P5VS

PAIN AS 5TH VITAL SIGN

FOR DOCTORS AND PARAMEDICS

HOSPITAL MELAKA

2023

REFERENCE CARD

PAIN FREE HOSPITAL

1

HISTORY OF PAIN FREE HOSPITAL

- ❑ First accreditation on 11thAugust 2016
- ❑ Second accreditation on 25th September 2018
- ❑ This year is 3rd Recertification

2

COMPONENTS OF PAIN FREE HOSPITAL

- ❑ Anesthesia & analgesia/Pharmacology
- ❑ Modern Surgical Techniques & Daycare surgery (i.e Minimal invasive surgery/ laparoscopy)
- ❑ Traditional & Complimentary medicine/ Non Pharmacology

3

OBJECTIVES

- ❑ Pain free Surgery
- ❑ Pain free Labour
- ❑ Pain free Procedures
- ❑ Pain free Rehabilitation
- ❑ Pain free Discharge

POLICY STATEMENT

FOR PAIN FREE PROGRAM

1. Pain Is The **FIFTH VITAL SIGN**
2. Pain Is Assessed In **ALL PATIENTS**
3. STANDARDIZED **PAIN ASSESSMENT TOOLS** Must Be Applied Consistently
3. Healthcare Providers Should **LISTEN AND RESPOND PROMPLY** To Patient's Report Of Pain And **MANAGE PAIN APPROPRIATELY**
4. Healthcare Facility Staff Should Be **CONTINUALLY EDUCATED AND AWARE** About Pain Assessment And Management



PATIENT CHARTER

(PIAGAM PELANGGAN)

1. Health care facility will endeavor to provide you with a pain free experience.
2. We pledge to treat pain from all conditions including pain from acute medical conditions, surgery, trauma, cancer and labour.
3. Your pain will be given prompt attention and managed within an hour.
4. All patients with pain will be assessed and treated by trained professionals : for those with acute pain conditions, we aim to achieve a pain score of less than 4.
5. Pain control will be individually tailored using appropriate medications as well as non-pharmacological methods including traditional and complementary medicine.
6. Our health care professionals will monitor your pain score and care for your comfort throughout your health care facilities stay.

1 WHAT YOU SHOULD KNOW?

PAIN SHOULD BE ASSESSED IN ALL PATIENTS (P5VS)

USING PAIN ASSESMENT TOOLS *

TECHNIQUE FOR MEASUREMENT OF PAIN

1. **SELF REPORTING by patient : MOH PAIN SCALE and IASP FACE SCALE**
2. **OBSERVER ASSESSMENT : FLACC,CPOT,PAINAD**

WHEN DO YOU TAKE PAIN SCORE?



- ❑on admission
- ❑on transfer in
- ❑scheduled interval
- ❑during painful procedures
- ❑when patient complains of pain
- ❑½ - 1 hour after administering analgesics

HOW DO YOU MANAGE PAIN?

- ❑ based on patients history and assessment and **MODIFIED ANALGESIA LADDER** and NON-PHARMACOLOGICAL TREATMENT.
- ❑ review back after ½ to 1 hour

WHAT DO YOU UNDERSTAND ABOUT THE FLOW CHART FOR ACUTE PAIN MANAGEMENT?

- ❑ **PLEASE READ UP ON FLOW CHART FOR DOCTORS/ PARAMEDICS**

  (which ever applies to you)

IF PAIN SCORE IS MORE THAN 6 HOW DO YOU MANAGE?

- ❑ I would like to activate the **IV MORPHINE PAIN PROTOCOL**

(PLEASE READ UP ON THE FLOW OF THE PROTOCAL AND HOW TO DILUTE IV MORPHINE FOR THE PROTOCOL)

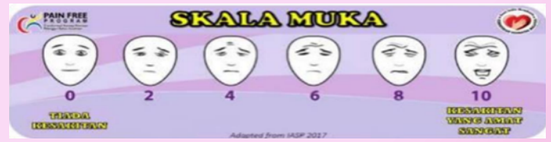
PAIN ASSESSMENT TOOL*

AGE	SCALE
ADULT	MOH PAIN SCALE
PAEDIATRIC:	
< 1 month	NIPS (Neonatal Infant Pain Scale)
1 month - 4 years	FLACC SCALE
4 - 7 years	FACES SCALE
> 7 years	MOH PAIN SCALE
Language barrier/Cognitively Impaired Patient	FLACC SCALE
Patient ventilated & sedated	CPOT/ BPS
Pain Assessment In Advanced Dementia	PAINAD

MOH PAIN SCALE



IASP/ FACE SCALE



FLACC SCALE

Category	Scoring		
	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
Cry	No cry (awake or sleep)	Moans or whimpers; occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractable	Difficult to console

PAINAD - Geriatric with Dementia

ITEMS	0	1	2
Breathing (independent of vocalization)	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-stokes respirations.
Negative vocalization	None	Occasional moan or groan. Low level of speech with a negative disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.
Facial expression	Smiling or inexpressive	Sad, rightened, frown.	Facial grimacing.
Body language	Relaxed	Tense. Distressed pacing. Fidgeting.	Rigid. Fist clenched. Knees pulled up. Pulling or pushing away. Striking out.
Consolability	No need to console	Distracted or reassured by voice or touch.	Unable to console, distract or reassure.
TOTAL			

CPOT

Indicator	Score		Description
Facial expression	Relaxed, neutral	0	No muscle tension observed
	Tense	1	Presence of frowning, brow lowering, orbit tightening, and levator contraction or any other change (eg, opening eyes or tearing during nociceptive procedures)
0 1 2	Grimacing	2	All previous facial movements plus eyelid tightly closed (the patient may have mouth open or may be biting the endotracheal tube)
Body movements	Absence of movements or normal position	0	Does not move at all (does not necessarily mean absence of pain) or normal position (movements not aimed toward the pain site or not made for the purpose of protection)
	Protection	1	Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements
	Restlessness	2	Pulling tube, attempting to sit up, moving limbs/thrashing, not following commands, striking at staff, trying to climb out of bed
Compliance with the ventilator (intubated patients)	Tolerating ventilator or movement	0	Alarms not activated, easy ventilation
	Coughing but tolerating	1	Coughing, alarms may be activated but stop spontaneously
	Fighting ventilator	2	Asynchrony: blocking ventilation, alarms frequently activated
or **Vocalization (nonintubated patients)**	Talking in normal tone or no sound	0	Talking in normal tone or no sound
	Sighing, moaning	1	Sighing, moaning
	Crying out, sobbing	2	Crying out, sobbing
Muscle tension Evaluation by passive flexion and extension of upper limbs when patient is at rest or evaluation when patient is being turned	Relaxed	0	No resistance to passive movements
	Tense, rigid	1	Resistance to passive movements
	Very tense or rigid	2	Strong resistance to passive movements, inability to complete them
Total		__/8	

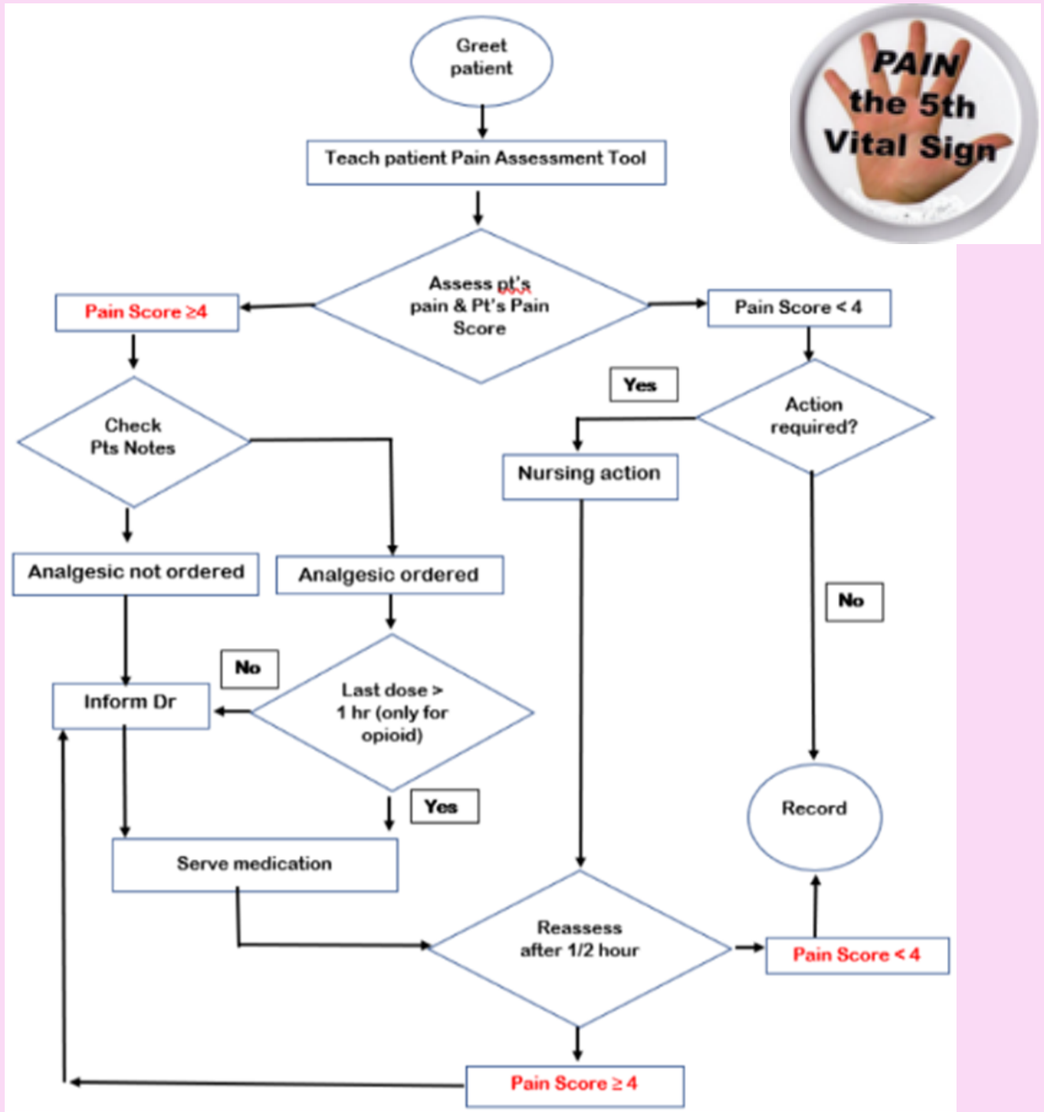
*Adapted with permission from Gélinas et al.[5]

2 PAIN MANAGEMENT FLOWCHART FOR PARAMEDICS

- PARAMEDICS

Q ; What is the acceptable pain score ? (Pain score <4)

Q : How do you manage the patient with Pain Score ≥ 4? (FLOWCHART)

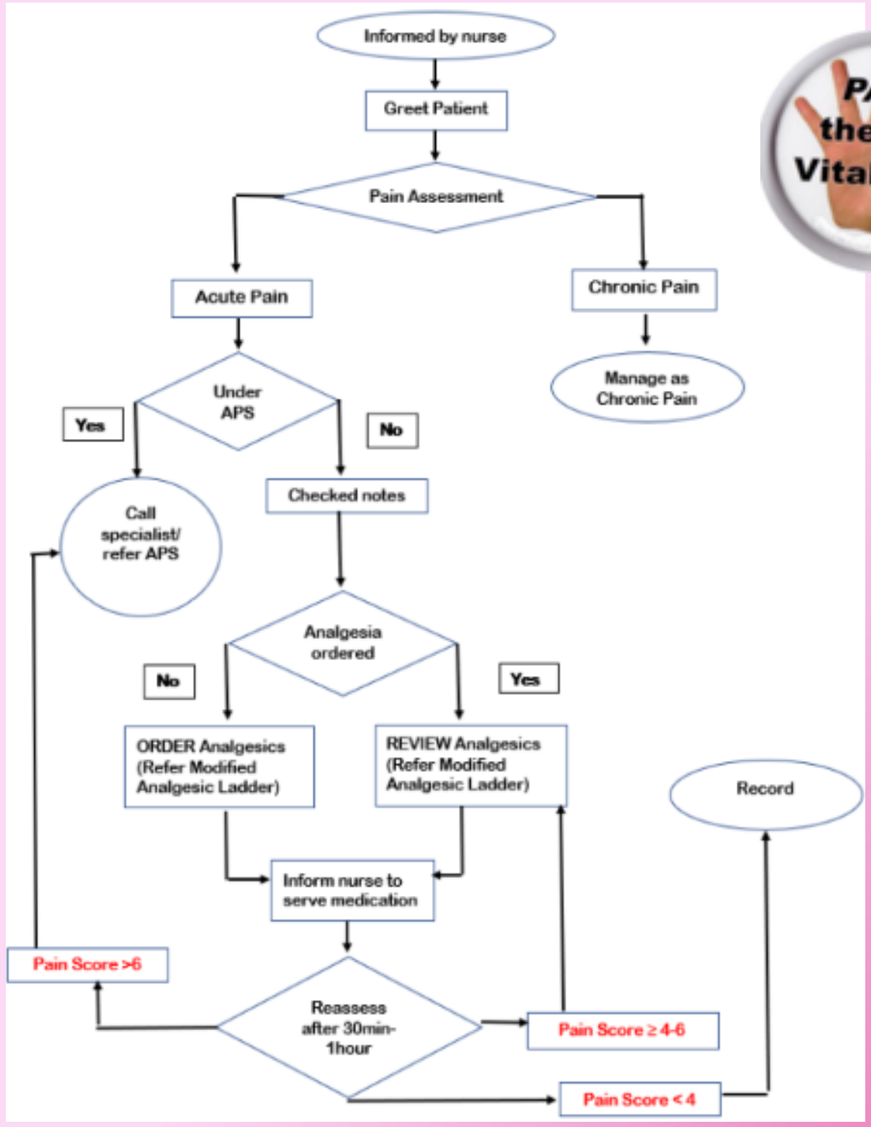


3 PAIN MANAGEMENT FLOWCHART FOR DOCTORS

- DOCTORS

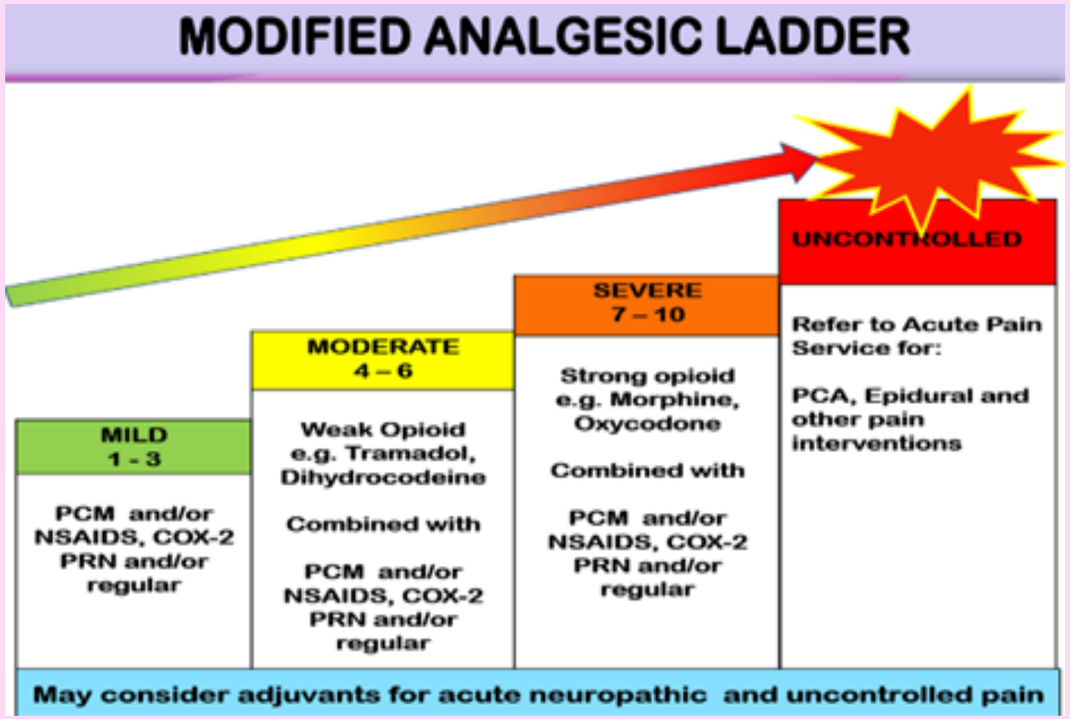
Q ; What is the acceptable pain score ? **(Pain score <4)**

Q : How do you manage the patient with Pain Score ≥ 4? **(FLOWCHART)**



4 PAIN MANAGEMENT

PHARMACOLOGICAL



NON - PHARMACOLOGICAL

NON PHARMACOLOGICAL APPROACHES

Physiotherapy approaches	• Rest, Immobilization, Cold compression, Elevation (RICE) • TENS • Heat/ Cold pack • Stretching exercise • Strengthening exercise
Physiological approaches	• Explanations and reassurance • Address anxiety • Breathing relaxation • Counselling
Traditional & Complementary medicine	• Acupuncture • Massage/ Aromatherapy • Music
Occupational Therapy	• Modification of activities of daily living, play, leisure and work

IF PAIN SCORE >6 (SEVERE),
TO INITIATE MORPHINE PAIN PROTOCOL

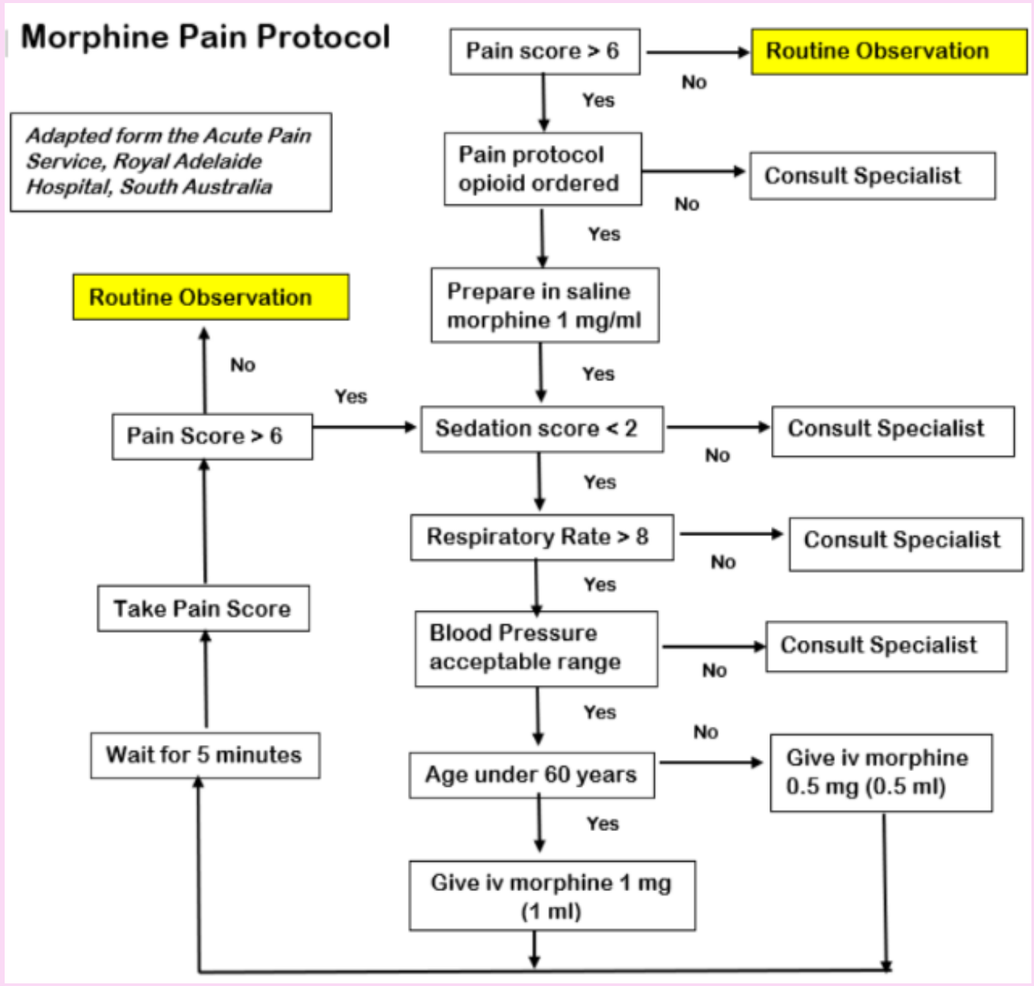


SEDATION SCORE (patient on opioids)

0	Patient is awake
1	Mild (occasionally drowsy)
2	Moderate (frequently drowsy, easily arousable)
3	Severe (difficult to rouse)

5 MORPHINE PAIN PROTOCOL

Q ; When to use morphine pain protocol ?



Q: What are the side effects of opioids?

- Nausea and vomiting
- Sedation
- Respiratory depression
- Constipation/ileus
- Urinary retention
- Pruritus



6 OPIOID COMPLICATIONS MANAGEMENT

(adapted from aps form)

Management of complications:

i)Respiratory Depression

- Sedation score : 2 and respiratory rate less than 10/minute OR
- Sedation score : 3 regardless of respiratory rate
- Give Naloxone (Narcan) 0.1mg IV STAT and repeat up to total of 0.4mg
- Call APS Team/Anaesthesia MO immediately

ii)Hypotension

- If systolic BP drop <90mmHg, stop infusion (if any). Call the ward doctor.
- Run 250mls Normal Saline or Hartmann's solution.

iii) Nausea and vomiting

- Give the patient IV Metoclopromide (Maxolon) 10mg 8hrly PRN, if still no relief, call APS team.

iv) Bromage Score

- Any persistent numbness or weakness (Bromage score ≥2),call APS team

v)Other problems

- For inadequate analgesia (PS>4), call APS Team immediately.
- For mild pruritus treat with calamine lotion. For severe pruritus inform APS Team.
- For other problems like urinary retention or giddiness, call the ward doctor