Waitemata District Health Board

Best Care for Everyone

☑ = YES ☒ = NO

(PLACE PATIENT LABEL HERE)

SURNAME: ______________________ NHI: __________

FIRST NAMES: ______________________

Date of Birth: ____ /____ /____ SEX: __________

LOWER BACK PAIN

Date: Time: Assessment nurse: Sign:

INCLUSION CRITERIA

- ☐ Lower back pain *(likely mechanical)*
- ☐ < 6 weeks duration *Acute flare up of chronic back pain may be included*

EXCLUSION CRITERIA

- ☐ Age < 15 or > 65
- ☐ Upper back / neck pain
- ☐ Abdominal pain
- ☐ Chest pain
- ☐ Significant trauma *e.g. fall > 1 m, RTC*
  Minor trauma is not an exclusion

☐ **Select Treatment Pathway on Whiteboard**
Enter actual time started
Data collected for Ministry of Health

STOP! Not suitable for this Best Care Bundle
Select 'BCB removed' Treatment Pathway
Continue usual nursing cares

NURSING ASSESSMENT *Aim < 30 minutes*

- ☐ History, examination and vital signs — *Document on Nursing Assessment Record*
- ☐ Record pain score:
  - *At rest* /10
  - *On movement* /10
- ☐ Administer analgesia — *Nurse initiated analgesia. Standing orders page 4*
- ☐ Provide self assessment sheet & pen — *Clip boards available in cubby hole in Acutes*
- ☐ Provide Back pain patient advice sheet

RED FLAGS (URGENT REVIEW) FLAGS *All red flags boxes must be populated ☑ = YES ☒ = NO*

- ☐ HR < 50 or >120
- ☐ Systolic BP < 90
- ☐ Fever > 38.5°C
- ☐ Spinal surgery < 6 wks
- ☐ Known AAA

☐ **NO RED FLAGS**

Continue Best Care Bundle

☐ **RED FLAGS PRESENT (ANY)** → Senior Dr review ASAP *(SMO / Senior Registrar)*

- ☐ Continue Best Care Bundle. Intervention if any: ______________________
- ☐ Exit Care Bundle: Reason: ______________________
  ↳ *Select '**BCB removed**' in TP column, Electronic Whiteboard. This signals the medical staff*

Dr Name: ______________ Sign: ______________

INVESTIGATION INDICATIONS *(ACC Red Flags) X-ray indications are in bold*

- ☐ Fever / rigors
- ☐ IV drug use
- ☐ Steroids
- ☐ IDDM / NIDDM
- ☐ Immunosupressed
- ☐ **Age > 50**
- ☐ **Worse pain supine or at night**
- ☐ **Loss bladder / bowel function**
- ☐ **Unintentional weight loss**
- ☐ **Any numbness / weakness in legs**
- ☐ **Unrelenting pain for > a few days**
- ☐ **Significant trauma**
- ☐ **Cancer history**
- ☐ **Not recovering as expected**
- ☐ Requested by Dr: ______________

☐ None present

No bloods or X-Rays indicated

☐ **Any** of the above indications require bloods and possibly X-Rays *(X-ray indications in **bold**)*

↳ ☐ Bloods sent ✓*General panel bloods, ✓ CRP, ✓ Ca 2+ ✓β-HCG ♀ 14-50y*
Blood cultures if temperature ≥ 38 °C

☐ *Urine only if signs of renal colic or UTI*

↳ X-Rays: ☐ Ordered ☐ Not ordered *Indications in **bold***
Discuss with lead SMO or clinician if unsure

LOWER BACK PAIN BEST CARE BUNDLE PATHWAY

7.7.201 A

CLINICIAN

ACUTE BACK PAIN DISPOSITION PATHWAY WDHB

Waitemata District Health Board

Best Care for Everyone

☑ = YES ☒ = NO

(PLACE PATIENT LABEL HERE)

SURNAME: ______________________ NHI: ____________

FIRST NAMES: ______________________________

Date of Birth: ______ /______ /______ SEX: ____________

ACUTE BACK PAIN DISPOSITION PATHWAY (< 2 WEEKS)

This pathway is designed as an inter-service agreement with General Medicine, Emergency Medicine, and Orthopaedics. It supports and does not replace clinical judgment. Use this pathway to decide disposition for patients that are not ready for discharge from ED < 4 hrs

Evidence of Cauda Equina or motor deficit?

e.g Decreased anal tone, urinary retention or >150 mL post void bladder volume

☐ YES →

- ☐ X-Rays and bloods as per Best Care Bundle
- ☐ SMO review
- ☐ Admit Orthopaedic service

☐ NO ↓

Are any RED FLAGS present?

- ☐ Active malignancy
- ☐ Immunosuppression
- ☐ Spinal surgery < 6 wks
- ☐ Haemodynamically unstable
- ☐ Known AAA
- ☐ Fever > 38.5° C
- ☐ Raised CRP
- ☐ Clinical concern
- ☐ Pain disproportionate to clinical findings

☐ YES →

SMO review:

1) Facilitate urgent imaging as appropriate: e.g:
   - *? Ruptured AAA → urgent C+ CT angiogram*
   - *Raised CRP → ? Discitis / osteomyelitis*

2) Early inpatient referral
   - *See below for appropriate service*
   - *Do not have to wait for all investigations to be completed*

☐ NO ↓

Are the bloods and X-rays UNREMARKABLE?

e.g. no evidence of pathological fractures / normal inflammatory markers

☐ NO → (SMO review, above)

☐ YES ↓

REMAIN IN ED / ADU until all diagnostic tests are available

Physiotherapy / MDT review if required

↓

Mobility assessment: **Can the patient safely mobilise?**

☐ YES ↓

Mobilising safely *and*

- ☐ All discharge criteria met

☐ YES ↓

- ☐ Discharge & transfer care to GP

☐ NO ↓

Unable to mobilise safely *and both*

- ☐ Medically well
- ☐ Normal functional status *(Usually manages independently)*

☐ YES ↓

- ☐ Admit Orthopaedic team

☐ NO ↓

Unable to mobilise safely *and any of*

- ☐ Multiple medical co-morbidities
- ☐ Functional limitation *(Usually needs assistance with ADL's)*
- ☐ Active malignancy
- ☐ Acute medical condition

☐ YES ↓

- ☐ Admit AT&R if appropriate *or*
- ☐ Admit General Medicine

If your patient does not completely fit into one of these categories discuss disposition at SMO level

Waitemata
District Health Board

Best Care for Everyone

☑ = YES ☒ = NO

(PLACE PATIENT LABEL HERE)

SURNAME: ______________________ NHI: __________

FIRST NAMES: ______________________________

Date of Birth: ______ /______ /______ SEX: __________

CLINICIAN

LOWER BACK PAIN BEST CARE BUNDLE PATHWAY

DISCHARGE CRITERIA **MUST MEET ALL**	ADMISSION CRITERIA *Disposition pathway page 2*
☐ Senior doctor agrees with discharge plan ☐ Able to mobilise *(even with residual pain)* ☐ Significant clinical improvement ☐ All Red flags addressed *(Raised CRP can be an early indicator of discitis / epidural abscess / osteomyelitis). Have you considered alternative non-spinal causes for back pain like AAA or renal colic?* ☐ No barriers to discharge identified	☐ Clinical Cauda Equina ☐ Motor deficit ☐ Persistent abnormal vital signs or red flags ☐ Severe unremitting pain ☐ Physiotherapist or MDT advice ☐ Senior clinician discretion Dr: ______________ *Refer to 'Disposition pathway' on page 2 for interdepartmental agreement on admitting inpatient team.*

DISCHARGE CHECK LIST	**FOLLOW UP -** *please document this in the EDS*
☐ Meets all discharge criteria above ☐ Prescription for home analgesia *(formulary page 4)* ☐ Patient information leaflet *(Bundle pack, EM CeDSS site, BCB page)* ☐ Medical certificate for 3 days if applicable ☐ ACC form signed if applicable	☐ Ask all patients to follow up with their GP *See BCB proforma link from the EDS - it is pre-populated with patient information* ☐ Consider outpatient physiotherapy referral *Not all patients need outpatient physiotherapy. Consider referral especially if yellow flags are present. See below.* *See EDS proforma (link from EDS) Already pre-populated with Physiotherapy and other useful patient advice*

OUTPATIENT PHYSIOTHERAPY *if indicated*

☐ **ACC patients**: give ACC 45
Encourage patient to arrange own appointment with private provider. (Provider list on BCB page, EM CeDSS). If not able we can refer WDHB but advise there may be a long wait

☐ **Non-ACC patients**: WDHB physiotherapy
Fax yellow referral form 2497. See BCB page, EM CeDSS. All referrals are prioritised. Advise there may be a long wait.

INDICATIONS AND PROCESS FOR MRI

- Cauda Equina
- Abnormal motor neurology
- Spinal claudication symptoms
- Back pain > 6 weeks

All MRI requests to be discussed with the on call Orthopaedic team.
Case by case discussion will determine timing (inpatient vs outpatient)
Orthopaedic team responsible for making the actual request.

Note: mechanical back pain without neurological compromise or red flags should be managed conservatively without the need for MRI.

BARRIERS TO RECOVERY: ACC YELLOW FLAGS

- Belief that pain and activity are harmful
- 'Sickness behaviors' (like extended rest)
- Low or negative moods, social withdrawal
- Heavy work, unsociable hours
- Overprotective family or lack of support
- Treatment that does not fit best practice
- Problems with claim and compensation
- History of back pain, time-off, other claims
- Problems at work, poor job satisfaction

Waitemata
District Health Board
Best Care for Everyone

☑ = YES ☒ = NO

(PLACE PATIENT LABEL HERE)

SURNAME: ______________________ NHI: __________

FIRST NAMES: ______________________

Date of Birth: ______ /______ /______ SEX: __________

LOWER BACK PAIN BEST CARE BUNDLE PATHWAY

FORMULARY / MEDICATION OPTIONS

CHECK ALLERGY STATUS AND SEE MEDSAFE OR OTHER TEXT FOR FULL LIST OF CONTRAINDICATIONS**

ALL MEDICATIONS MUST BE CHARTED ON THE NATIONAL / ELECTRONIC MEDICATION CHART

ANALGESIA FOR USE IN HOSPITAL AND ON DISCHARGE

Note: Please prescribe regular and PRN dosing, especially on discharge

Medication	Dose	Route	Freq	Notes
Paracetamol	1 g	Oral	Q 6 hourly	*Standing order*
Ibuprofen	400 mg	Oral	Q 6-8 hourly	*Standing order* *Up to 800 mg TDS. (Max 2400 mg/day)* *Ensure normal eGFR (> 60 ml /1.73 m2)*
Codeine phosphate	30 - 60 mg	Oral	Q 6 hourly	*Standing order. Max 400 mg / day* *Constipating. Consider laxative or stool softeners*
Morphine	5 mg (max)	IV	SLOW push	*Standing order. < 50 kg = 0.1 mg/kg IV > 50 kg = 5 mg*
ALTERNATIVE ANALGESIA				
Tramadol	50-100 mg	Oral	4-6 hourly	*High Side effect profile, ↓ seizure threshold* *Max 400 mg / day*
Diclofenac SR	75 mg	Oral	Twice daily	*Ensure normal eGFR (>60 ml/1.73 m2)* *Max 150 mg Daily.* *Consider Omeprazole 20 mg PO daily. GI upset common*
Amitriptyline	10 mg	Oral	Nocte	*Option for discharge. Increasing to 20 mg nocte*
Baclofen	5 mg	Oral	TDS	*Caution in known Psychiatric patients and elderly.* *Causes drowsiness, ↓ seizure threshold, and GI upset*
Diazepam	2 - 5 mg	Oral		*Note: Only at senior doctor discretion where muscle spasm significant. Not for routine use.*
Rapid release oxycodone (eg Oxynorm ® liq or cap)	5 mg	Oral	1 hourly PRN	*Max 30 mg / 24h. Safer in renal impairment. Constipating* *Liquid formulation not available in ED. (Source from ADU)* *2.5 mg Liquid oxynorm equivalent to 5mg oral morphine*
Rapid release morphine (eg Sevredol ®)	5 - 10 mg	Oral	1-4 hourly	*Max 60mg/24h. Care in renal impairment. Constipating*
Ketamine	10-20 mg	IV		*For severe unremitting pain only. SMO guidance.*

ADDITIONAL INFORMATION

Bundle documents	Best Care Bundle Low Back Pain full guideline - via Emergency Medicine CeDSS site
ACC Guideline	http://www.acc.co.nz/PRD_EXT_CSMP/groups/external_ip/documents/internet/wcm002131.pdf ACC New Zealand Acute Low Back Pain Guide
Health Point Guidelines	www.healthpointpathways.co.nz

TOP TIPS

Acute low back pain is a common presentation. Our key roles include:

- Pain relief and mobilisation
- Ensure that serious underlying illness or pathology is absent.

Most patients will be able to leave the hospital after assessment however serious illness does occur and may be subtle and overlooked, especially in the early stages. e.g. epidural abscess, discitis and osteomyelitis. Rarely other conditions cause back pain that is not from the spine. e.g. aortic pathology / renal colic. Beware of the patient with immunosupression and raised inflammatory markers.