperative and Anaesthetics
KEY TERMS	Pain, Wound, Dressing
SUMMARY	This document outlines the procedures to be undertaken to minimise pain associated with wound dressings. It specifies activities to be undertaken to assess, treat and evaluate a patient's pain when removing a dressing and when redressing wounds.

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1. POLICY STATEMENT

The pain experienced by adults and children during wound interventions and dressing changes will be appropriately managed in South Eastern Sydney Local Health District (SESLHD) to minimise distress to the individual.

2. BACKGROUND

Pain by definition is an individual and subjective experience. The most accurate and reliable evidence of the existence of pain and its intensity is an individual's report[1].

Regular assessment of pain leads to improved pain management[2]. Assessment and measurement of pain are fundamental to the practice of assisting in the diagnosis of the cause of a patient's pain, selecting an appropriate analgesic therapy and evaluating then modifying that therapy according to the patient's response.

Pain should be assessed within a biopsychosocial model which recognises that physiological, psychological and environmental factors influence the overall pain experience.

Understanding the cause of the wound pain will assist in the appropriate intervention and management. For example:

- Procedural pain
- Inflammation process - the pain component should reduce over 5 days
- Tissue damage - (nociceptive pain) and or nerve damage (neuropathic pain)
- Wound exudate - that is not contained can cause periwound skin irritation
- Ischemic pain - reduced oxygen to wound bed
- Wound infection - (local or systemic)
- Psychological - consider assessment and counselling for the patient due to anxiety and depression having a direct impact on their mood and pain levels[3].

Untreated pain prevents healing and can lead to chronic pain[4].

Uncontrolled or unexpected pain requires a reassessment of the individual and consideration of alternative causes for pain (e.g. new surgical/medical diagnosis, neuropathic pain).

Pain and/or anxiety may be experienced by patients who are having their wounds attended for many reasons including:

- The wound is always painful
- Procedural pain
    - The application or removal of dressings
    - Cold and chemical solutions used for irrigation and cleaning
    - Antiseptic solutions used on surrounding tissues and internal wounds
- Patients see or smell their wounds
- Staff reactions (both verbal or non-verbal) to patients' wounds
- Ineffective positioning of the patient
- Inappropriate timing of dressings.

If a patient has significant or uncontrolled pain, refer them to the appropriate Medical Officer (MO) or the Pain Service (Acute or Chronic) for review. It is recommended

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that wound interventions are limited prior to appropriate reviews being completed and adequate analgesia administered.

Wound Pain - Acute

Normal body response to skin injury. The wound pain should resolve within 3 months[1]. Pain caused by inflammation is a normal part of the wound healing process and resolves within 5 days. Inflammation that continues after 5 days needs to have review and additional intervention.

Wound Pain - Chronic

Patients with chronic or palliative wounds may experience ongoing chronic wound pain. They will require long term management with wound dressings and pain management strategies.

No wound product should increase the patient's pain level during wear-time, application or removal.

Definitions

Wound pain Acute	Normal body's response to tissue injury and treatment. The pain does not persists past 90days[1]
Wound pain Chronic	Persistent pain that lasts weeks to years cause by ongoing inflammation, dysfunctional nerves or tissue damage. https://my.clevelandclinic.org/health/articles/12051-acute-vs-chronic-pain

Abbreviations

MR	Medical Record
MO	Medical Officer (includes General Practitioner for community patients)
MDT	Multidisciplinary team

3. RESPONSIBILITIES

3.1 Employees will:

Ensure that they work within their scope of practice and attend relevant education related to this procedure.

3.2 Line Managers will:

Ensure all clinical staff are given the opportunity to attend District wound management education and that all clinicians work within this procedure and have appropriate resources and stock items to implement the recommendations within this procedure.

3.3 Medical staff will:

Ensure that they work within their scope of practice and attend relevant education related to this procedure.

4. PROCEDURE

4.1 Assessment

- Review the patient's wound pain history and previous pain management strategies and analgesia requirement during dressing changes.

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- Select the most appropriate pain tool to use based on patient's age and cognitive ability. **Note Involvement of family/carers with children and special needs adults is imperative for any wound intervention.**
  Examples of self-reporting pain-intensity measurement tools, refer to Appendix A: Examples of self-reporting pain-intensity measurement tools.
- Document in the patients' health care record see section 5 documentation
  - the name of pain assessment tool being used
  - the outcome of the assessment
  - the strategies to be used to prevent or management wound pain
- Complete an initial assessment of the wound pain on admission to ward/unit/service. **Note** other pain the patient may have which is not wound pain and strategies in place of that pain. If required refer to MO, MDT
- Continue to assess the patients wound pain, before, during and after wound intervention using the designated assessment tool

4.2 Action

Before wound intervention is commenced,

- prepare the patient and the environment
- time the wound intervention to provide an environment of comfort and to minimise distress
- initiate pain management plan, which may include prescribed analgesia. See 4.2.2 Types of analgesia

4.2.1 Considerations

Consideration needs to be given to the:

- environment
- anticipated time the wound intervention takes
- ability of the patient to cope with the intervention

Sedation or anaesthetic maybe more appropriate than bedside strategies if the

- wound is extensive, this enables the wound to be properly assessed, cleaned and dressed. This can significantly reduce patient discomfort and results in time efficient wound management
- wound intervention is scheduled to last longer than one hour,
- patient is in a high dependency or intensive care environment
- patient is distressed and pain relief methods as suggested in this document have not been effective

4.2.2 Types of Pain relief

Pharmacological

Administration of systemic analgesia is the most common intervention used for relieving pain.

Appropriate analgesia or pain management is to be administered to the patient in line with local prescribing guidelines and product information. Once administered it is essential the analgesia is given time to work.

The following list of analgesia modes are suggestions only. Clinicians are strongly advised to seek advice from the acute pain services (APS) and must adhere to the SESLHD

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Formulary and local guidelines. Locations with nil or limited access to APS or in Community Setting, are recommended to seek advice from hospital pharmacists or refer patients to their General Practitioners.

Systemic analgesia
- Must be prescribed by Medical Officer, Nurse Practitioner or another approved prescriber.

Topical analgesia
- Must be prescribed by Medical Officer, Nurse Practitioner or another approved prescriber.
    - Lidocaine gel – for intact skin only
    - Tetracaine (Amethocaine) Local Angel® – for minor wounds only.

Inhalation analgesia
- Must be prescribed by Medical Officer, Nurse Practitioner or another approved prescriber.
    - Nitrous oxide 50%/Oxygen 50% (e.g. Entonox). NB* adhere to local hospital clinical business rules or seek advice from the pain service
    - Methoxyflurane inhaler (*green whistle*) – **prescribing restricted to Pain Team ONLY.** NB* adhere to local hospital clinical business rules

Non-pharmacological / Miscellaneous

Non-pharmacological pain management strategies are to be used by staff with appropriate levels of training in the particular therapy or device:
- Aromatherapy
- Breathing/relaxation
- Diversional therapy/play therapy
- Music therapy
- Positioning e.g. using pillows
- Transcutaneous Electrical Nerve Stimulation (TENS).

Manufacturer's instructions to be adhered to

4.3 Dressing Removal

Suggested methods of dressing product removal are listed below (local guidelines are to be adhered to in relation to these):
- Removing in shower (if applicable)
- Soaking with normal saline (Sodium Chloride 0.9%)
- Syringing with warm normal saline (Sodium Chloride 0.9%) through blunt needle
- Utilising adhesive removal wipes (e.g. Remove™) or spray (e.g. Niltac™) (alcohol free adhesive remover wipes should be used if periwound skin is excoriated or broken). Note: Spray remover recommended for paediatric patients.

For portable negative pressure devices using foam filler prior to attempting to remove any dressings: Refer to SESLHDPR/728 - Negative Pressure Wound Therapy Procedure for further details
- Turning the device off at least 30minutes prior to allow time for the pressure to equalise in the wound bed and the dressing to separate from the tissues[5].

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- Injecting saline solution under the dressing may also help to reduce pain and facilitate atraumatic removal[5].

4.4 Evaluation

The effectiveness of the pain management plan must be evaluated regularly and appropriately amended.

Evaluation can occur using the following methods:

- Asking the patient about their pain before, during and after the wound intervention
- Observing the patient for non-verbal signs of pain before, during and after wound intervention
- Assessment of the pain score using pain measurement tools.

5. DOCUMENTATION

- Patient's health care record - Electronic Medical record eMR (e.g. BTF and electronic wound care templates)
- eMedication in the patients Electronical Medical Record (eMR)
- SESLHD Wound assessment and management plan (SEI060.118).
- Patient Controlled Analgesia (PCA)/Pain charts

6. AUDIT

Not required.

7. REFERENCES

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Internal References

SESLHDPR/297 - Wound Assessment and Management

8. REVISION AND APPROVAL HISTORY

Date	Revision Number	Author and Approval
March 2009	Final draft	Area Wound Committee – new policy
September 2015	1	To be endorsed by the ISLHD Drug and Quality Use of Medicines Committee
September 2015	1	SESLHD and ISLHD wound committee
August 2017	2	SESLHD and ISLHD wound committee
October 2017	2	Links to other LHD documents and UK websites removed.
December 2017	2	Processed by Executive Services prior to publishing.
December 2022	3	Minor review. SESLHD and ISLHD wound committee. Updated hyperlinks and definitions. Approved by Executive Sponsor.
May 2023	3	Approved by the SESLHD Drug and Therapeutics Committee.

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Appendix A: Examples of self-reporting pain-intensity measurement tools

These are available on eMR Between the Flags tab (BTF)

BTF observations on the left hand menu, then go down to neurological and press **+** (add) to go to pain scale tools, select the most appropriate tool for your patient cohort.

Numerical pain intensity scale[1,11]

Ask the patient to rate their pain on a scale of 0 – 10, where 0 represents no pain and 10 represents the worst pain you can imagine.

Verbal categorical rating scale[1]

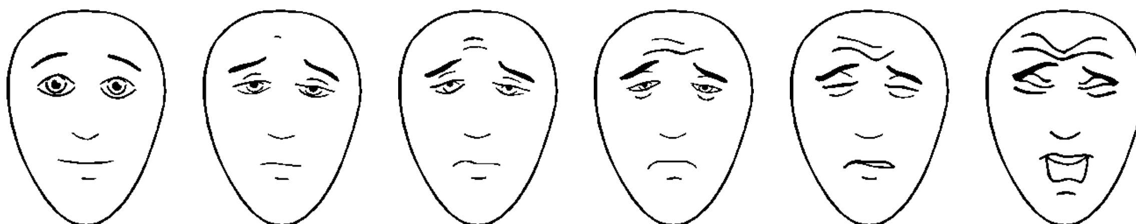
Ask the patient which word best describes his/her current level of pain:

NO PAIN	MILD PAIN	MODERATE PAIN	SEVERE PAIN

Visual Analogue Scale (VAS)[12]

Ask the patient to select the point on a 10cm line which reflects how he/she feels:

Faces Pain Scale – Revised (FPS-R)[6,13]



The Faces Pain Scale – Revised (FPS-R)

Instructions:

In the following instructions, use the word "hurt" or "pain", whichever seems to be better understood by the child

These faces show how much something can hurt. This face *[point to the left-most face]* **shows no pain. The faces show more pain** *[point to each from left to right]* **up to this one** *[point to the right-most face]* **– it shows very much pain. Point to the face that shows how much you hurt** *[right now].*

Notes to administrator:

Score chosen face on a 0-10 scale, counting left to right 0-2-4-6-8-10 where 0='no pain' and 10='very much pain'.

IMPORTANT: Make the endpoints clear to the child (i.e. no pain/very much pain). Do not use words like 'happy' or 'sad' – the scale is for measuring pain intensity and not mood. This scale is intended to measure how a child feels inside, not how the child thinks their face appears to others.

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Pain Assessment in Advanced Dementia Scale (PAINAD)[7]
A Five-item observational tool for use among patients with dementia
The tool and guidelines available via weblink:
http://dementiapathways.ie/_filecache/04a/ddd/98-painad.pdf

The Abbey Pain Scale[8]
Used for patients with dementia or who cannot vocalise.
The tool and guidelines available via weblink:
http://www.health.gov.au/internet/publications/publishing.nsf/Content/triageqrg~triageqrg-pain~triageqrg-abbey

Paediatric Populations[10,14,15]

THE FLACC SCALE[9]

Category	Scoring		
	1	2	3
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort

Each of the five categories (F) Face; (L) Legs; (A) Activity; (C) Cry; (C) Consolability is scored from 0-2, which results in a total score between zero and 10.

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