Western Health

# FRACTURED NECK OF FEMUR (# NOF) ANALGESIA REFERENCE SHEET

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## PAIN MANAGEMENT requires FREQUENT ASSESSMENT, INTERVENTION, REVIEW and DOCUMENTATION

## ASSESSMENT

→ **Assess pain severity using appropriate Pain Scale tool**
- Tool used is informed by patient age, language, comprehension & cognitive state
- Consider using an interpreter
- Use the pain scale consistently (leave a copy of the pain scale at the bedside).

**Pain Scales**: *Self Report is superior to Observer Rating*
1. **Descriptor** (nil, mild, moderate, severe, unbearable)
2. **Numerical Rating Scale: "0-10"**
3. **Faces pain scale**
4. **Abbey pain scale** - *if cognitively impaired*

→ **Assess Functional Activity Score (FAS)**

→ **Assess source of pain**

consider other sources of pain: pressure areas, urinary retention, faecal loading, pre-existing chronic pain

→ **Assess for Opioid Induced Ventilatory Impairment (OIVI) using Sedation Score**

→ **Assess for other side effects from previous medication & interventions**

Including: nausea, vomiting, constipation, delirium

| Sedation Score (SS) | Functional Activity Score (FAS) | Assess current analgesic use, efficacy & side effects |
|---|---|---|
| **0** Alert<br>**1** Sometimes drowsy, easily roused, can stay awake once woken.<br>**2** Often drowsy, easily roused, yet falls asleep easily, unable to stay awake.<br>**3** Often drowsy, difficult to rouse, indicating severe OIVI | **A** Activity is unrestricted by pain (coughing, transfers, mobilising)<br>**B** Pain mild/somewhat limits activity<br>**C** Pain severely limits activity | → Previous analgesia (opioid naïve or tolerant?)<br>→ Drugs, doses, routes<br>→ Total opioid dose in past 12-24 hours (use opioid calculator to calculate OMED)<br>→ Intervention efficacy?<br>→ side-effects?<br>→ Renal and/or Hepatic impairment |

## INTERVENTIONS

| FASCIA ILIACA BLOCK | PLUS | PARACETAMOL | PLUS | OPIOID |
|---|---|---|---|---|
| → As soon as practical by ED or Anaesthetic doctor<br>→ **NB: Volume and dose are critical**<br>→ **Suggest**: Ropivicaine 3mg/kg (max 200mg) diluted to 40 ml in N/Saline<br>→ **Observations as Table 3.3** | | → 1g oral TDS STRICT<br>→ @ 0800, 1400, 2200<br>→ ***Continue while fasting***<br>→ Consider IV or soluble formulations if intolerant of tablets | | → **Table 1** for age-appropriate dose ranges<br>→ **Table 2** for titration of dose<br>→ Oral preferable to parenteral once initial severe pain is controlled<br>→ ***Continue while fasting***<br>→ Consider Buprenorphine or Fentanyl if renal impairment : eGFR < 30ml/min or morphine intolerant |

## REVIEW

→ **Review response to interventions and for both efficacy & side effects**

→ **Adjust management accordingly**

→ **Document opioid specific observations before dose & 1 hour post dose**

= Pain score/description + Respiratory rate + Sedation score + Functional Activity Score (FAS)

## DOCUMENTATION

→ **Document each & every assessment, intervention and review**

# OPIOID: Dose range, observations & modifications

## Table 1: Suggested dose range for intermittent oral and subcutaneous opioids (dose interval = Q2 hr PRN)

| **AGE years** | **MORPHINE,** subcut. If eGFR > 30ml/min **mg** | **FENTANYL, subcut.** If eGFR < 30ml/min **microg** | **Buprenorphine** Sublingual **microg** | **Oxycodone IR,** oral Tablet/ capsule/ liquid **mg** | **Tapentadol IR,** oral **mg** |
|---|---|---|---|---|---|
| <60 | 5.0 – 10.0 | 80 - 150 | 200-400 | 5 - 10 | 50 - 100 |
| 60-75 | 2.5 – 7.5 | 40 – 80 | 200-400 | 2.5 - 7.5 | 50 |
| 75-85 | 2.5 – 5.0 | 40 – 80 | 200 | 2.5 - 5 | 25 - 50 |
| >85 | 2.0 –3.0 | 25 – 50 | nil | 1 – 3 (liquid) | 25 |

## Table 2: Guidance for opioid titration & assessment

| | |
|---|---|
| **Step 1: Assess and Document:** | Pain + Sedation score + Respiratory rate + FAS |
| **Step 2: Intervention:** | Initial dose from **middle** of dose range (ie Fentanyl 40-80microg → choose 60microg) |
| **Step 3: Review 1 hour post dose:** | Pain + Sedation score + Respiratory rate + FAS |

**Step 4: Subsequent dose of opioid decided by results of Pain, FAS, Sedation & Resp Rate assessments:**

| | | | |
|---|---|---|---|
| **IF** | **If, since the previous dose**……. **Pain or FAS** → improved significantly **AND Sedation:** → at 1 hr = 0 → OR has been 1 or 2 for < 2 hours → AND has not been 3 **AND Resp Rate** → 10 or more at all times | **If *evidence of OIVI*, since the previous dose**……. **Sedation score** → has been 2 for more than 2 hrs → OR 3 at any time **OR Resp Rate** → Less than 10 at any time *Even if the Pain or FAS has not improved* | **If, *NO evidence of OIVI*, since the previous dose**……. **Pain or FAS** → Has not improved significantly **AND** Sedation → at 1 hr = 0 → OR has been 1 for less than 2 hours → AND has not been 2 or 3 **AND Resp rate** → 10 or more at all times |
| **THEN** | Administer **SAME** dose next time | **REDUCE** subsequent dose | Consider **INCREASE** in the next dose |

## Table 3: SPECIAL CONSIDERATIONS

**Elderly/frail:**
- → DO NOT routinely prescribe: Tramadol, NSAIDs, COX-2 inhibitors or Benzodiazepines
- → These medications have potentially significant side-effects and should only be prescribed in consultation with the Orthogeriatric (OGS) team or APMS
- → Paracetamol TDS if small, mal-nourished or hepatic impairment

**Buprenorphine (Norspan) patch:**
- → Leave patch in situ
- → Prescribe opioid doses as per opioid naïve patient initially and consider increasing dose if higher end of dose range fails to control pain and has not resulted in side-effects
- → Consult APMS for further advice if pain not controlled.

**Buprenorphine Opioid Substitution Therapy (OST)**
Suboxone, Subutex, Long acting injectable buprenorphine (LAIB)
- → Continue usual dose
- → Consider split dosing if patient agreeable (not mandatory)
- → Seek advice: APMS & addiction medicine

**Opioid tolerant – see relevant WH PPG**
**Morphine, Oxycodone, Fentanyl patch, Methadone, Suboxone**
- → Continue usual opioid & route, unless contraindicated
- → May require higher PRN opioid doses: 10-20% of pre-morbid daily opioid dose.
- → patients may consistently report high pain scores, yet their function/distress level may improve over time.
- → Document FAS carefully. Titrate dose to function rather than pain score (scores may remain elevated)

**Observations for Fascia Iliaca Block (FIB) :**
**Prior to Block, then 30 & 60 mins after block**
- → as for opioid analgesia
- → HR + BP + SpO2

**For 30 minutes post insertion of FIB**
- → Continuous pulse oximetry (HR and SpO2)
- → BP every 10 minutes

**Consider Continuous regional analgesia**
- → If significant surgical delay anticipated
- → Seek advice from APMS/Anaesthesia

## RESOURCES: Contact the Pain Management Service for analgesia advice if usual strategy inadequate

| | | |
|---|---|---|
| **Western Health Procedures:** | → Intermittent Opioid Analgesia for Acute Pain and Associated Observations<br>→ Regional Analgesia | |
| **Western Health Pain Management staff resource posters** | → Staff resource posters (wh.org.au)<br>→ Pain Assessment tools<br>→ Fascia Iliaca Block Nursing Care | → Intermittent opioid guidelines<br>→ Nursing Care of the Patient with a Regional Analgesia Infusion |
| **Websites:** | → Faculty of Pain Medicine (ANZCA) opioid calculator http://www.opioidcalculator.com.au/<br>→ Australian & New Zealand College of Anaesthetists and Faculty of Pain Medicine, Acute Pain Management: Scientific Evidence, 5th edition 2020, https://www.anzca.edu.au/search-results?rUrl=%2fHome&searchtext=5th+edition&searchmode=exactphrase&smartsearchfilter=3;<br>→ Victorian Dept Health: Managing & treating pain: https://www.health.vic.gov.au/patient-care/managing-and-treating-pain | |
| **Patient Information:** | → Older people in hospital - Pain management - Better Health Channel | |