SESLHD PROCEDURE COVER SHEET

NAME OF DOCUMENT	Wound – Managing Pain at Dressing Change
TYPE OF DOCUMENT	Procedure
DOCUMENT NUMBER	SESLHDPR/437
DATE OF PUBLICATION	December 2017
RISK RATING	Low
REVIEW DATE	December 2022
FORMER REFERENCE(S)	PD 275 Wound Management – Managing Pain at Dressing change
EXECUTIVE SPONSOR or **EXECUTIVE CLINICAL SPONSOR**	Dr Greg Keogh SESLHD Director of Surgery, Perioperative and Anaesthetics Greg.Keogh@health.nsw.gov.au
AUTHOR	SESLHD Wound Management Committee
POSITION RESPONSIBLE FOR THE DOCUMENT	Sally Peters SESLHD Clinical Stream Nurse Manager - Innovation and Improvement sally.peters@health.nsw.gov.au
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

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY

Feedback about this document can be sent to SESLHD-ExecutiveServices@health.nsw.gov.au

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.

Untreated pain prevents healing and can lead to chronic pain[3].

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
- The application or removal of dressings
- Cold and chemical solutions are used for irrigation and cleaning
- Antiseptic solutions are 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 Acute Pain Team (or alternative in your facility or Network) for consultation. It is recommended that wound interventions are limited prior to appropriate reviews being completed and adequate analgesia administered.

Chronic Pain

Patients with chronic wounds require ongoing management of their chronic pain.

Most chronic wounds consist of venous and arterial leg ulcers, pressure ulcers and diabetic foot ulcers. Some will heal within six months whilst others will never heal, requiring long term management with wound dressings and pain management.

Chronic wound pain has two characteristics, one relating to the tissue damage (nociceptive pain) and the other relating to the nerve damage (neuropathic pain). Appropriate management of chronic wound pain is different to the management of wound pain at dressing change, encompassing other types of pharmacology. Chronic wound pain needs to be assessed and managed in addition to pain at dressing change.

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

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

An initial assessment of the pain associated with a wound is to be completed on admission to ward/unit or during the initial presentation to a particular service (e.g. community nursing). The SESLHD Wound Assessment and Management Plan form S0056 must be used to document the findings.

An appropriate pain assessment tool is to be utilised to obtain an objective perspective of the experiences felt by the person with the wound. A numerical scale is included within the SESLHD Wound assessment and management plan; however, utilisation of pain assessment tools used within the facility can be adopted.

The use of alternate pain assessment tools must be documented clearly in the patient's health care record and on the SESLHD Wound Assessment and Management Plan so as continuity can be maintained.

Examples of self-reporting pain-intensity measurement tools: refer to Appendix A
- Verbal Numerical Rating Scale (0-10)[1]
- Verbal Descriptor Scale (e.g. pain none, mild, moderate, severe)
- Visual Analogue Scale
- Faces Pain Scale-Revised[5].

Examples of pain-indicating behavioural scales for clients unable to communicate: refer to Appendix B

- Pain Assessment in Advanced Dementia [6] (PAINAD) Scale
- Abbey pain scale[7].

The patient's pain should be assessed before, during and after wound intervention using the designated assessment tool. This needs to be recorded on the SESLHD Wound Assessment and Management Plan and in the patient's health care record. It is also important to note any other pain the patient may have which is not wound pain, so that the right drug for the right pain is prescribed and administered.

Involvement of family/carers with children and special needs adults is imperative for any wound intervention.

4.2 Action

Before wound intervention is commenced, prepare the patient and the environment. Timing of the wound intervention needs to be appropriate to facilitate an environment which is conducive to comfort and to minimise distress.

4.2.1 Considerations

Consideration needs to be given to the environment, the anticipated time the wound intervention takes and the ability of the patient to cope with the intervention. For extensive wounds, the provision of sedation or anaesthetic in the operating theatre enables the wound to be properly assessed, cleaned and dressed. This can significantly reduce patient discomfort and results in time efficient wound management.

- If the wound intervention is scheduled to last longer than one hour, it may be more appropriate to schedule time in the operating theatre.
- If the patient is in a high dependency or intensive care environment, sedation may be an option prior to/during the wound intervention
- If the patient is distressed and non-pharmacological methods as suggested in this document have not been effective, sedation or general anaesthesia must be considered.
- The presence of a parent or a family member can reduce a child's anxiety during the procedure. Familiar comforters such as favourite toys/blankets should also be used.

4.2.2 Types of Analgesia

Appropriate analgesia or pain management is to be administered to the patient in line with prescribing guidelines and product information. Once administered it is essential that the analgesia is given time to work. Suggested types are listed below (local guidelines are to be adhered to in relation to these):

<u>Systemic analgesia</u>

- As prescribed by Medical Team/Nurse Practitioner.

Topical analgesia

- As prescribed by Medical Team/Nurse Practitioner
- Emla cream™ (Lignocaine and prilocaine cream) – for intact skin only
- Lignocaine gel – for intact skin only
- Other local anaesthetic gel preparations e.g. Amethocaine or 'local angel' – for minor wounds only.

Inhalation Analgesia

- Nitrous oxide e.g. Entonox
- Methoxyflurane inhaler.

Miscellaneous/non-pharmacological

- 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

See Appendix C for links to relevant paediatric policies

Visualisation - must be employed by staff with appropriate levels of training.

4.3 Dressing Removal

Suggested methods of dressing product removal are listed below (local guidelines are to be adhered to in relation to these):

- Removal in shower (if applicable)
- Soaking with normal saline (Sodium Chloride 0.9%)
- Syringe with warm saline through blunt needle
- Utilisation of adhesive removal wipes (alcohol free adhesive remover wipes should be used if periwound skin is excoriated or broken).

For Topical negative pressure devices prior to attempting to remove any dressings:

- Switch off negative pressure vacuum assisted therapy to allow foam to inflate.

  and/or
- Inject normal saline down the tubing and close clamp to allow foam to re-expand.

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

- National In-Patient Medication Chart
- SESIAHS Wound assessment and management plan
- Patient's health care record
- Patient Controlled Analgesia (PCA)/Pain charts
- Community / out-patient health care records

6. AUDIT

Not required.

7. REFERENCES

External References

No	Reference
1	Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine. 2005, Acute Pain Management: Scientific Evidence. Approved by the NHMRC
2	Swanson T (2014) chapter 3 Assessment in Wound management for the advanced practitioner Edited by Swanson T, Asimus , M & Guinesss, B page 76, IP Communications, Melbourne
3	Paris PM, Yealey DM. Chapter 187: Pain Management. In Marx J, Adams J, Rosen P et al, eds. (2006) Rosen's Emergency Medicine: Concepts and Clinical Practice, 6th ed, Philadelphia, PA: Mosby
4	Pain Concern retrieved from web 23/2/09 http://www.painconcern.org.uk
5	Faces pain intensity scale from the *Paediatric Pain Sourcebook.* Copyright © 2001. Used with permission of the International Association for the Study of Pain and the Pain Research Unit, Sydney Children's Hospital. Randwick NSW Or Hicks, C.L., von Baeyer, C.L., Spafford, P., van Korlaar, I., & Goodenough, B. (2001) The Faces Pain Scale – Revised: Toward a common metric in paediatric pain measurement. *Pain 93*:173-183.
6	Warden V, Hurley AC, Volicer L. (2003) Development and psychometric evaluation of the pain assessment in advanced dementia (PAINAD) scale. J Am Med Dir Assoc 4:9-
7	Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L; Parker, D and Lowcay, B. Funded by the JH & JD Gunn Medical Research Foundation 1998 – 2002. The Royal College of General Practitioners Website: http://www.health.gov.au/internet/publications/publishing.nsf/Content/triageqrg~triageqrg-pain~triageqrg-abbey
8	Merkel, S et al (1997) *The FLACC: A behavioral scale for scoring postoperative pain in young children*. Paediatric Nurse 23(3), p. 293-297. Copyright 1997 by Jannetti Co. University of Michigan Medical Center. Reprinted with permission.
9	Witt, N., Coynor, S., Edwards, C. & Bradshaw, H. (2016). A guide to pain assessment and management in the neonate, Current Emergency and Hospital Medicine Reports, Vol. 4, No. 1, PP. 1-10 https://link.springer.com/article/10.1007/s40138-016-0089-y

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.

Appendix A

Numerical pain intensity scale[4]

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

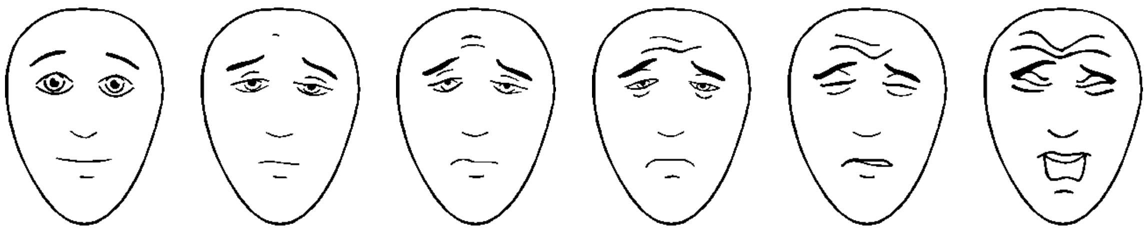
Ask the patient which word best describes his/her current level of pain:

NO PAIN	MILD PAIN	MODERATE PAIN	SEVERE PAIN

Visual Analogue scales

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

No pain **Worst pain you can imagine**
0 **10**



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 <u>no pain</u>. The faces show more pain** *[point to each from left to right]* **up to this one** *[point to the right-most face]* **– it shows <u>very much pain</u>. 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.

Appendix B

The Abbey Pain Scale

Used for patients with dementia or who cannot vocalise.

The tool and guidelines available via web-link:

http://www.health.gov.au/internet/publications/publishing.nsf/Content/triageqrg~triageqrg-pain~triageqrg-abbey

Appendix C

Paediatric Policies[9]:

THE FLACC SCALE[8]

Category	Scoring		
	1	2	3
	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
	No cry (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams or sobs, frequent complaints
	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.

PAIN MANAGEMENT – Neonates
Link:
https://link.springer.com/article/10.1007/s40138-016-0089-y

SUCROSE - MANAGEMENT OF SHORT DURATION PROCEDURAL PAIN IN INFANTS
Link:
https://link.springer.com/article/10.1007/s40138-016-0089-y

INHALATION ANALGESIA PROCEDURES
Nitrous Oxide 50%/Oxygen 50% Patient Administration CLIN005
Link:
http://seslhnweb/shseh/Policies/policies.asp#N