



RURAL/REMOTE PAIN RELIEF INVESTIGATION AND EVALUATION (REPRIEVE)

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Introduction

QAS attends over 700 traumatic injury related incidents per day, over half of which occur outside major cities. Inadequate pain relief is linked to negative physiological and psychological consumer outcomes, and reduced quality of life. The purpose of this study was to:

1. investigate whether there are differences in paramedic perceptions and experiences of prehospital pharmacological pain management of trauma cases in regional/rural/remote areas vs major cities.;
2. identify perceived barriers/facilitators to optimal pharmacological pain management, and whether these differ by remoteness.

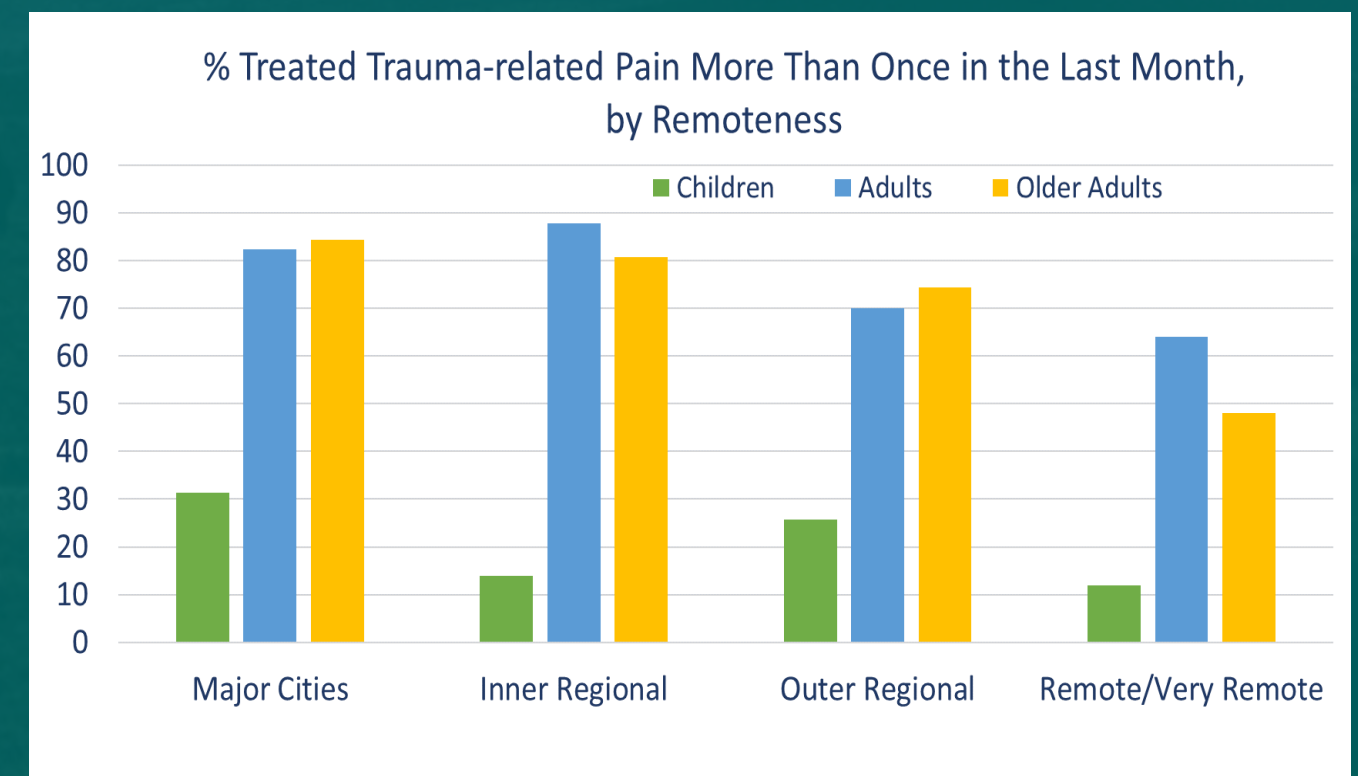
Methods

A mixed methodology approach was used. Operational QAS staff participated in a cross-sectional online survey (approx 10-15mins), regarding experience and perceptions of pain relief administration for moderate and severe pain, as well as barriers and facilitators to pain management. Semi-structured interviews were also conducted, transcribed, coded and thematically analysed.

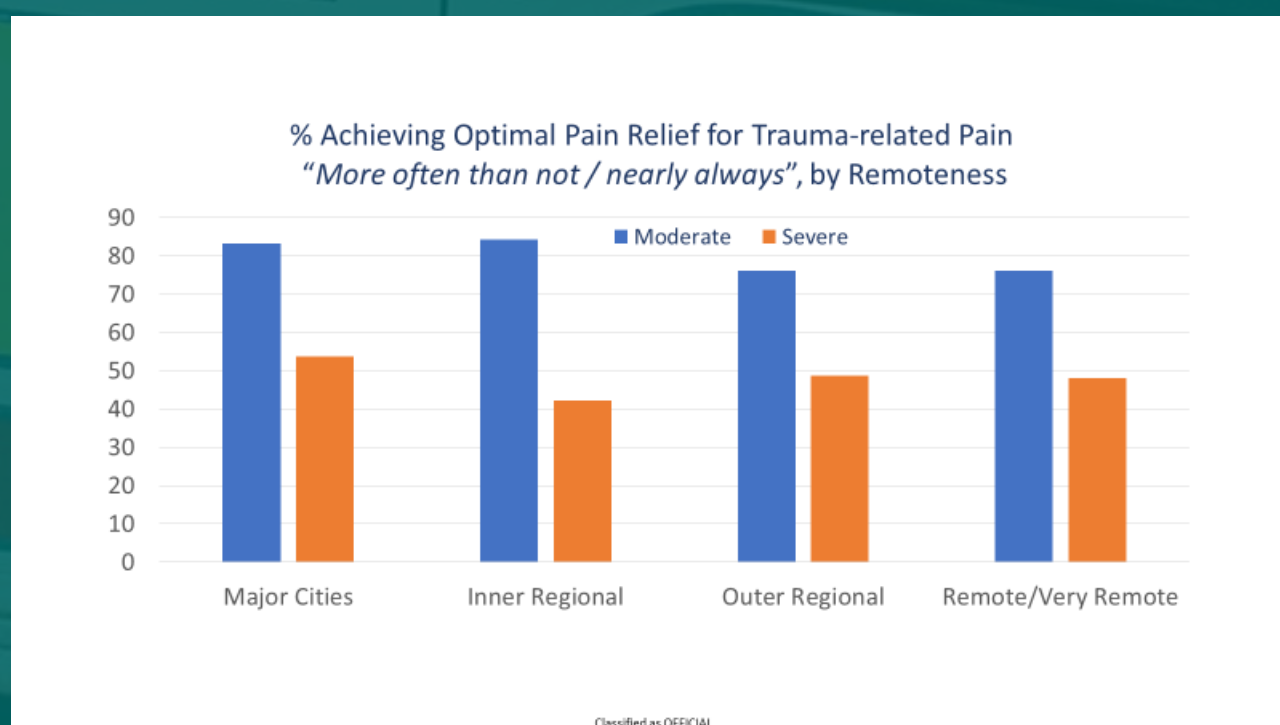
Results

There were 326 survey participants (51% major cities; 18% inner regional, 23% outer regional; 9% remote/very remote), and 32 interview participants. Average years of service was 11.5yrs (SD=9.05yrs).

Approximately 80% of survey respondents reported that they had treated trauma-related pain in both adults and older adults (65+yrs) at least once per month in the last 3 months, but only one-quarter had treated children. Fewer respondents from outer regional and remote/very remote areas reported treating children, adults and older adults for trauma-related pain than in major cities and inner regional areas ($p < .05$, Figure 1).



Results continued..



For moderate trauma-related pain, most (81%) respondents reported achieving optimal pain management "more often than not / nearly always", vs 50% for severe trauma-related pain. This did **not** differ by remoteness ($p > 0.05$; Figure 2).

Barriers to provision of optimal pain management included:

- clinician factors (confidence, experience, scope of practice, clinician bias, partner conflict),
- patient factors (age, alcohol/substance use, comorbidities, language barriers, current medications, concerns about side effects of pain relief), and
- operational/organisational factors (road conditions, transport times, complicated extrication, technical/communication issues, organisational culture, operational demand, single-officer response).

Discussion

These findings are preliminary. Further analyses are underway to identify factors associated with perceived pain reduction and what factors influence pain management. By clearly identifying barriers, enablers and innovative solutions for pain management, we aim to ensure high-quality, patient-centred care for patients with trauma-related pain in all areas of Queensland.

