Pain management algorithm for mental health services for older people

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Complete pain assessment

Able to communicate/articulate pain - use e.g., visual analogue scale (VAS)
Unable to communicate/articulate pain - use e.g., Abbey Pain Scale
Consider non-pharmacological management of the presenting condition

Chronic/acute pain identified

Prescribe PRN **or** regular [1]Paracetamol PO 1 gram every 4 hours (maximum daily dose of 4 grams in 24 hours). Ensure patient is receiving regular administration at the maximum dose before moving onto the following step

Monitor Pain using the appropriate assessment tool e.g., VAS/Abbey Pain Scale

Ineffective Pain Relief

Add [2]weak opioid (e.g., Codeine phosphate as a regular or PRN dose). Consider laxatives

Monitor Pain using the appropriate assessment tool e.g., VAS/Abbey Pain Scale

Ineffective Pain Relief

Consider increased dose of weak opioid or consider [3]stronger opioid e.g., Buprenorphine patch, morphine

Monitor Pain using the appropriate assessment tool e.g., VAS/Abbey Pain Scale

Ineffective Pain Relief

Increase dose of [3]stronger opioid. If ineffective, seek advice from clinical pharmacist or consider referral to specialist pain clinic

No pain identified

No further action but assess regularly

Effective pain relief

Inflammatory pain

[1]Paracetamol 1 gram every 4 hours as regular/ PRN

Monitor Pain using an appropriate assessment tool e.g., VAS/Abbey Pain Scale

Ineffective Pain Relief

Add topical NSAIDs if osteoarthritis of knee or hand

Monitor Pain using the appropriate assessment tool e.g., VAS/Abbey Pain Scale

Ineffective Pain Relief

Consider adding oral [4]NSAID+PPI. Seek advice from clinical pharmacist

Monitor Pain using the appropriate assessment tool e.g., VAS/Abbey Pain Scale

If ineffective: consider opioids. Refer to rheumatology if symptoms persist

- **For a new presentation of neuropathic pain or chronic primary or secondary pain, seek advice from specialist pain clinic or refer to NICE guidelines**
- **For advice on palliative care and end of life treatment, please consult specialist palliative care team or regional guidelines**

Title	Pain management algorithm for Mental Health Services for Older People		
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Additional Considerations:

[1]PARACETAMOL:

- Exercise caution when prescribing paracetamol to patients with low body weight (under 50kg) as these patients may be at increased risk of experiencing hepatotoxicity at therapeutic doses. Clinical judgement must be used when prescribing for these patients, especially in the presence of additional risk factors such as malnutrition and alcoholism.

[2]WEAK OPIOID (codeine phosphate):

- Opioid therapy may be considered for patients with moderate or severe pain, particularly if the pain is causing functional impairment or is reducing their quality of life.
- 20-40% of the general population cannot metabolise codeine. Therefore, if deemed to be ineffective consider an alternative weak opioid such as dihydrocodeine. Tramadol should be avoided in older adults due to increased risk of adverse effects.
- Start at low doses e.g., codeine phosphate 15 mg four times daily and titrate upwards based on therapeutic response.
- Addiction potential should be considered prior to prescribing opioids,

[3]STRONGER OPIOIDS:

- Constipation is a common side effect – ensure adequate laxatives are prescribed. Other side effects include increased drowsiness which can increase falls risk. Monitor closely for side effects
- Consider use of an opiate conversion chart to calculate total daily opiate requirement if required
- The risk of harm significantly increases with equivalent doses above 120mg of morphine without an increased benefit. However, this must be individualised and carefully monitored.
- **Buprenorphine Transdermal Patches:** Provides 24-hour release of analgesia. To be considered when oral medications have failed or cannot be taken. This is for chronic pain only as it takes up to 72 hours to reach adequate levels. If the patient is already on codeine or other opioids, consider continuing for 24 hours after the initial application of the buprenorphine patch. Do not consider altering dose of buprenorphine until 72 hours after initial administration. Use body charts to record patch placement. If skin irritation occurs, consider alternative opioid. If patch begins to peel off, follow manufacturers advice. If indicated, a referral to specialist pain clinic must be made. On discharge, if used, ensure clinical rational for analgesic patch is stipulated in discharge letter to GP.
- **Buprenorphine Transdermal Patches and Effects of Heat:** Heat can increase the absorption of medication from transdermal patches increasing the risk of adverse effects. Therefore, patients should be advised to avoid exposure to external heat sources such as heat packs, electric blankets, heat lamps, saunas etc. Fever can also increase absorption from patches resulting in increased plasma levels.
- Ensure patient and carers are counselled about the potential for life-threatening harm from accidental exposure to patches particularly in children and this guide is followed to reduce potential for medication errors.

[4]ANTI-INFLAMMATORIES:

- Must be prescribed with caution in the elderly due to increased risk of abdominal bleeding; potential adverse effects on renal function and increase in arterial blood pressure. If lithium, anticoagulants, antiplatelets or SSRIs are already prescribed use anti-inflammatories with great caution. Consider co-prescription of proton pump inhibitors (PPI). All older people taking NSAIDs should be routinely monitored for gastrointestinal, renal, and cardiovascular side effects, and drug–drug and drug–disease interactions. Check for interactions prior to prescribing NSAIDs/NSAIDs + PPI.
- The lowest effective dose of NSAID or COX-2 selective inhibitor should be prescribed for the shortest time necessary
- NSAIDs are more effective for persistent inflammatory pain than paracetamol. For osteoarthritis, NICE recommends that oral NSAIDs/selective COX-2 inhibitors may be substituted for paracetamol/topical NSAIDs where these have been ineffective for pain relief or added to paracetamol where paracetamol or topical NSAIDs provided insufficient pain relief.

Guidance on specific types of pain:

- ***Acute pain*** - must be managed according to condition by the most appropriate team, involve acute services as necessary.
- ***Neuropathic Pain***: – seek advice from clinical pharmacist, medical staff, or specialist pain management services
- ***Inflammatory pain:*** Continue with caution as may take longer for anti-inflammatory effects. MUST have regular review and monitor U's and E's, LFT's, if deranged then stop NSAIDs
- Topical capsaicin should be considered as an adjunct to core treatments for knee or hand osteoarthritis.

All prescribing decisions must have a clearly documented clinical rationale. The need to continue treatments should be considered at each review, with a view to deprescribing where appropriate. eGFR and interactions must be considered in all prescribing. This consideration must be documented within the electronic patient record. Please consult a clinical pharmacist for any further questions/advice.