Analgesic Ladder for Adults in Acute Pain

Oral Route	No Oral Route
Mild Pain (see mild pain protocol on HEPMA)	
• **Oral Paracetamol 1g** regularly four times-a-day (**500mg** four times-a-day if <50kg or in hepatic impairment/nutritional deficiency) • **+/- 3 days of Oral Ibuprofen 400mg** three times-a-day (check for contraindications)	• **IV Paracetamol 1g** regularly four times-a-day (**500mg** four times-a-day if <50kg or hepatic impairment/nutritional deficiency
Moderate Pain (see moderate pain protocol on HEPMA)	
• **Oral Paracetamol 1g** four times-a-day (**500mg** four times-a-day if <50kg or hepatic impairment/nutritional deficiency) • **Oramorph: 5mg** five times-a-day + hourly PRN (**2.5mg** five times-a-day if elderly) • **+/- 3 days of Oral Ibuprofen 400mg** three times-a-day (check for contraindications) ***If renal impairment change Morphine to:*** • **Oxynorm 2.5mg** five times-a-day + hourly PRN (**1.25mg** five times-a-day if elderly)	• **IV Paracetamol 1g** four times-a-day (**500mg** four times-a -day if <50kg or hepatic impairment/nutritional deficiency) • **Subcutaneous Morphine 2.5mg** five times-a-day + hourly PRN (**1.25mg** five times-a-day if elderly) ***If renal impairment change Morphine to:*** • **Subcutaneous Oxynorm 1.25mg** five times-a-day + hourly PRN (**0.675mg** five times-a-day if elderly)
Severe Pain (see severe pain protocol on HEPMA)	
• **Regular Paracetamol +/- Ibuprofen** (see above) If no oral route **IV Diclofenac 75mg** twice daily can be used (check for contraindications and d/w Acute Pain Team. Diclofenac is given as an IV infusion). • **Titrate: IV Fentanyl** or Morphine (avoid Morphine in renal impairment) • **Intravenous PCA**: **Protocol E-Fentanyl** OR Protocol A-Morphine (avoid Morphine in renal impairment) **Please seek advice from pain team before modifying the bolus dose or background rate on a PCA.** • If unable to control pain using this regime then please call the Acute Pain team	

We recommend that the prescription is reviewed daily in accordance with pain assessment. The prescription should be de-escalated as soon as it is clinically indicated to do so and a clear deprescribing plan for opioids should be in place at the time of discharge from hospital.

Please note the following additional resources that should be consulted when indicated:

- **Renal Handbook** – available on Clinical Handbook.
- Use **MUST/Refeeding** score: to identify nutritional deficiency.