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Table of content:

Acronyms:

IASP	The International Association for the Study of Pain
PAT	Pre-admission testing
NRS	Numerical Rating Scale
FLACC	Face, Legs, Activity, Cry, & Consolability Scale
CPOT	Critical-care Pain Observation Tool
N-PASS	Neonatal Pain Agitation Sedation Scale
PRN	As needed
MOH	Ministry of Health

1. Definitions:

Pain is a sensation of unpleasant sensory and emotional experience caused by actual or potential tissue damage and mediated by specific nerve fibers to the brain where its conscious appreciation may be modified by various factors.

1.1 **Pain Classification**:

1.1.1 Nociceptive Pain: Visceral or somatic. Usually caused by stimulation of pain receptors, which arise from tissue inflammation, mechanical deformation, ongoing injury, or destruction. It responds well to common analgesic medications as well as non-drug strategies.

1.1.2 Neuropathic Pain: the peripheral or central nervous system is involved. Neuropathic pain responds less predictably to conventional analgesics. May respond to adjuvant analgesic drugs.

1.1.3 Psychologically based pain syndromes: Traditional analgesia is not indicated.

1.1.4 Pain Management is an overview of strategies and considerations for effective acute and chronic pain management in patients.

1.1.5 Pain Rating Scale means a tool used to assess and measure of the intensity of pain.

1.1.6 Pain Treatment Plan means a healthcare provider's plan to help patients to manage all kinds of pain.

1.1.7 Central Sensitisation refers to an increase in the response of nociceptor to either normal or sub-threshold afferent input, resulting in:

- Hypersensitivity to stimuli.
- Responsiveness to non-noxious stimuli.
- Increased pain response evoked by stimuli outside the area of injury, an expanded receptive field.

1.2. **Pain Team is** a group of healthcare professionals assigned to manage patient pain in a healthcare institution. Includes but not limited to: doctors, anaesthetist, nurses, pharmacist, and respiratory therapist and physiotherapist.

2 Introduction:

Managing pain is vital to patient care, particularly in the emergency room where it can hinder the opportunities to treat and manage pain-causing conditions. Pain remains one of the most common reasons for patients to require medical attention, yet despite this, it often remains unassessed and treated. Acute pain on its own is very distressing, and if untreated can lead to complications and, in the longer-term, can generate to chronic pain. Therefore, pain assessment is crucial if pain management is to be effective. Globally, pain assessment is regarded as the fifth vital sign, so pain must be evaluated along with other vital signs.

This policy has been developed in order to promote the health, safety and welfare of patient in health services. It aims to establish guidelines to meet the international and national standards for the assessment, monitoring and management of pain. Moreover, this document is design to be implemented in Oman, based on MoH approved medication (analgesics) list.

3 Purpose:

The main purpose of pain management policy is to understand how to assess, reassess, and manage pain in a safe and effective manner. Moreover, it involves a multidisciplinary approach and includes doctors, nurses, pharmacists, and other healthcare providers.

4. Objectives:

- To reduce the incidence and severity of pain and, in some cases, prevent further health problems and enhance the quality of life.
- To establish standards of practice that will assist professional staff in assessing, monitoring, and managing patients' pain.
- To educate the patient, family, and staff.
- To enhance function, reduce suffering, and minimize adverse effects.
- To eliminate chronic pain, it should be possible to control pain to a tolerable level and allow people to function at an acceptable level.

5. Outcome:

The expected outcome of successful deployment of this policy is to elevate the healthcare professional's experience, safe practice and to reduce the morbidity that is associated with unmanaged pain.

6. Policy:

A pain management policy promotes health, safety, and welfare by establishing requirements for pain assessment, monitoring, and management in health care.

7. Procedure:

7.1. **Patient Explanation and understanding process:** remember the way you introduce the pain management process to your patient, will result in the successful management of your patient's pain or a patient not understanding the process may end up suffering. Be proactive in your patient's pain management.

- It is the nurse's responsibility to ensure that the patient fully understands the process and that they know what steps to take to ensure that their pain is addressed:

- Introduce yourself to the patient and his/her attender.
- Assess all painful procedures that may be done
- Explain the policy used at MOH to manage pain whilst in hospital.
- Show them the special tools used to assess their level of pain.
- Discuss the patient's condition and the pain that may encounter due to their medical condition or surgery they may be having.
- Explain which tool will be used, according to the patient's age and mental ability.
- Ensure appropriate pain assessment is carried out to ensure pain is addressed in a timely manner.
- Ensure that the patient/attender understands the tool and how to use it.
- Explain when the nurse will reassess the patient's pain.
- Explain who should the patient contact if they are experiencing pain and when they should contact, to ensure that their pain is treated, as early as possible.
- Ask the patient/attender to repeat to you what actions they should take if they are in pain, this will ensure that they have understood what you have explained to them.
- Explain ways in which pain medication may be administered oral tablets/injections
- Ask patients/attender if they have any questions that they want to ask you and if they are happy with everything that you have explained to them.

7.2. Initial Assessment of Pain:

Aim of pain assessment: to identify factors, physical and psychological, that affect patients in their perception of pain. The ultimate goal would be effective pain relief

- As the pain assessment is the fifth vital sign, pain must be evaluated along with the other vital signs. All patients must be assessed in the clinic, emergency room and during admission for pain. Pain assessment is the first step to successful pain management.
- Considering treatment/analgesics used at home for pain control, and obtain a medication history.
- Ask and document the type of medications/treatments the patient uses at home for pain control, e.g. traditional meds, Panadol, ice packs, etc.
- Ask if the medications being used are effective.
- Ask for allergies or reactions to pain medication and document it clearly in Al-Shifa system.

7.3. Pain Assessment Tools used at MOH (see Appendices):

7.3.1. There are five standardized tools used at MOH:

Appendix 1:	Numerical Rating Scale (NRS) (Adult patients)
Appendix 2:	FLACC Scale (Children age between 2 months and/or individual that are unable to communicate their pain)
Appendix 3:	Wong-Baker Faces Scale (Children age between 3 years to above)
Appendix 4:	CPOT Scale (Adults patient in the Intensive Care Unit)
Appendix 5:	N-PASS (Neonatal Pain Agitation Sedation Scale)

7.4. Pain Management:

- Ask the patient if he/she has pain.
- Use the assessment tool, relevant to patient (see appendix 1-5)
- Pain must be assessed:
    - As the Fifth Vital Sign, once each shift when routine vital signs are taken for all patients
    - Every 4 hours while awake, if mild to moderate pain levels present
    - Every 4 hours for first 24 hours post-operative
    - Every 2 hours or more often as needed, if patient complains of severe pain
    - After a maximum of 30 minutes following any intervention
    - Critically ill patients in ICU, CCU and HD

- Confirms the pain score and documents in Al-Shifa system (see section 6.8)
- As per pain score see below table, provide medication as per doctor's prescription

Pain Score	Medication
Mild pain (1-4)	Non-opioid analgesics such as nonsteroidal anti-inflammatory drugs (NSAIDs) or Paracetamol with or without adjuvants. For example: Paracetamol NSAIDs, including COX-2 inhibitors*
Moderate pain (5-7)	Weak opioids with or without non-opioid analgesics, and with or without adjuvants. For example: Codeine Tramadol Paracetamol combined with codeine or tramadol
Severe pain (8-10)	Strong opioids with or without non-opioid analgesics, and with or without adjuvants. For example: Morphine, Fentanyl, Oxycodone, Pethidine*, Gabapentin, pregabalin2 Adjuvants*** Ketamine & Clonidine **Pethidine:** In exceptional circumstances, pethidine should be use when the patient has a severe allergy to morphine and other opioid medications. Pethidine should not be used continuously for more than 48 hours or at doses greater than 600 mg/24 hours. Pethidine should be stopped after 48 hours, and an alternative opiate used if necessary.

***Reference: WHO analgesic ladder modified based on availability of medication in MoH**

6.5.1 MOH Pharmaceutical management options for treating pain could apply for acute, chronic, post-operative and for palliative care (see appendices 6):

6.5.2 Non-pharmacological interventions options for treating pain:
Although these strategies alone are frequently insufficient for moderate to severe pain, they are usually helpful in conjunction with pharmacological therapy. Non-pharmacological approaches for pain management can enhance comfort, promote sleep and enhance the quality of life.

Such strategies may include but are not limited to:		
Strategy for adults	Strategy for children	Strategy for both
• Progressive muscle relaxation • Guiding the patient in deep breathing • Religious support • Exercise	• Distraction • Favorite blanket, teddy bear • Presence of parent/companion • Picking up child • Rocking child	• Ice or warm compresses as ordered • Repositioning • Dimming the lights • Reducing noise • Referral to multidisciplinary team • Massage
To prevent anxiety and fear related to an anticipated painful experience (e.g. insert cannula, physical examination, etc.) by distraction such as:		
• Play therapy • Rewards • Involve parents/caregiver in treatment of child • Refer to alternative pain management technique		

Make use of **alternative pain management techniques** in combination with analgesics prescribed by the physician		
Strategy for children	Strategy for adults	Strategy for both
• Encourage presence of parents • Swaddling • Vocalizing • Holding patient • Rocking • Pacifiers • Feeding • Favorite toy, teddy bear • Storytelling	• Mobilization • Guiding patient in deep breathing • Immobilization, graded mobilization • Religious support, meditation, prayer • Relaxation techniques: Imaging, deep breathing, and progressive muscle relaxation	• Listening to music, watching television, reading • Art, Drawing • Companion reading to the patient • Food • Visiting with family and friends • Change of scenery to day room or outside if permitted • Distraction • Ice or warm compresses as ordered • Repositioning • Dimming the lights, reducing noise

6.6 Pain reassessment:

- For patient with invasive tubes or lines: every 2-4 hours.
- For patient's prescription or infusion analgesics and/or sedatives: every 2-4 hours
- For patient receiving analgesia /sedation PRN: assess response one hour after dosage
- For post-operative patient: hourly for the first 24-48 hours, then every 4 hours until medication complete.
- After a procedure and pain management, reassessment must be performed.

6.6.1 Communicate the following to physician/ Pain nurse if:

Ineffective pain relief within one hour of intervention
Side effects experienced due to prescribed medications:

- Nausea, vomiting, rash, itching, pruritus
- Mental confusion, delirium, hallucinations
- Constipation unrelieved by standing order medications e.g. Dulcolax
- Respiratory depression due to possible overdose of prescribed medications
- Excessive sedation
- Hypersensitivity reactions
- Anaphylactic reaction to prescribed medications

6.7. A side effect of opioid medication:

- It is important in the nurse reassessment process of pain management, that respiratory depression is considered.
- If an adult patient is showing signs of respiratory depression (Respiratory rate less 10, SPO2 below 92%, level of consciousness is altered), if pediatric patient showing signs (increase heart rate, color change, grunting, nasal flaring, wheezing) follow the below steps:

- Stop opioid administration
- Attempt to wake the patient.
- Administer 40% oxygen
- Seek urgent assistance from on-call anesthetist/doctor /outreach team/pain team.
- If respiratory arrest occurred, activate code BLUE / CPR Team.
- Monitor and reassess at regular 15-minute intervals until RR is above 10
- Administer 100-200 micrograms of Naloxone IV immediately *(is an opioid antagonist medication used to reverse opioid overdoses. The medication can be given by intramuscular, subcutaneous, and intravenous injection, as per doctor's order)*
- Repeat this dose if no or limited response after 2 minutes.
- Document in AL-Shifa system (Kardex)
- Be aware that respiratory depression can return as the naloxone may act for a shorter period than the opioid.

6.8. Documentation:

Pain must be documented in vital sign page and pain assessment page in AL-Shifa system

- In the Face sheet, enter Patient ID
- In the Readings bar, click Assessment, then Pain Chart tab
- Choose Protocol used, e.g. Numerical Pain Rating
- Enter Site of pain, then during which shift was the pain score was assessed
- Choose from drop box the analgesic prescribe to be given
- Enter any side effects associated with analgesics
- All teaching must be documented on the remarks on admission, and triage
- Reassess pain documented in nursing notes

7. Responsibilities:

It is recommended for effective pain management that multidisciplinary approach be followed. It applies to all healthcare staff directly involved with the patient in MOH institution, as following is not limited to:

- Physicians or surgeons
- Pain Management Physicians
- Medical Physician
- Anesthesiologist
- Pharmacist
- Nurses
- Dietitian
- Respiratory Therapist
- Patient Educator
- Clinical Facilitator
- Continual Professional Developer

7.1 Physician or Surgeon:

- Assess patient pain,
- Treatment of pain is the responsibility of the attending physician,
- A prescription is written for the initial management of pain,
- In case of unrelieved pain, the attending physician will reassess it and order an appropriate intervention.
- The physician/surgeon should consider regular and as required analgesia, both opioid and non-opioid medications when writing the prescription.

7.2 Anaesthesiologist:

- Anaesthetists assess patient pain level,
- In the operating room, the Anaesthesia Care Team is responsible for administering appropriate analgesia,
- If necessary, the anaesthesiologist may ask the surgeon to administer local anaesthesia, e.g. vitreo-retinal procedures.
- If necessary, anaesthesiologists prescribe and administer appropriate analgesia in recovery room.

7.3 Pharmacist:

- The pharmacist will aid and assist in selection and dispensing analgesics available on the Formulary.
- Pharmacist will participate as required in pain medication teaching and educational activities to healthcare professionals and patients.
- A pharmacist will be available to aid and assist in activities to monitor and improve the Pain Management Process.

7.4 Pain Management Team:

- Provide a structured approach to manage pain through comprehensive assessment, planning and evaluation patient with pain.
- Guidance to medical staff and nurses on best way to manage patient pain.

7.5 Registered Nurses:

- The nurse will obtain initial and ongoing pain assessments during the patient's hospitalization.
- When pain is present or anticipated, the nurse will dispense analgesics as ordered.
- If pain is unrelieved, the nurse will inform the physician for further orders. Action taken will be noted on the Pain Management remark Sheet and administration of analgesics will be noted on the Medication Record
- Alternative methods of pain relief, such as positioning, cold or hot compress, etc. as well as consult with other interdisciplinary team members, e.g. pain management staff, physician and pharmacist etc. will be implemented when appropriate and documented on the nursing note
- The nurse will educate the patient on the use of the PAT, and interventions available for pain relief during hospitalization and post-discharge. Teaching will be documented on the nursing note.

7.6 Dietitian:

- The dietitian will provide verbal, written and visual educational material to patients, after evaluating the patient's nutritional status, and to see if he/she has any food allergies.
- Special diets are given to patients receiving medications that cause food-drug interactions.
- The dietitian will assess for food preferences and will provide "comfort foods" when required during patient's hospital stay.

7.7. Social Worker:

- Inform nursing staff regarding any complaints of pain.
- Assess patient for social and psychological issues which may be contributing to the patient's pain and address identified problems.
- Provide support for patient, companion, family and friends.

7.8. Respiratory Therapist:

- The respiratory therapist is responsible to inform nursing staff and or doctor of any signs of respiratory distress or depression and/or pain during their rounds and treatment.

7.9. CPD:

- Support staff education related to pain management.
- Act as advisors with nursing practice pain management issues.
- Develop and maintain annual competency framework.

8. Document History and Version Control

Version	Description	Review Date
1	Initial Release	May 2026

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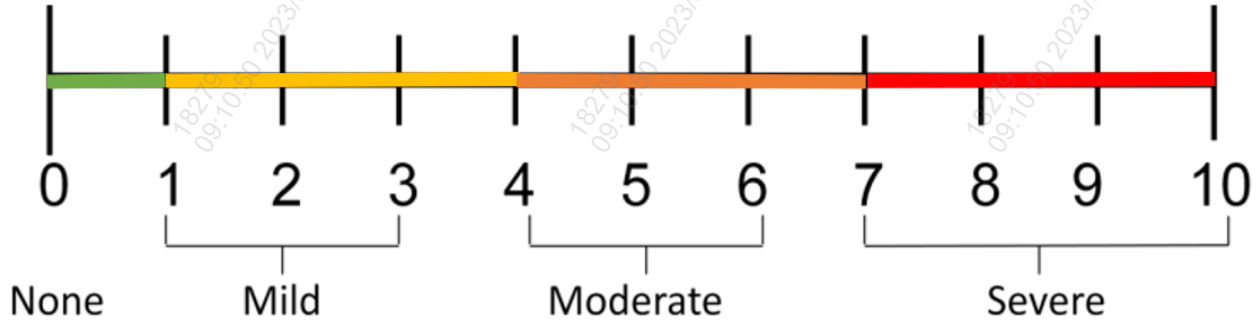
Appendix 1



Numerical Rating Scale (NRS) (Adult patients)

Definition:
A tool used to score the level of pain of the adult patient, taking into account developmental age, cognitive ability and visual acuity.

Description:
It has four colors to denote different intensities of pain, green for no pain, yellow for mild, orange for moderate, and red for severe pain.

The tool grades range from zero (0) to ten (10):

- 0 - 1 denoting/describes no pain
- 1 – 4 mild pain
- 5 – 7 moderate pain
- 8 – 10 severe pain

Procedure:

- Explain that 0 means no pain and 10 means the worst pain imaginable
- The yellow part represents mild pain; the middle of the scale (orange) shows moderate pain and the red part means severe pain
- Ask the patient which area of the scale represents his/her pain most accurately

Appendix 2

Categories	Score zero	Score one	Score two
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	Kick or legs drawn up
Activity	Lying quietly, normal position mover easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
Cry	No crying (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort.

FLACC Scale

Definition:

A tool used to assess pain in children between the ages of 2 months and 7 years or in individuals who cannot communicate their pain.

Description:

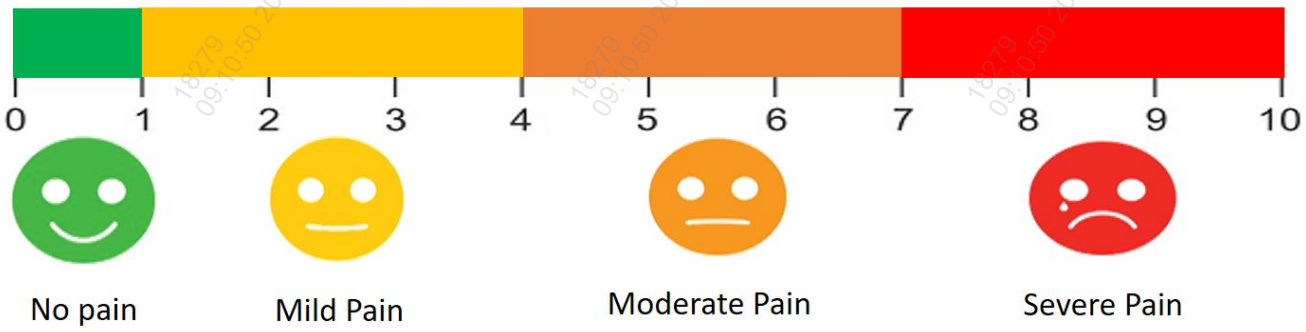
The FLACC Scale is a behavioral scale has five categories (Face, Legs, Activity, Cry, and Consolability)

Procedure:

Score each of the five categories (Face, Legs, Activity, Cry, Consolability) from 0 - 2 and add them up to get a total from 0 -10.

0 would be no pain, 1 – 3 mild discomfort, 4 - 6moderate pain, and 7 -10 severe pain

Appendix 3:



Wong-Baker Faces Scale (Children age between 3 years to adults)

Definition:

This tool helps children communicate about their pain between the ages of 3 and older or in individuals who cannot communicate their pain.

Description:

It has four colors to denote different intensities of pain, green for no pain, yellow for mild, orange for moderate, and red for severe pain:

The tool grades range from zero (0) to ten (10):

- 0 - 1 denoting/describes no pain
- 1 – 4 mild pain
- 5 – 7 moderate pain
- 8 – 10 severe pain

Procedure:

- Observation of behavior and self-report are the primary methods in assessing a child
- For a patient in pain, explain that each face represents a person who is happy or sad, depending on how much or little pain he has:

- White or 0 is for a person who is “very happy” because he doesn’t hurt at all
- Yellow or1 - 4 means “it hurts a little bit”; Blue or 5 - 7 “it hurts a lot more
- Red or 8 - 10 “it hurts as much as you can imagine, but you don’t have to feel like crying to feel this bad”
- Ask the patient to select the face or color that best describes how

Appendix 4

Indicator	Description	Score	
Facial expression	• No muscular tension observed • Presence of frowning, brow lowering, orbit tightening, & levator contraction • All of the above facial movement plus eyelid tightly closed	• Relaxed, neutral • Tense • Grimacing	0 1 2
Body movement	• Dose not move at all (does not necessarily mean absence of pain). • Slow, caution movement, touching or rubbing the pain site, seeking attention through movements. • Pulling tube, attempting through moving limbs/ thrashing, not following commands, striking at staff, trying to climb out of bed	• Absence of movements • Protection • Restlessness	0 1 2
Muscle tension Evaluation by passive flexion & extension of upper extremities	• No resistance to passive movements • Resistance to passive movements • Strong resistance to passive movements • Strong resistance to passive movement, inability to complete them	• Relaxed • Tense, rigid • Very tense or rigid	0 1 2
Compliance with the ventilator (intubated patients)	• Alarms not activity, easy ventilation • Alarm stop spontaneously • Asynchrony: blocking ventilation, alarms frequently activated	• Tolerating ventilator or movement • Coughing but tolerating • Fighting ventilator	0 1 2
OR		•	
Vocalization (extubated patients)	• Talking in normal tone or sound • Sighing, moaning • Crying out, sobbing	• Talking in normal tone or no sound • Sighing, moaning • Crying out, sobbing	0 1 2
Total, range			0-8

CPOT Scale

Definition: It was developed to assess pain in critically ill patients.

Description:

There are four behavioral domains on the scale: facial expression, body movements, muscle tension, and compliance with ventilation for intubated patients or vocalization for extubated patients.

Procedure:

- Score each of the four categories (facial expression, body movements, muscle tension, and compliance with ventilation for intubated patients or vocalization for extubated patients) from 0 - 2 and add them up to get a total from 0 -8.
- 0 would be no pain, 1 – 3 mild discomfort, 4 – 6 moderate pain, and 7 -10 severe pain
- Frequency of pain assessment and reassessment

Pain must be assessed & reassessed:

- Every 4 hours while awake, if mild to moderate pain levels present
- Every 4 hours for first 24 hours post-operative
- Every 2 hours or more often as needed, if patient complains of severe pain
- After a maximum of 30 minutes following any intervention

Appendix 5

Assessment Criteria	Sedation		Normal	Pain/ Agitation	
	2	1	0	1	2
Crying Irritability	No cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking Constantly awake or Arouses minimally/ no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex ↓ Muscle tone	Relaxed hands & feet Normal tone	Intermittent clenched toes, fists or finger splay	Continual clenched toes, fists, or finger splay body is tense
Vital signs HR, RR, BP, SPO2	No variability with stimuli Hypoventilation or apnea	< 10% variability from baseline with stimuli	Within baseline or normal for gestational age	↑ 10-20% from baseline SPo2 76-85% with stimulation↑ quick recovery	↑ ➢ 20% from baseline SPO2 < 75% with stimulation- slow recovery out of sync with vent
Neonatal Pain Assessment and Sedation Scale (N-PASS)					

Definition: It is to assess the levels of pain, agitation, and sedation in critically ill neonates with acute and/or ongoing pain

Description:

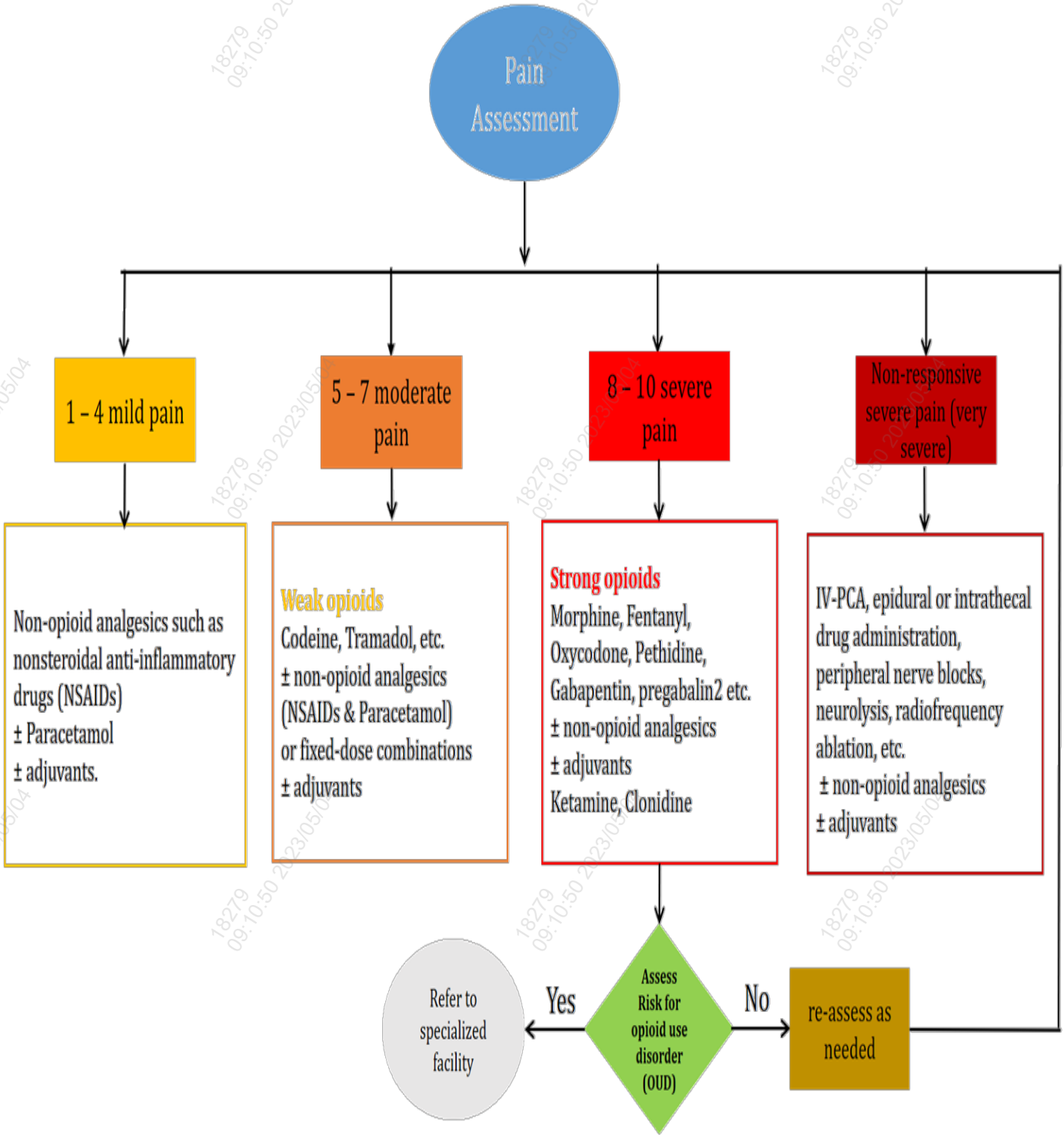
There are five assessment criteria on the scale: crying irritability, behavior state, facial expression, extremities tone and vital signs

Procedure:

- Every behavioral and physiological criterion pain is scored from 0 to +2, then summed
- Based on the premature infant's gestational age, points are added to the pain score to compensate for their limited ability to communicate pain behaviorally or physiologically
- Pain score is documented as a positive number (0 to 10).
- Scores greater than 3 indicate treatment
- In cases of known pain/painful stimuli, interventions are indicated before the score reaches
- Frequency of pain assessment and reassessment

Appendix 6

Pain Management



For more information please refer to: <u>Oman National Formulary for MOH</u>