Wound Pain Pathway

For assessment and management of wound- and lymphoedema-related pain

NHS Oxford Health NHS Foundation Trust

Screen for wound-related pain

Ask every patient:
Do you have pain related to your wound?

- At rest?
- With movement?
- Overnight?
- During dressing changes?

If the patient cannot communicate verbally (e.g. dementia, stroke, learning disability, acute confusion), observe non-verbal indicators (refer to Bolton Pain Assessment Tool).

If NO pain reported or observed - continue routine monitoring and reassess regularly
If YES - proceed to pain assessment

Pain assessment

Assess pain intensity and context

Assessment tools:

- If adult can communicate verbally - Numerical Rating Pain Scale
- If communication difficulty - Bolton Pain Assessment Tool
- If child or cognitive impairment - Wong-Baker Faces Pain Scale

Use OLDCARTS mnemonic to support structured holistic assessment:

- **O**nset - determines when and how the pain began (sudden / gradual / triggering events)
- **L**ocation - identifies the exact area of pain and whether it radiates to other regions (localised / radiating / diffuse)
- **D**uration - assesses how long the pain lasts and where it is intermittent or constant (acute / chronic / constant / intermittent / procedural / background) **(See guidance 1 overleaf)**
- **C**haracter - describes the type of pain which can indicate underlying pathology and guide treatment. *It is important to determine which type of pain the patient is experiencing as they require different treatments.* **(See guidance 2 overleaf)**
- **A**ggravating factors - identifies activities, movement or conditions that worsen the pain (exertion / touch / Pressure / temperature / movement / posture)
- **R**elieving factors - previous interventions or actions that reduce pain (rest / medications / lifestyle modifications)
- **T**iming - examines patterns of pain occurrence (morning vs evening / relation to meals or activity)
- **S**everity - measures intensity (refer to pain intensity section above)
- Also consider impact (sleep / mobility / QoL / wound care tolerance). Remember to complete the Wound Quality of Life checklist (Link here).

In wound care, pain is not just a symptom, it is a diagnostic signal. Any pain that is severe, worsening, neuropathic, function-limiting, or dispoportionate should trigger prompt reassessment and escalation, as it may indicate complications that are not yet visually apparent.

Red flags (see Guidance 3 overleaf):

- If pain is severe (>7/10), despite appropriate analgesia or worsening over 48 hours.
- If pain is disproportionate to wound appearance or worsens rapidly, suspect ischaemia or infection and escalate urgently
- Increasing pain at rest or at night (including hanging legs out of bed for alleviation)

Escalatiom and referral triggers (see Guidance 3 overleaf):

- Neuropathic pain features predominate
- Pain limits wound care or mobility
- If pain causing a significant impact on the patient's quality of life, treatable disease has been excluded or treatment completed and first line therapies have failed, consider referral to OUH Pain Management Centre ***(See Guidance 4 overleaf)***

Management

For all patients (all pain types):

- Explain procedure and set expectations
- Offer patient choice and control
- Validate pain experience
- Address anticipatory pain and anxiety (e.g. fear from previous painful dressings, loss of control in chronic wounds, sleep disturbances amplifying pain perception)
- Identify wound-related contibutors **(See guidance 5 overleaf)**

Non-pharmacological management

Nursing interventions:

- Select a wound cleansing solution that the individual finds comfortable and consider temperature of irrigants. If using tap water, use boiled, cooled lukewarm water. Do NOT microwave
- Maintain moisture balance in the wound bed and peri-wound skin
- Select non-adherent dressings where possible to reduce pain associated with dressing removal
- Offload pressure and support positioning
- Elevate limb / manage oedema if indicated
- Consider contacting patient to administer analgesia prior to dressing change
- Avoid unecessary touching or probing and prevent wound from friction
- Use silicone based-dressing for comfort where appropriate (e.g. Silicone Wound Contact Layer, Kliniderm Foam Silicone Border or RespoSorb Silicone Border)
- Reduce dressing change frequency where safe to do so (consider infection, exudate levels etc)

Procedural comfort:

- Soak dressings before removal (in line with wound cleansing guidelines)
- When required (e.g. for procedural pain), topical anaesthetic can be applied to the wound while the surrounding skin and/or peri-wound is cleansed (liaise with Tissue Viability for further information)
- If thorough cleansing and mechanical debridement is not tolerated, sterile gauze can be soaked in antisurfactant solution and left on the wound to commence loosening of debris and non-viable tissue while cleansing and debriding the peri-wound and surrounding skin.
- Pat the wound dry if required, starting proximally and working down.
- Slow, atraumatic technique ***(see guidance 6 overleaf)***
- Consider scheduling care at patient's most comfortable time
- Use adhesive remover for adhesive dressings

NICE guidance (NG193) on non-pharmacological pain management:

- *1.2.1 Offer a supervised group exercise programme. Take people's specific needs, preferences and abilities into account*
- *1.2.2 Encourage people with chronic pain to remain physically active for longer-term general health benefits*
- *1.2.3 Consider ACT or CBT for pain, delivered by healthcare professionals with appropriate training - liaise with GP*
- *1.2.5 Consider a single course of acupuncture or dry needling, within a traditional Chinese or Western acupuncture system if delivered in a community setting and is delivered by a band 6 HCP with appropriate training - liaise with GP*

Pharmacological management:
Liaise with GP/prescriber for analgesia (report pain type, current pain scores and trends, impact on wound care tolerance and response to non-pharmacological measures)

- **Nociceptive pain -** the WHO analgesic ladder (link here) provides a general guide to pain management e.g. non-opioids/NSAIDs (Paracetamol, Naproxen), low-dose opioids (Codeine), strong opioids opioids (Morphine, Tramadol)
- **Neuropathic pain** - unlike nociceptive pain, neuropathic pain does not usually get better with common analgesia, such as Paracetamol. Adjuvant analgesic (or co-analgesics) are drugs with a primary indication other than pain, that have analgesic properties e.g. tricyclic antidepressants (Amitriptyline, Duloxetine), anti-convulsants (Gabapentin, Pregabalin).

Reassess and evaluate

It is recommended to undertake regular reviews or sooner if any concerns arise or the patient's condition changes:

- Pain score change
- Patient verbal feedback
- Tolerance of wound
- Non-verbal pain indicators

Has pain improved?

If YES - continue plan and monitor
If NO/WORSE - escalate to GP prior to OUH pain clinic ***(See guidance 4 overleaf)***

Guidance 1 – Duration

Background pain:
- **What it is:** pain that is present most or all of the time
- **Pattern:** continuous or near-continuous, with relatively stable intensity
- **Cause:** ongoing underlying pathology (e.g. tissue damage, inflammation)
- **Management focus:** regular, around-the-clock analgesia

Procedural pain:
- **What it is:** pain that occurs during or immediately after a specific procedure or intervention
- **Pattern:** predictable, short-lasting and time-limited
- **Cause:** medical or nursing procedures that provoke pain
- **Management focus:** pre-emptive or short-acting analgesia

Intermittent pain:
- **What it is:** pain that comes and go, with pain-free intervals in between
- **Pattern:** episodic, may be predictable or unpredictable
- **Cause:** can be triggered (e.g. movement) or spontaneous
- **Management focus:** breakthrough or as needed (PRN) analgesia, sometimes alongside background pain control

Guidance 2 - Characteristics

A. Nociceptive pain (somatic / visceral) - usually arising from the direct damage to tissue. Signals are picked up by sensory receptors (nociceptors) which are transmitted to the spinal cord and then the brain where they are interpreted as pain.
Suspect nociceptive pain if:
- Pain is aching, throbbing, sharp, tender or dull
- Localised to wound
- Worse with movement, pressure, inflammation
- Proportionate to tissue damage

Management focus: reduce tissue injury and inflammation

B. Neuropathic pain (non-nociceptive / sensory abnormalities) - caused by lesions, damage to or dysfunction of the nervous system which causes an abnormally strong response. Normally chronic (long-term).
Suspect neuropathic pain if:
- Pain is burning, shooting, electric, stabbing, tingling, numbness, pins and needles
- Pain from light touch - allodynia (see further infromation below)
- History of diabetes, nerve injury, stroke, shingles

Management focus: minimise nerve stimulation and escalate for adjuvant therapy

C. Mixed pain - elements of nociceptive and neuropathic pain, common in chronic wounds
Suspect mixed pain if:
- Background aching pain with sharp/burning episodes
- Partial or poor response to simple analgesia

Management focus: treat inflammatory drivers and reduce nerve sensitisation.

Types of complex neuropathic pain

Allodynia
- When something that previously was not painful to a person or shouldn't hurt feels extremely painful e.g. feeling pain from clothing or bedding touching the skin
- A type of peripheral and central neuropathic pain where there is an issue between how the nerves send and receive messages within the nervous system.
- Common with diabetes, trigeminal neuralgia, complex regional pain syndrome, multiple sclerosis, fibromyalgia, opioids, chemotherapy drugs, migraines, excessive alcohol intake, severe vitamin B or D deficiency, shingles, trauma (e.g. amputation, radiation therapy or stroke).

Hyperalgesia
- Arises when nociceptive pain and the psychological impact is not managed, leading to a prolonged inflammatory response and a heightened sensitivity to pain that feels disproportionate to the injury/an exaggerated response from a normally painful stimulus e.g. excruciating pain when touching a recent burned area of skin
- Causes include burns, bites or stings from insects/animals, cancer, diabetes, immune and inflammatory conditions (lupus, MS), infections that attack the nervous system (shingles), migraines, pain disorders (complex regional pain syndrome), trauma (any kind of injury, including nerve damage, muscle injuries, broken bones etc).

Guidance 3 – Escalation and referral triggers in wound pain

Red flags

Severe pain (>7/10) despite appropriate analgesia or worsening over 48 hours
This is not typical of uncomplicated wound healing and should prompt urgent reassessment. Pain that is disproportionate to the wound's appearance or rapidly escalating must be treated as a red flag until proven otherwise—consider ischaemia, localised or spreading infection or compartment syndrome. Ischaemic pain may precede visible tissue necrosis and infection can cause severe pain before obvious clinical signs - do not dismiss as anxiety or low pain threshold.
- Immediately escalate suspected sepsis to 999, suspected limb-threatening ischaemia to vascular services, and suspected cellulitis to the GP.
- Reassess wound aetiology, vascular status, infection (refer to the AMBL2 tool), analgesia effectiveness and dressing choice.
- Follow the Lower Limb Care Pathway, and treat as time-critical—especially in patients with diabetes (refer to OCDEM) or vascular disease. Do not delay urgent escalation while awaiting routine wound review.
- Refer to non-pharmacological management methods overleaf.
- Consider escalation to MDT as indicated - e.g. Tissue Viability, CTS

Increasing pain at rest or at night (including hanging legs out of bed for alleviation)
Suggests critical limb ischaemia / severe arterial insufficiency,
- Refer to Lower Limb Assessment form.
- Review PMH (look for risk factors for arterial disease such as PAD, diabetes, smoking etc.)
- Urgent Vascular referral.

Orange flags

Neuropathic pain features predominate
When pain is described as burning, shooting, electric, stabbing, tingling, or is associated with allodynia or hyperalgesia, neuraopthic mechanisms should be suspected. Neuropathic wound pain often responds poorly to standard analgesics. Indicates nerve injury, chronicity, or sensitisation. Common in diabetic foot ulcers, pressure injuries, post-surgical or post-burn wounds.
- Screen using neuropathic pain descriptors
- Escalate to GP
- Adapt wound care to minimise nerve stiulation and trauma

3. Pain limits wound care or mobility
Pain that prevent with wound assessment, dressing changes, debridement or mobilisation is a functional red flag. It suggests inadequate pain control, which can compromise wound care, increase infection risk and contribute to reduced mobility, raising the risk of pressure injury, thrombosis and deconditioning.
- Liaise with GP regarding review of timing and adequacy of analgesia (incuding pre-procedural analgesia)
- Refer to non-pharmacological mangement methods overleaf
- Consdier escalation to multidiscplinary (MDT) team - CTS, Tissue Viability

Resources for clinicians: (links below are interactive)
- NICE guidance (NG193) - Chronic pain in over 16s
- SIGN national clinical guideline - Management of chronic pain
- BJN Pain associated with venous leg ulcers: the complexity of management

Resources for patients:
Patient information on understanding chronic pain, self-care, mental health support, help to get more active, help with sleep, help with nutrition and phone/tablet apps can be found on the OUH Pain Management Centre website.

References: Oxford Pain Management Centre (2025); Chronic Pain (NICE, 2021); Neuropathic Pain (NICE, 2020); A guide to pain assessment and management in adults (Ford, 2024); Management of chronic pain (SIGN, 2025)

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Guidance 4 - OUH Pain Management Centre

Referrals can be completed by clinicians and sent to:
oxfordshire.msk@nhs.net

Referral criteria:
- Adult: 18 years or older
- Pain causing a significant impact on the patient's quality of life
- Treatable disease has been excluded or treatment completed
- First line therapies have failed

Exclusion criteria:
- Treatable disease that has not been optimised by the appropriate specialty.
- Significant untreated psychiatric or substance misuse disorders.
- Patients who have previously attended the PMC for the same condition and have been discharged within the past 2 years. However, advice can be given via email advice service: oxonpainadvice@nhs.net
- Patients who have been seen and discharged from another pain clinic for the same complaint.

Guidance 5- Wound-related contributors

Infection/inflammation
- Refer to AMBL2 tool and Biofilm Pathway

Suspected Ischaemia
- Urgent referral to Vascular
- Refer to Lower Limb Care Pathway
- Do NOT apply compression therapy

Chronic oedema/lymphoedema
- Refer to Lower Limb Care Pathway
- Apply compression bandaging where clinically indicated
- Encourage leg elevation, exercise, good skin care and emollient therapy

Moisture imbalance
- Refer to Exudate Management and Skin Care Barrier Pathways
- If lymphorrhoea is present, refer to Lower Limb Care Pathway and commence compression therapy where clinically indicated

Dressing trauma/adherence
- Review dressing choice and dressing change frequency

Friction/mechanical irritation
- Stabilise dressing, reduce movement

Guidance 6 – Atraumatic dressing removal technique:

