IPQ Nurse Training

Essential Pain Management

Workplace competency record: assessing pain, multimodal analgesia, safe opioid practice and escalation

Version 1.0, October 2026. Review due October 2027.

Complete this record alongside the Essential Pain Management e-learning, during supervised practice in your own clinical area. It covers pain assessment, multimodal and stepped analgesia, safe opioid practice, care of patients who cannot self-report, chronic pain and analgesic stewardship. It does not cover regional anaesthesia, epidural or patient-controlled analgesia management, or paediatric pain, each of which requires separate training and sign-off.

Step 1	Step 2	Step 3	Then
E-learning passed	**Supervised practice and assessment**	**Independent practice**	**Reassessment at your employer's interval**

How this course works

This course has no classroom session. Competence is built and assessed where you work, with a competent practitioner. Sign-off in section 10 is what authorises independent practice, within your employer's policy.

A note for assessors

Pain management is a decision-making skill, not a procedure. Most of what is assessed here is what the practitioner notices, what they ask, what they give, what they do not give, and when they escalate. Assessors should test reasoning, not recall: ask "why that drug, for this patient, now?" at every opportunity.

Practitioner and assessment details

Name		**Job title and band**	
NMC PIN		**Ward or department**	
Organisation		**Named assessor**	
Date e-learning passed		**Final assessment score**	

Before you start

Requirement	Date	Confirmed by
E-learning completed and final assessment passed at 12 of 15 or above (certificate seen)		
Local policies read: pain assessment and scoring, controlled drugs, opioid prescribing and monitoring, naloxone administration, NSAID prescribing		
Knows which pain assessment tools this organisation uses, including the tool for patients who cannot self-report		

Requirement	Date	Confirmed by
Knows where naloxone is kept in this clinical area, and the local protocol for giving it		
Knows the local route to the pain team, palliative care team and pharmacy, and their hours		
Understands that passing the e-learning does not authorise any change to a prescription		

How this record is completed

Your assessor observes you in practice and marks each criterion on the scale below. Up to three observed occasions are recorded in columns 1, 2 and 3. Every criterion must reach level I before that section is signed off.

	Level	What it means
N	**Not yet demonstrated**	Step omitted, performed unsafely, or not explained when asked
P	**With prompting**	Performed correctly but needed a cue, a reminder or a question to prompt the next step
I	**Independently**	Performed correctly, in the right order, without prompting, and able to explain why

Safety-critical criteria

Criteria marked * are absolute. If one of these is not met, the occasion stops there, is recorded as N, and is repeated after further teaching. These are the steps where getting it wrong causes avoidable harm.

Section 1. Assessing pain

Observed on a patient reporting pain, and on a patient who cannot self-report.

Criterion	1	2	3	Date and assessor initials
1. Asks about pain as a matter of routine, with observations and at handover, rather than waiting to be told				
2. Takes a structured pain history using SOCRATES, and records the answers rather than a single number				
3. Scores pain both at rest and on movement, coughing or deep breathing, and recognises that a comfortable patient at rest may still be in uncontrolled pain *				
4. Uses the pain assessment tool this organisation has adopted, consistently and correctly				
5. Accepts the patient's own report of their pain as the most reliable measure, and does not substitute their own judgement for it				
6. For a patient who cannot self-report, uses an observational tool (for example Abbey Pain Scale or PAINAD) and assesses behaviour, facial expression, vocalisation, body language, agitation and changes from that person's normal *				
7. Recognises new confusion, agitation, withdrawal or refusal of care in a patient with dementia as possible expressions of pain, and assesses rather than sedates				
8. Screens for neuropathic features (burning, shooting, electric, numbness, allodynia) and recognises that these need different drugs				
9. Identifies the likely type of pain: nociceptive, neuropathic, visceral, mixed or nociplastic, and says what that means for treatment				
10. Recognises pain that is a warning sign rather than a symptom to treat: new severe pain, pain out of proportion to the findings, compartment symptoms, chest pain, abdominal rigidity, and escalates before giving analgesia *				
11. Asks what the patient has already taken, including anything brought in from home or bought over the counter				
12. Asks what the pain stops them doing, and agrees a realistic functional goal with them rather than aiming for zero				
13. Reassesses after every intervention, within the timeframe appropriate to the route given, and records the result				
14. Documents the score, the site, the type, the action taken and the effect, contemporaneously				

Assessor note

A pain score recorded once and never repeated is not an assessment. The number that matters is the one taken after you did something about it.

Section 2. Multimodal and stepped analgesia

Observed giving analgesia to a prescription, and reasoning about what the patient needs.

Criterion	1	2	3	Date and assessor initials
1. Explains what multimodal analgesia means and why combining drugs with different mechanisms works better than increasing one				
2. Matches the step of analgesia to the severity of the pain, and does not start at the top or stay at the bottom out of habit				
3. Checks allergies, current analgesia and the total paracetamol load from all sources, including combination preparations, before administering *				
4. States the standard adult paracetamol dose and the circumstances in which it must be reduced, including low body weight				
5. States the main cautions and contraindications for NSAIDs: renal impairment, gastrointestinal history, cardiovascular disease, asthma sensitivity, older age, anticoagulation and dehydration				
6. Checks renal function and hydration before giving an NSAID, and does not give one to a patient who is hypovolaemic, acutely unwell or has deteriorating kidney function *				
7. Knows when gastroprotection should accompany an NSAID				
8. Names the weak opioids in common use and a typical adult dose for each				
9. Does not combine a weak and a strong opioid, and stops the weak opioid when a strong one is started *				
10. Knows that codeine and tramadol depend on individual metabolism, and that the response varies between patients				
11. Knows the approximate oral potency of oxycodone compared with morphine, and does not treat milligram for milligram as equivalent				
12. Recognises the common adjuvants for neuropathic pain and states that they take days to weeks to work, so the patient must be told to persist				
13. Recognises when the route is wrong for the situation, and when a drug given orally will not work fast enough				
14. States the contraindications to Entonox, including suspected pneumothorax and any trapped air				
15. Advises the patient on what to expect, including constipation with opioids, and ensures laxatives are considered at the same time as the opioid is started				
16. Escalates uncontrolled pain rather than repeating an ineffective intervention, and does not adjust a prescription themselves *				

Section 3. Safe opioid practice

The section where errors cause the most harm. Observed on at least two occasions.

Criterion	1	2	3	Date and assessor initials
1. Checks the prescription, the patient's identity, allergies and what has already been given, including by another route or by another member of staff, before every opioid dose *				
2. Follows local controlled drug procedure correctly, including the second check, the register and witnessed disposal of any waste				
3. Records a sedation score before and after giving an opioid, using the local scale, and knows that increasing sedation is the earliest reliable warning of opioid toxicity, before the respiratory rate falls *				
4. Monitors respiratory rate and sedation at the intervals local policy sets after an opioid, and does not rely on oxygen saturation alone to detect respiratory depression *				
5. Recognises the full picture of opioid toxicity: increasing sedation, falling respiratory rate, pinpoint pupils, confusion, myoclonic jerks				
6. Knows where naloxone is kept, the local protocol for giving it, and that it must be titrated rather than given as a single large dose in a patient on opioids for pain *				
7. States that naloxone wears off before most opioids do, and that the patient must be monitored continuously afterwards and the episode escalated and documented *				
8. Knows that a transdermal patch is for stable, ongoing requirements and is not appropriate for acute or rapidly changing pain				
9. Never cuts a patch, checks for and removes the old patch before applying a new one, rotates the site, and documents the site and time *				
10. Recognises that heat (a hot bath, a heat pad, fever) increases absorption from a patch and can cause toxicity				
11. Recognises that a patient on a patch still needs breakthrough analgesia prescribed, and knows that the patch itself cannot be titrated quickly				
12. Recognises accumulation risk in renal impairment, particularly with morphine, and escalates rather than continuing to give repeated doses to a patient who is becoming drowsy *				
13. Knows what oral morphine equivalence is for, and that any conversion between opioids is a prescribing decision requiring pharmacy or medical input				
14. Reports an opioid incident, including an omitted dose, a wrong dose, a missing patch or a naloxone episode				

The error that kills

Sedation before respiration. The commonest fatal pattern is a drowsy patient whose respiratory rate is still recorded as normal, so nobody acts. A practitioner who says "pinpoint pupils" as the first sign has not understood the sequence and should be taught again before sign-off.

Section 4. Patients who need a different approach

Criterion	1	2	3	Date and assessor initials
1. Starts lower and goes slower in older and frail patients, and states why				
2. Checks renal and hepatic function before and during opioid or NSAID use in older, frail or acutely unwell patients *				
3. Recognises that an opioid-tolerant patient needs their usual opioid continued as well as additional analgesia for the new pain, and that withholding it causes withdrawal and worse pain				
4. Distinguishes tolerance, physical dependence and addiction, and uses those words accurately rather than interchangeably				
5. Does not withhold analgesia from a patient with a history of substance use, and recognises that under-treating pain in this group is both common and harmful *				
6. Involves the pain team or specialist early for a patient with complex or pre-existing opioid requirements				
7. Adapts assessment for a patient with a learning disability, a communication difficulty or whose first language is not English, and uses an interpreter rather than a family member where the policy requires it				
8. Recognises that a patient approaching the end of life needs anticipatory prescribing and a different balance of risk, and escalates for a palliative review				
9. Recognises when pain is contributing to delirium, and when sedating medication is making it worse				
10. Checks for and acts on the practical causes of pain that need no drug at all: a full bladder, a tight dressing, a badly positioned limb, constipation, a pressure area				

Section 5. Beyond medicines, chronic pain and stewardship

Criterion	1	2	3	Date and assessor initials
1. Offers and documents non-pharmacological measures alongside analgesia: positioning, splinting or supporting, heat or cold where appropriate, rest and activity pacing, distraction, reassurance and sleep				
2. Explains the difference between acute and chronic pain, and why the chronic pain approach is function first rather than score first				
3. Recognises that opioids are of limited benefit in most chronic non-cancer pain, and does not promise the patient that they will take the pain away				
4. Supports a patient through a flare-up without automatically escalating the opioid dose				
5. Reviews whether an analgesic started for an acute problem is still needed, and flags for review rather than continuing it indefinitely on the discharge list *				
6. Knows what analgesic stewardship means and can name two things they personally do that support it				
7. Gives clear, written discharge information on what to take, when to stop, what the side effects are and who to contact				
8. Knows who to contact in this organisation for pain advice, for palliative care and for pharmacy, and the hours those services run				

Section 6. Escalation, communication and documentation

Criterion	1	2	3	Date and assessor initials
1. Escalates pain that is uncontrolled despite the prescribed analgesia, within the timeframe local policy sets *				
2. Hands over using SBAR, including the score at rest and on movement, what has been given, when, and what effect it had				
3. Escalates again if the response is inadequate or does not come, and knows the route for doing so, including going above the first responder *				
4. Escalates a suspected new or serious cause of pain as an emergency rather than as a request for analgesia				
5. Involves the patient, and where appropriate those close to them, in decisions about their analgesia				
6. Documents the assessment, the intervention, the reassessment and the escalation, contemporaneously and legibly				
7. Reports an incident where one has occurred, including a delayed or omitted dose and uncontrolled pain				

Section 7. Underpinning knowledge

Asked verbally by the assessor. Record the substance of the answer, not a tick.

Question	Response noted by assessor
1. What is the difference between acute and chronic pain, and why does it change how you treat it?	
2. Walk me through SOCRATES on a patient you have looked after this week.	
3. How would you assess pain in a patient with advanced dementia who cannot tell you they are in pain?	
4. What is neuropathic pain, how would you recognise it, and why do ordinary painkillers work poorly for it?	
5. Does pain always mean tissue damage? Give me an example where it does not.	
6. What does multimodal analgesia mean, and why is it better than simply increasing one drug?	
7. Who should not have an NSAID, and why? Give me at least four groups.	
8. What is the earliest sign of opioid toxicity, and what is the sign people wrongly look for first?	
9. What would you do if a patient on regular morphine became increasingly drowsy with a respiratory rate of 9?	
10. Why must you keep monitoring a patient after giving naloxone?	
11. A patient is admitted already taking a strong opioid at home for chronic pain, and now has a fractured hip. What happens to their usual opioid, and why?	
12. What is the difference between tolerance, dependence and addiction?	
13. Why should a transdermal patch never be used for acute pain, and never be cut?	
14. What does analgesic stewardship mean, and what do you personally do that supports it?	
15. Name three things that cause pain and need no analgesia at all.	

Section 8. Scenarios

Talked through with your assessor. Record what the practitioner says they would do, and in what order.

Question	Response noted by assessor
1. A patient with acute pancreatitis scores 9 out of 10. They have had paracetamol an hour ago and nothing else is prescribed. What do you do?	
2. A patient with fractured ribs is comfortable lying still and refuses to take a deep breath. Their pain score at rest is 2. Is their pain controlled? What do you do?	
3. A woman with dementia and a fractured neck of femur is agitated and hitting out at staff. She says she is fine when asked. What is your assessment and what do you do?	
4. Four hours after a dose of morphine, a patient is rousable only to voice, with a respiratory rate of 8 and pinpoint pupils. Talk me through what you do, in order.	
5. A patient asks you to cut their fentanyl patch in half because they feel too sleepy. What do you say and what do you do?	
6. A patient known to use heroin is admitted with cellulitis and severe pain. A colleague says to "go easy on the opioids". What is your response?	
7. A patient with an eGFR of 22 is prescribed regular oral morphine and is becoming drowsy on day three. What is happening and what do you do?	
8. A patient with burning, shooting leg pain has had their codeine increased twice with no benefit. What would you suggest, and to whom?	
9. A patient with chronic back pain is being discharged on a strong opioid started for an acute flare three weeks ago. What is your concern and what action do you take?	

Section 9. Supervised practice log

Record every supervised episode, including those that did not go to plan. Your employer sets the number required.

Date	What you did (assessment, analgesia given, monitoring, escalation...)	What you would do differently	Level (N/P/I)	Supervisor initials

Range of practice

Competence in pain management is only demonstrated across different kinds of patient. Your assessor confirms you have been observed with each of the following.

Patient group	Date	Level (N/P/I)	Assessor initials
A patient with acute post-operative or post-injury pain			
A patient who cannot self-report (dementia, delirium, communication difficulty or reduced consciousness)			
A patient with neuropathic pain			
A patient already taking opioids before admission			
A patient whose pain was uncontrolled and had to be escalated			

Reflection and action plan

Write a short reflective account against this course for your revalidation portfolio. The prompts below are a starting point, not a form to fill in.

A patient whose pain you nearly missed, or whose pain someone else had missed. What did you notice, and what did you do?

Something you now do differently with analgesia, or with assessment, because of this course.

A gap you still have, and how you will close it.

Agreed actions

Action	How it will be evidenced	By when

Section 10. Assessment of competence and sign-off

Completed by a competent assessor after direct observation in practice, when every criterion in sections 1 to 6 is at level I and sections 7 and 8 have been answered satisfactorily.

Requirement	Date	Assessor initials
Sections 1 to 6: every criterion observed at level I		
Section 3 (safe opioid practice): observed on at least two separate occasions		
Section 7: underpinning knowledge answered satisfactorily		
Section 8: scenarios answered satisfactorily, including the opioid toxicity scenario		
Section 9: supervised practice log and range of practice completed to the number your employer requires		
Reflection and action plan completed with the practitioner		

Scope of this sign-off

Signed off for	Not signed off (separate training and sign-off required)
Pain assessment, including patients who cannot self-report	Patient-controlled analgesia (PCA)
Administering prescribed analgesia, including opioids	Epidural and regional block management
Monitoring for and recognising opioid toxicity	Syringe driver set-up and management
Escalation, SBAR handover and documentation	Prescribing or adjusting any prescription

Assessor declaration

I confirm that the practitioner named in this record has completed the Essential Pain Management e-learning, has been directly observed in practice, and has demonstrated every criterion in sections 1 to 6 at level I. They are assessed as competent to assess pain, administer prescribed analgesia including opioids, monitor for and recognise opioid toxicity, and escalate appropriately, independently and within this organisation's policy, subject to ongoing review.

Assessor name, signature and date	Practitioner signature and date	Reassessment due

What this record does not cover

This record does not authorise the practitioner to prescribe, to adjust a prescription, or to convert between opioids. It does not cover patient-controlled analgesia, epidural or regional analgesia, syringe drivers, or paediatric pain, each of which requires separate training and sign-off, and it does not replace your employer's own competency framework or controlled drug policy.

Built on: NMC Code; NMC and RPS standards for medicines management; British National Formulary; NICE NG193 (chronic pain in over 16s), CG173 (neuropathic pain) and NG46 (controlled drugs: safe use and management); Faculty of Pain Medicine and Royal College of Anaesthetists guidance on acute pain and opioids; Resuscitation Council UK guidelines. Local policy applies where it differs.