NATIONAL NURSING AUDIT MINISTRY OF HEALTH MALAYSIA

**ELEMENT 5: CONTINUUM OF CARE**

# 5.6 PAIN 5TH VITAL SIGN

## Introduction

Pain is a common symptom that is experienced by many patients. Very often, patients have to tolerate severe pain due to poor pain management due to our prejudice, ignorance and fear of side effects of pain medication. Pain in adults is often under-recognised and under-treated due to: ignorance, inexperience, overwork, fears of addiction to opioid and serious side effect such as respiratory depression. (JCAHO 2001).

Pain assessment is an important aspect in patient care that we need to seriously undertake in order to make patients' stay comfortable. Doctors and nurses should not just guess what the patient's pain level is; rather, we should ask the patient and believe the patient's report of his/her pain level. According to JCAHO 2001, all patients have the right to pain management and pain relief.

"Pain as 5th Vital Sign" brings about multiple benefits to the patients, and to the organization. It helps to promote *holistic patient-centred care; reduces post-operative morbidity; facilitate recovery and discharge, improves* nurse-patient interaction, doctor-patient interaction and client satisfaction. It is also an important criteria for the accreditation of Pain Free Hospital status in Malaysia. "Pain as 5th Vital Sign incorporates the 10'S' as recommended by the Nursing Division, Ministry of Health, Malaysia, thereby promoting client satisfaction.

Pain 5th vital sign has been implemented in many countries worldwide as people are looking towards pain free hospitals and more effective means of pain management. It has also become a requirement in hospital accreditation system. (JCAHO 2006). Therefore, to benefit from the goodness of pain 5th vital sign, this project was taken up to ensure patients' comfort and early recovery, particularly trauma patients, post surgery patients and ill patients such as cancer patients and patients in severe pain.

## 2. OBJECTIVES :

2.1 To meet objectives of the Pain Free Hospital Concept of the Ministry Of Health.

2.2 To keep patients pain free or keep pain to a minimal level to promote patient comfort.

2.3 To assess pain for all patients correctly, accurately and enhance patient mobility.

## 3. STANDARD

3.1 Nurses implement Pain 5th Vital Sign correctly and effectively.

3.2 Nurses exhibit soft skill and caring component during pain assessment.

3.3 Nurses document pain level accurately.

3.4 Nurses carry out nursing intervention effectively.

## 4. CRITERIA

| Structure | Process | Outcome |
|---|---|---|
| 1. There is a standard operating procedure (SOP) for performing Pain 5th Vital Sign. | 1. Greet patient. | The nurse uses some form of soft skill when greeting the patient. |
| 2. MOH Pain Scale | 2. Nurse inform patient the purpose of the pain assessment ruler. | The nurse shows and inform the patient purpose of the pain ruler. |
| | 2.1. Nurse teach patient to verbalize pain score using the pain scale | Patient is able to verbalize pain score |
| | 2.2 Nurse reinforces teaching ( *if patient does not understand or does not know how to give pain score - optional).* | |
| 3. The nurse has knowledge and skill in using the pain scale to obtain patient's pain score. | *(For subsequent observations)* 3. Nurse asks patient his/her pain score. | Patient is able to verbalize pain score |
| 4. The nurse has knowledge and skill in carrying out related nursing actions to relieve pain. | 4. The nurse carries out nursing action according to patient's pain score. | Nurse follows the flow chart in the implementation of pain management. |
| 5. The nurse carries out nursing action based on the outcome of pain score. | **(If pain score less than 4 (<4 ):** 5. Nurse carries out the necessary nursing action, e.g. non-pharmacological methods. | Nurse carries out necessary nursing action |
| | 5.1 Nurse asks whether patient is comfortable and requires medication. | |
| 6. The nurse documents pain scores, nursing action and / or analgesics given | 6..Nurse documents Pain score in the observation form or Hospital Information System (HIS). | Nurse documents pain score accurately |
| | 6.1 Nurse documents nursing action taken / analgesic given. | Nurse documents nursing action and analgesic if given. |

| Structure | Process | Outcome |
|---|---|---|
| 7. Management of Pain<br><br>7.1 There is :<br><br>i. A training Module for Pain 5th Vital Sign :<br><br>ii. MOH Pain Scale<br><br>iii. A standard flow chart to guide nurses on implementation of Pain 5th Vital Sign.<br><br>iv. Observation form<br><br>v. Hospital Information System (HIS)<br><br>7.1.1 The nurse has knowledge on use of the flow chart.<br><br>7.2 The nurse has knowledge on nursing action required and follows the flow chart. | (Choice Of Nursing Action)<br>**7.1 *If pain score is < 4 (or mild pain):***<br><br>Nurse carries out nursing action if necessary; OR Nurse ask patient whether patient is comfortable and needs any medication for his/her pain.<br><br>a. If Yes (patient requires medication), nurse may serve Tab Paracetamol as prescribed.<br><br>b. Record pain score, nursing action (if any) OR pain medication served in the observation form / Hospital Information System (HIS)<br><br>c. If 'No' (does not require medication), nurse only documents pain score in the observation form or Hospital Information System (HIS).<br><br>***7.2 If pain score is ≥ 4, [4-10]***<br>7.2.1 Nurse checks patient's notes for prescription.<br><br>7.2.2 If doctor has prescribed analgesics, nurse serves or administers analgesics as ordered.<br><br>7 .2.3 If doctor has not prescribed, nurse inform doctor for prescription. | Nurse follows the Nursing Flow Chart for nursing intervention<br><br>Patient is comfortable<br><br>Documentation is complete and accurate.<br><br>Documentation is complete and accurate.<br><br>Nurse follows the pain management flow chart for nurses<br><br>Nurse inform doctor if no analgesics is ordered. |

| Structure | Process | Outcome |
|---|---|---|
| | 7.2.4 Nurse serves or administers analgesics as ordered.<br><br>(For mothers in labour entonox, analgesics.If analgesic is not given, record nursing action carried out such as reassurance/ encourage deep breathing, back rub or massage.) | Patient received his/her analgesic<br><br>Antenatal mother received backrub or massage from the nurse who attended to her. |
| | 7.2.5 Nurse records medication served. | Documentation is complete and accurate. |
| | **REASSESSMENT**<br>7.2.6 Nurse reassess patient's pain score after 30 minutes to 1 hour and document accurately. | Nurse carry out reassessment of pain score after serving medication.<br>(30 mins after injection,<br>1 hour after oral tablet) |
| | 7.2.7 Nurse record reassessed pain score accurately. | Documentation is complete and accurate.<br><br>Patient's pain is reduced and patient is more comfortable. |

## 5. AUDIT GUIDELINE FOR IMPLEMENTATION OF PAIN 5TH VITAL SIGN

### 5.1 INCLUSION CRITERIA

Patients admitted to the hospital – in paediatric ward, medical, surgical, obstetric, oncology, palliative wards, burns cases, orthopaedic, psychiatric wards, trauma patients, ill cases, ICU patients who are not on ventilators.

### 5.2 EXCLUSION CRITERIA

Unconscious, sedated patients, patients on ventilator and mentally challenged patients who are not able to cooperate to give their pain score.

### 5.3 METHODOLOGY

5.3.1 Direct observation of pain assessment for pain score.

5.3.2 **Setting** : Medical, Surgical, Orthopaedic, Renal, Urology, Oncology, Palliative, Hepatobiliary ward, Paediatrics, Specialised areas, ICU and CCU if patients are conscious.

5.3.3 **Sample Size** : 30% of nurses working in the ward

5.3.4 **Sampling method** : Convenient sampling

5.3.5 **Time Frame :** 6 weeks

5.3.6 **Instrument** : MOH pain scale.

5.3.7 **Standard** : 90% compliance

## 6. DEFINITION OF OPERATIONAL TERMS:

6.1 Unconscious patients: patient who is unaware of his/her surroundings, as in sleep or of being unresponsive to stimulation.

(*Oxford Medical Dictionary, Mobi Systems 2018)*

6.2 MOH pain scale : Pain scale that is specially designed and printed for use in the MOH hospitals. It is a combination of the numeric rating scale and visual analogue scale.

*(Pain as 5th Vital Sign. Guidelines for Paramedics: Management of pain in Adult patients Guidelines for Doctors: Management of Pain in Adult patients. 3rd Edition MOH, KKM)*

6.4 Post surgery patients: any patient who has undergone a surgical operation.

*( www. Meriam-webster.com, Retrieved 15 April 2019)*

6.5 Trauma patient : Is someone who has suffered a serious or life threatening injury as a result of an event such as a car accident, gun shot wound or fall.

*(https://www.traumasurvivorsnetwork.org,Retrieved 15th April 2109)*

6.6 Pain 5th Vital Sign : pain scoring is considered the 5th Vital Sign after the four vital signs (i.e, Blood pressure, pulse, respiration and temperature) carried out for all patients in the wards every 4hourly as required or upon any specific intervals.

*(Pain as 5th Vital Sign. Guidelines for Paramedics: Management of pain in Adult patients Guidelines for Doctors: Management of Pain in Adult patients. 3rd Edition MOH, KKM, page 11)*

6.7 Implementation Pain as 5th Vital Sign: On admission, all patients are informed on the use of the MOH pain scale and are taught on how to score the pain using the pain scale. If patients are unsure, repeat teaching until they understand and are able to score the pain score accurately. For subsequent observations, if the patients already understood and know how to score the pain, no further teaching is required.

6.8. Pain score on activity is not required but has been in practice by the APS nurses. Only one pain score is required as the 5th Vital Sign taken at that point of time.

6.9. Nursing actions : Nursing actions can be any action carried out by the nurse to reduce pain. These actions need not be ordered by the doctor but carried out according to nursing concepts based on patients' pain scores. Nursing actions are actions carried out when pain score is less than 4, to help reduce pain levels. Some of the nursing actions can be elevating the affected limb with pillow, repositioning patient, adjusting a blocked catheter or a gentle rub. Pain scores more than 4 require other actions such as checking case notes for medication ordered, informing the doctor if there is no analgesics prescription and serving or administering the analgesics.

6.10. Pain Flow Chart: Recommended flow chart for the implementation of pain 5th vital sign. It shows the flow of nursing actions depending on the pain score. For pain score less then 4, nurse may carry out nursing action if necessary but the nurse will still have to ask whether the patient is comfortable and requires any medication. When pain score is more than 4 (4-10), check patient's notes for analgesics ordered by doctor. If analgesics are not ordered, inform doctor of patient's high pain score for analgesics prescription. If analgesics have been ordered, serve and document in the observation chart.

6.11 Reassessment of pain score: For high pain scores, nursing action or reassessment of pain scores is done after 30 minutes for injection analgesics or 1 hour after oral analgesics is given.

## 7. Rating System

### 7.1Technical component:

7.1.1 Teach patient how to verbalize their pain score using the MOH pain scale.

(Optional: Only on first admission. Subsequent observation teaching is not required if patient understands and able to give pain score.)

7.1.2 Reinforce teaching if patient does not understand. (optional : no need to reinforce if patient already knows.

7.1.3 Take nursing action as per flow chart based on the patient's pain scores. 7.1.4 Reassess pain scores after nursing actions.

7.1.5 Follow the pain flow chart.

### 7.2 Soft skills

7.2.1 Smile, greet / acknowledge patient

7.2.2 Inform / explain to patient purpose of MOH pain scale;

7.2.3 Explain to patient the purpose of the MOH pain scale. (Optional: Only on first admission).

7.2.4 Give reassurance when patient is in severe pain and while waiting for medication.

7.2.5 Listen to patient and respond promptly and politely.

### 7.3 Documentation component

7.3.1 Record accurately pain scores after asking the patient.

7.3.2 Record accurately pain scores after reassessment for pain scores 4-10.

7.3.3 Record nursing actions carried out in the observation chart / Hospital Information System (HIS)

7.3.4 Record analgesics served or administered.

## 8.AUDIT FORM

Audit form (E5 AF5.6)

| | |
|---|---|
| **NATIONAL NURSING AUDIT,**<br>**MINISTRY OF HEALTH MALAYSIA** | **VERSION 3/2019** |
| **ELEMENT 5 : CONTINUUM OF CARE** | |
| **TOPIC : 5.6 PAIN AS 5TH VITAL SIGN** | **DATE : 11.4 2019** |
| **DOCUMENT NO : E5 AF5.6** | **PAGE No. 1/6** |

### 8.1 STANDARD

8.1.1 Nurses implement Pain 5th Vital Sign correctly and effectively.

8.1.2 Nurses exhibit soft skill and caring component during pain assessment.

8.1.3 Nurses document accurately pain scores

8.1.4 Nurses carry out nursing intervention effectively.

8.1.5 At least 90% compliance to standards.

### 8.2 OBJECTIVES :

8.2.1 To meet objectives of the pain free hospital concept of the MOH.

8.2.2 To keep patients pain free or keep pain to a minimal level to promote patient's comfort..

8.2.4 To assess pain for all patients correctly, accurately and to enhance patients' mobility and reduce morbidity .

Date of audit : .....

Locality : .....

Auditors :

Auditor 1 : .....

Auditor 2 : .....

N.B. Instructions for Auditors
i. Tick (√ ) at the appropriate column;
2. If the item is optional, tick N/A
3. S / T/ D indicate soft skill / technical skill / documentation respectively.

| S/N | ITEM /*PERKARA* | SOURCE OF INFORMATION *SUMBER MAKLUMAT* | YES/ *YA* | NO/ *TIDAK* | N/A |
|---|---|---|---|---|---|
| S1 | Smile and Greet / acknowledge patient<br>*Senyum dan beri salam kepada pesakit* | Listen & Observe nurse<br>*Dengar dan perhati* | | | |
| S2 | Explain / inform the purpose of the pain assessment ruler<br>*Menerangkan/memberitahu pesakit tujuan penilaian skala tahap kesakitan* | Listen & Observe nurse<br>*Dengar dan perhati* | | | |
| T1 | Teach patient to give pain scores<br>*Mengajar pesakit cara memberitahu skor kesakitan* | Listen & Observe nurse<br>*Dengar dan perhati* | | | |
| T2 | Reteach if necessary<br>*Mengajar semula sekiranya perlu* | Listen & Observe<br>*Dengar dan perhati* | | | |
| | **Pain Score (Skor Kesakitan) < 4 (0-3)** | | | | |
| T3 | Follow the Pain flow chart for nursing action<br>*Mengikut carta aliran kesakitan untuk tindakan kejururawatan* | Observe nurse<br>*Perhati* | | | |
| T4 | Ask patient whether she is comfortable and needs any medication<br>*Bertanya sama ada pesakit selesa atau memerlukan ubatan* | Listen & Observe nurse<br>*Dengar dan perhati* | | | |
| D1 | Document pain score<br>*Merekod skor kesakitan* | Observe & check document<br>*Perhati & periksa dokumen* | | | |
| T5 | Carry out nursing action<br>*Meneruskan tindakan kejururawatan* | Observe nurse<br>*Perhati* | | | |
| D2 | Document nursing action<br>*Merekod tindakan kejururawatan* | Observe & check document<br>*Perhati dan periksa dokumen* | | | |

| S/N | ITEM /*PERKARA* | SOURCE OF INFORMATION *SUMBER MAKLUMAT* | YES/ *YA* | NO/ *TIDAK* | N/A |
|---|---|---|---|---|---|
| | **If pain score is (sekiranya skor kesakitan) ≥ 4 (4-10)** | | | | |
| D3 | Document pain score<br>*Merekod skor kesakitan* | Observe & check document<br>*Perhati dan periksa dokumen* | | | |
| T6 | Check Doctor's prescription ordered<br>*Memeriksa preskripsi yang diarahkan oleh doctor* | Observe nurse<br>*Perhati* | | | |
| T7 | Inform doctor if analgesics not ordered<br>*Beritahu doktor sekiranya analgesik tidak diarahkan* | Listen & Observe nurse<br>*Dengar & Perhati* | | | |
| T8 | Check time of last dose analgesics.<br>*Memeriksa waktu terakhir dos analgesik diberikan* | Observe nurse<br>*Perhati* | | | |
| T9 | Serve medication as prescribed OR Carry out nursing action as required.<br>*Memberikan ubat mengikut preskrepsi ATAU meneruskan tindakan kejururawatan yang perlu* | Observe nurse<br>*Perhati* | | | |
| D4 | Record analgesics served.<br>*Merekod analgesik selepas diberi.* | Observe & check document<br>*Perhati dan periksa dokumen* | | | |
| T10 | Reassess pain score 30 mins – 1 hour after serving of analgesics.<br>*Nilai semula skor kesakitan 30 minit sehingga 1 jam selepas analgesik diberi* | Observe nurse<br>*Perhati* | | | |
| D5 | Record reassessed pain score<br>*Rekod penilaian semula skor kesakitan* | Observe & check document<br>*Perhati dan periksa dokumen* | | | |
| T11 | Advice patient to inform nurse if pain is not relieved<br>*Nasihat pesakit supaya memberitahu jururawat sekiranya kesakitan tidak berkurangan* | Listen / Observe Nurse<br>*Dengar/Perhatikan* | | | |

| S/N | ITEM /*PERKARA* | SOURCE OF INFORMATION *SUMBER MAKLUMAT* | YES/ *YA* | NO/ *TIDAK* | N/A |
|---|---|---|---|---|---|
| S3 | Listen, respond promptly and politely to patient's questions.<br>*Dengar dan respon segera dengan sopan pertanyaan dari pesakit* | Listen & observe nurse<br>*Dengar/Perhatikan* | | | |
| S4 | Give reassurance and make patient comfortable<br>*Mententeramkan dan memberi keselesaan kepada pesakit* | Listen & observe nurse<br>*Dengar/Perhatikan* | | | |
| D6 | Accurate and complete documentation.<br>*Dokumentasi yang tepat dan lengkap* | Check document<br>*Periksa dokumen* | | | |

***AUDIT REPORT (Please [√] in the appropriate box)***

| Criteria | Item | Conformance | Non conformance | N/A |
|---|---|---|---|---|
| Technical | 11 | | | |
| Documentation | 6 | | | |
| Soft skill | 4 | | | |
| **Total** | 21 | | | |

***Conformance*** ☐ ***Non-Conformance*** ☐

**REMARKS**

| NO. | REMARKS |
|---|---|
| | |
| | |

***Auditor 1[Name and Signature]: ……***

***Auditor 2 [Name and Signature]: ……***

**Calculation: $\frac{\text{Item conformance}}{\text{Total item – item N/A}} \times 100$

**Example:**

**Calculation: Item conformance X 100

Total item – item N/A

**Pain score ≥ 4**

Technical: $\frac{8}{8-0} \times 100 = \frac{800}{8} = 100\%$

Documentation : $\frac{4}{4-0} \times 100 = \frac{400}{4} = 100\%$

Soft skill: $\frac{4}{4-0} \times 100 = \frac{400}{4} = 100\%$

| Criteria | Item | Conformance | Non conformance | N/A |
|---|---|---|---|---|
| Technical | 8 | 100% | 0 | 0 |
| Documentation | 4 | 100% | 0 | 0 |
| Soft skill | 4 | 100% | 0 | 0 |
| **Total** | 16 | **(100 + 100 + 100 = 300 ÷ 3) = 100%** | **(0+0+0= 0 ÷ 3) = 0%** | **(0 + 0 + 0 = 0 ÷ 3) = 0%** |

Note: To minimize N/A as much as possible. The nurse can be lead to answer if situation arises.