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NHS West Suffolk Clinical Commissioning Group

PAIN ASSESSMENT AND MANAGEMENT FOR WOUNDS IN ADULTS
Guidance on pain assessment and management for wounds in adults in primary care

Key messages

- Involve patient with pain and wound assessment and ongoing care
- Assume all wounds may be painful
- Assess pain each time a dressing related procedure is carried out
- Reconsider dressing choice if soaking is required for removal or removal leads to bleeding/trauma either around wound or surrounding tissue
- Chronic wounds: consider undertaking holistic wound assessment using the Best Practice Statement
- Consider need for referral to specialist services e.g. Leg Ulcer Clinic, Tissue Viability, Lymphodema, Vascular, Dermatology, Podiatry, Neurology , Diabetic, Well Being, Physiotherapy or Pain Services.

STEP 1

Assessment

- Establish concerns, expectations and agreed goals
- Assess pain and impact on quality of life. Consider using Patient Questionnaire, and the appropriate Pain assessment tool
- Identify type of wound pain and distinguish between background, incident pain and/or pain during or after dressing procedures. Further information: see Appendix A
- Assess for and address and treat local wound factors causing pain: infection, ischaemia, oedema, excessive exudate, maceration of surrounding skin, excessive dryness or dermatological problems or inappropriate diagnostic or therapeutic interventions

Cognitive impairment

- *Mild /moderate dementia*: self report is the most valid and reliable indictor of pain. It may be necessary to ask questions about pain in different ways to elicit a response
- *Advanced dementia*: Use a behavioural pain assessment scale e.g. Abbey Pain Scale , PAINAD or Doloplus

Neuropathic pain

- Use DN4 to assess for possibility of neuropathic/mixed pain i.e. burning, stabbing shooting, electrical shocks, pins and needles, tingling, numbness

STEP 2

Non-pharmacological strategies

See overleaf for strategies to

- Reduce anxiety at dressing removal
- Reduce pain with wound cleansing
- Manage pain during wound dressing

Minimise prolonged exposure or unnecessary stimulus to the wound. Remember slight touch may cause pain

STEP 3

Pharmacological strategies: prescribing

- Consider preventative analgesia (e.g. need for an immediate release preparation 30-60 mins prior to wound dressing)
- Consider need for local anaesthetic agent (e.g. EMLA cream to facilitate cleansing / debridement of leg ulcers in adults. Apply 30-60 mins prior to dressing)
- Refer to the Suffolk GP Wound Care Formulary or Suffolk Community Wound Care Formulary
- WSCCG guidance: Acute Pain Ladder, Opioid Prescribing in Acute Pain-Key Recommendations, Chronic Pain Ladder , Neuropathic Pain ladder
- Patient information leaflets: Taking Opioids For Pain, Driving and Pain, Opioid Safety, Anti-Neuropathic Drugs, NSAIDs

STEP 4

Pharmacological strategies: de-prescribing

Consider reducing potentially problematic polypharmacy, adverse drug effects, inappropriate or ineffective medication use. Deprescribing should be undertaken in partnership with patient (and sometimes their carer)

- Opioid Tapering Guidance Resource Pack, Pregabalin and Gabapentin Withdrawal Summary Guidance , Lidocaine 5% Medicated Plasters. Guidance for Non – Cancer Pain
- Patient information leaflets: Gabapentinoid Reduction, Lidocaine 5% Medicated Plasters

If non-pharmacological approaches and analgesic management unsuccessful, reassess and review diagnosis and treatment plan, consider referral to Pain Service and/or condition specific service

Please turn over leaf for Step 2 non-pharmacological strategies

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Non-pharmacological strategies

Strategies to reduce anxiety

Discuss with the patient

- Expectations, fears and concerns relating to wound and dressing change
- What to expect
- Triggers that increase pain intensity
- Strategies that reduce pain
- How much they would like to be involved in their wound care/dressing i.e. removal of dressing themselves
- Whether they would like a family present or a supportive carer present during dressing change
- Offer time out during the procedure and negotiate a signal e.g. hand/finger raise or hand clap
- Benefits for slow rhythmic breathing technique during the dressing procedure or any helpful relaxation strategy e.g. distraction, listening to music, singing or use of IT etc.

Strategies to reduce pain with wound cleansing

Type of wound	Recommendations
Acute wound	Use gentle stream of warm 0.9% normal saline to clear wound of visible debris
Surgical wound	Showering or bathing usually adequate to clean simple wounds
Chronic wounds	Excessive exudate: gently remove the exudate surrounding the wound using a gentle stream of warm tap water or 0.9% normal saline. Remove debris with a soft gauze swab
Leg ulcers	To remove exudate and promote comfort it is good practice for patients to soak their legs and feet in a basin of warm tap water before redressing
If it is not necessary don't clean wound	

Strategies to manage pain at wound dressing

Avoid

- Products that adhere to wound bed
- Wound dressing drying out
- Avoid any unnecessary stimulus to wound from touching, prodding/poking or drafts from open windows/fans
- Unnecessary pressure/friction from dressing, tape or bandage

Do

- Handle the wound gently and be aware that even slight touch can cause an increase in pain
- Consider whether patient wishes to remove dressing themselves
- Support the surrounding skin during dressing removal if required
- Select wound product appropriate for type of wound that maintains moist wound healing whilst managing exudate
- Ensure correct application and removal of dressing as per manufacture's instruction and according to exudate levels
- Protect surrounding skin with a barrier cream/film if required
- Assess comfort of dressing, tape and bandage after dressing
- Regularly review the frequency and necessity of dressing changes (aiming for lower frequency)
- Work gently and swiftly to apply dressing

References

1. Wounds UK (2018) Best Practice Statement: Improving holistic assessment of chronic wounds.
2. Wounds International (2016) Best Practice Statement. Optimising patient involvement in wound management
3. World Union of Wound Healing Societies (2004) Principles of best practice: Minimising pain at wound dressing related procedures.
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5. Brown (2014). Strategies to reduce or eliminate wound pain. *Nursing Times.* 110: 15, 12-15.
6. NHS Forth Valley (2018) Wound management formulary 1st Ed. V 5.3
7. EWMA (2019) e-learning. Basics of wound management

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PAIN ASSESSMENT FOR WOUNDS IN ADULTS
Types of wound pain and common causes

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Appendix A.

Types of wound pain	
Type	**Description**
Background pain	• Pain around the wound even at rest when no wound manipulation is taking place. It may be intermittent (e.g. similar to cramp or night time pain or continuous pain (e.g. like a toothache). • Caused by pain aetiology, local wound factors (e.g. infection, ischaemia, maceration) and other related pathologies (e.g. peripheral vascular disease, diabetic neuropathy, oedema etc). • The patient may also have pain that is not related to wound pain but impacts on their pain experience and quality of life (e.g. acute, chronic or cancer pain).
Incident pain	Occurs at the site of wound triggered by activities such as sneezing, coughing, walking, changing positions, or following dressing slippage
Procedural pain	Directly related to activities associated with a procedure e.g. dressing removal, wound cleaning, dressing application.
Operative pain	Arises from an invasive wound intervention e.g. biopsy, wound debridement.

Common causes of wound pain	
Causes	**Description**
Infection	Redness, heat, swelling
Ischaemia	Peripheral artery symptoms and signs **Intermittent claudication** Aching or burning in leg muscles on exercise which is relieved by rest. Never present at rest or exacerbated by position of limbs. **Critical limb ischaemia** Rest pain in foot for more than 2 weeks. Patient frequently hanging their leg/s out of bed to reduce symptoms. Can be difficult to distinguish from neuropathy. Pain may be resistant to opioids. **Acute life threatening ischaemia** Rare, often sudden onset but also indicated by sudden deterioration of claudication. Patient will have one or more of the '6 Ps' **P**ain at rest, **P**allor, **P**ulselessness, **P**araesthesia, **P**aralysis, **P**erishingly cold
Oedema	Swelling from fluid accumulation in body tissues
Exudation	Higher density and amount of exudate.
Maceration	Damage to periwound skin.
Inappropriate diagnostic or therapeutic interventions	Wet to dry dressing changes, debridement or iatrogenic device insertion.

Please turn over leaf for verbal descriptive pain assessment questions

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PAIN ASSESSMENT FOR WOUNDS IN ADULTS
Verbal descriptive pain assessment questions

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Does the patient have background/ incident pain?
Does the patient experience pain during or after dressing related procedures?

PQRST	Questions to ask to assess character and severity of pain
P Provoking & palliating factors	**Triggers** • **During dressings:** what makes the pain worse, e.g. dressing removal, exposure of wound, wound cleansing, having the dressing applied? • What makes the pain worse, e.g. touch, positioning, movement, day versus night? **Reducers** • **During dressings:** what helps reduce the pain, e.g. removing the dressing yourself, slow removal of dressing, time out, or other strategies? • What makes the pain better, e.g. medication, bathing, leg elevation, hanging leg/s over side of bed, type of wound dressing, distraction or relaxation?
Q Quality	• **During dressings:** describe the pain during dressing removal? • At rest describe the pain or soreness in your wound, e.g. aching or throbbing (likely to be nociceptive pain) or sharp, burning, stabbing shooting, electrical shocks, pins and needles, tingling, or a numbness sensation? (likely to be neuropathic pain).
R Region/radiation	• Where is the pain? • Is the pain limited to your wound or do you feel pain in surrounding areas? Consider using a body map.
S Severity	**Use pain scales (see overage)** • How severe is your pain on a scale of 0-10, with zero being no pain and 10 being worst pain possible **during and after dressing procedures.** • How severe is your pain on a scale of 0-10, with zero being no pain and 10 being worst pain possible that you have on a daily basis? (intensity may vary with rest and movement). • How much does the pain interfere with your daily activities and sleep?
T time	• When did your wound pain first start? • Is the pain occasional/ intermittent or constant? • **Following dressings:** how long does it take for the pain to resolve? • If intermittent how long does the pain last?
U Understanding	• What are your expectations? • Do you have any concerns? • Does the pain cause you to feel worried or low in mood?

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