NATIONAL NURSING AUDIT MINISTRY OF HEALTH MALAYSIA

ELEMENT 5: **CONTINUUM OF CARE**

5.6 PAIN AS 5TH VITAL SIGN

1. INTRODUCTION

Pain is one of the main reasons patients are admitted to hospital, and unrelieved pain is a major reason patients fear hospitalization, especially for surgery or other painful procedures. Pain is often considered unavoidable; however, with modern drugs and techniques, there are many simple and effective ways to relieve pain (Pain Free Program, 2023).

Poor pain management in patients is due to:

i. Ignorance
ii. Inexperience
iii. Overwork
iv. Traditional fears related to opioids, including fear of addiction and fear of side effects like respiratory depression
v. Failure of patients to ask for pain relief

Recognition and assessment of pain are essential components of patient care to ensure patient comfort. As pain is a subjective experience, the patient's self-report is considered the gold standard for pain measurement. Healthcare professionals should not estimate a patient's pain level but should actively assess pain by asking the patient and accepting the patient's report as valid (Pain as the 5th Vital Sign Guideline, 2018).

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.

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. METHODOLOGY

3.1	Design	:	Direct observation of pain assessment for pain score.
3.2	Setting	:	Patient in hospital/ institution
3.3	Inclusion criteria	:	Patients admitted to the hospital
3.4	Exclution criteria	:	Unconscious, sedated patients and patients unable to reliably self-report pain
3.5	Population	:	Registered nurses
3.6	Sample design	:	Convenient sampling
3.7	Sample size	:	30% of nurses working in hospital/ institution
3.8	Frequency	:	Once a year
3.9	Duration	;	2 months
4.0	Instrument	:	Check list (E5 AF 5.6 Pind.1/2026)

4. STANDARD

≥95% compliance to standard of managing pain as 5th vital sign.

5. DEFINITION

NO	TERMS	DEFINITIONS
1.	UNCONSCIOUS PATIENTS	A patient who is unaware of their surroundings, such as being asleep or unresponsive to stimulation, is considered unconscious (Oxford Medical Dictionary, Mobi Systems, 2018).
2.	CONSCIOUS PATIENTS	Is an awake status, when a person is fully aware of his or her surroundings and understand, talks, moves, and responds normally
3.	PATIENTS UNABLE TO RELIABLY SELF-REPORT PAIN	Severe cognitive impairment, Acute psychiatric instability, Sedated patients, Other conditions preventing accurate communication of pain
4.	MOH PAIN SCALE	All pain assessment tools as recommended by MOH eg. Scale 0-10, Critical Care Pain Observation Tools (CPOT), FLACC Scale (Paediatric Tools), The Abbey Scale and PAINAD (for dementia)
5.	POST SURGERY PATIENT	Any patient who has undergone surgery
6.	TRAUMA PATIENT	A person who has suffered a serious or life-threatening injury as a result of an event such as a car accident, gunshot wound, or fall is considered a trauma survivor (Trauma Survivors Network, 2019).
7.	PAIN 5TH VITAL SIGN	Pain scoring is considered the fifth vital sign, after the four traditional vital signs (i.e., blood

		pressure, pulse, respiration, and temperature), and is carried out for all patients in the wards every four hours or at specific intervals as required (Pain Free Program, 2023).
8.	IMPLEMENTING PAIN AS 5TH VITAL SIGN AND "PAIN FREE PROGRAMME"	The Ministry of Health (MOH) aims to ensure that all medical staff are trained in the assessment and management of pain so that patients admitted to the hospital do not have to suffer from unrelieved pain (Pain Management Handbook, 2023).
9.	PAIN FLOW CHART	The recommended flow chart for implementing the fifth vital sign of pain outlines nursing actions based on the patient's pain score. For a pain score less than 4, the nurse may perform nursing interventions if necessary, but should still assess whether the patient is comfortable and requires any medication. For a pain score of 4–10, the nurse should first check the patient's notes for any analgesics ordered by the doctor. If no analgesics are prescribed, the nurse should inform the doctor of the patient's high pain score to request an analgesic prescription. If analgesics have been prescribed, the nurse should administer them and document the action in the observation chart (Pain Management Handbook, 2023).
10.	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.

6. WORK PROCESS

Structure	Process	Outcome
1. There is a standard operating procedure (SOP) for performing Pain 5th Vital Sign.	Greet patient.	The nurse uses some form of soft skill when greeting the patient.
2. MOH Pain Scale	Nurse inform patient the purpose of the pain assessment tools	The nurse shows and inform the patient purpose of the pain assessment tools.
	2.1 Nurse teach patient to verbalize pain score using the pain assessment tools	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).	
	2.3 Nurse know how to analyse pain by using the tools for ventilated patient (For subsequent observations)	The nurse able to analyse pain assessment tool

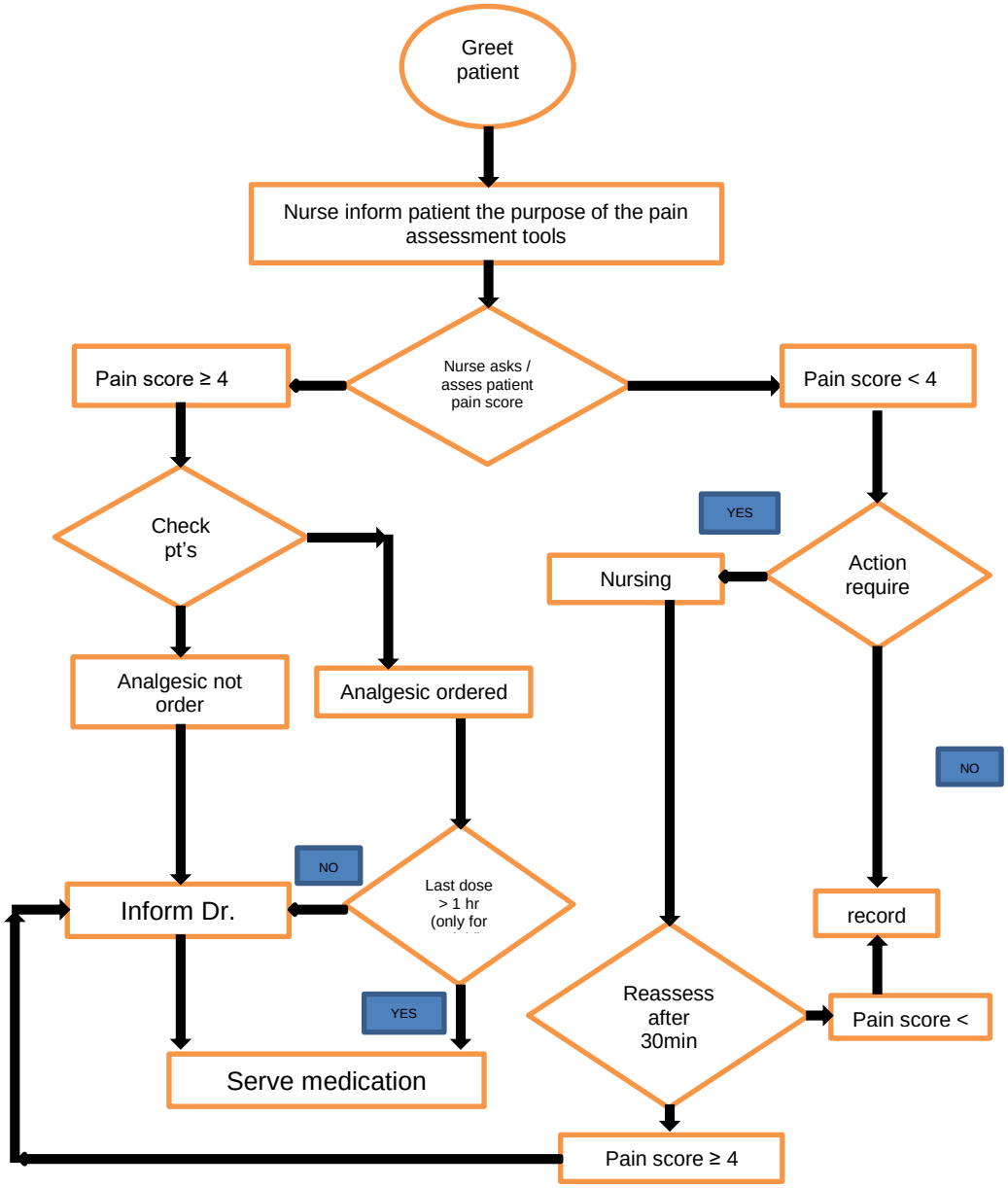
3. The nurse has knowledge and skill in using the pain scale to obtain patient's pain score.	Nurse asks/ asses patient pain score.	Patient/ nurse is able to recognise pain score
4. The nurse has knowledge and skill in carrying out related nursing actions to relieve pain.	The nurse carries out nursing action according to patient's pain score. **If pain score is < 4 (or mild pain):**	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.	Nurse carries out nursing action if necessary; OR Nurse ask/ asses patient whether patient is comfortable and needs any medication for pain	Nurse carries out necessary nursing action and patient able to answer the questions
	(Choice Of Nursing Action)	Nurse follows the Nursing Flow Chart for nursing intervention
	a. If Yes (patient requires medication), nurse may serve Tab. Paracetamol as prescribed	Nurse documents pain score accurately and documents nursing action if analgesic is given.
	b. Record pain score, nursing action (if any) OR pain medication served in the	

	observation form/ Hospital Information System (HIS) or Electronic Medical Report (EMR) c. If 'No' (does not require medication), nurse only documents pain score in the observation form or EMR	
	Nurse documents pain score in the observation form	Documentation is complete and accurate.
6. The nurse documents pain scores, nursing action and / or analgesics given	6.1 Nurse documents nursing action taken/ analgesic given.	Patient is comfortable
7. Management of Pain	**If pain score is ≥ 4, [4-10]**	
7.1. There is : a) A training Module for Pain 5th Vital Sign b) MOH Pain Scale c) A standard flow chart to guide nurses on implementation of		Nurse follows the pain management flow chart for nurses

Pain 5th Vital Sign. d) Observation form e) Electronic Medical Report (EMR)		
7.1.1 The nurse has knowledge on use of the flow chart.	7.1.1 Nurse checks patient's notes for prescription.	Nurse inform doctor if no analgesics is ordered.
	7.1.2 If doctor has prescribed analgesics, nurse serves or administers analgesics as ordered.	Patient received analgesic
	7 .1.3 If doctor has not prescribed, nurse inform doctor for prescription.	
	7.1.4 Nurse serves or administers analgesics as ordered.	
	(For mothers in labour, Entonox or analgesics. If analgesic is not given, record nursing action carried out such as	Antenatal mother received back rub or massage from the nurse who attended to her.

	reassurance/ encourage deep breathing, back rub or massage.)	
	7.1.5 Nurse records medication served.	Documentation is complete and accurate.
	Reassessment	
7.2 The nurse has knowledge on nursing action required and follows the flow chart.	7.2.1 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. (30 mins after injection, 1 hour after oral tablet)
	7.2.2 Nurse record reassessed pain score accurately.	Documentation is complete and accurate. Patient's pain is reduced and patient is more comfortable.

FLOW CHART MANAGEMENT OF PAIN AS A 5TH VITAL SIGN



7. TECHNICAL SPECIFICATION FOR PAIN AS 5TH VITAL SIGN

Indicator	Percentage of compliance to standard of managing pain as 5th vital sign.
Rationale	Pain as the 5th Vital Sign promotes holistic, patient-centered care, reduces post-operative complications, enhances patient-provider interactions, and boosts client satisfaction, while also meeting criteria for Pain Free Hospital accreditation in Malaysia by incorporating the Nursing Division's recommended 10 S's.
Definition	The Revised IASP Definition of Pain (2020) describes pain as a subjective experience with both sensory and emotional components, regardless of tissue damage or the ability to communicate.
Criteria	**Inclusion:** All patients in hospital/ institution **Exclusion:** Unconscious, sedated patients and patients unable to reliably self-report pain
Numerator	Total conformance of items
Denominator	Total number of items – Total number of items marked as NA
Formula	$\frac{\text{Numerator}}{\text{Denominator}} \times 100\%$
Standard	≥ 95%
Data Collection	1. **Where:** Data will be collected in hospital/ institution 2. **Who:** Data will be collected by the NNA Committee in hospital 3. **How to collect:** Audit Form (E5 AF 5.6 Pind.1/2026) 4. **How frequent:** Once a year and duration 2 months 5. **Who should verify:** All data must be verified by the Head of Nursing.

References	1. International Association for the Study of Pain (IASP). (2020, July 16). Revised IASP definition of pain: IASP's 50th anniversary – Working together for pain relief throughout the world. IASP Press.

8. AUDIT FORM

NATIONAL NURSING AUDIT MINISTRY OF HEALTH MALAYSIA	**VERSION 8/ Pind.1/2026**
ELEMENT 5 : CONTINUUM OF CARE	
TOPIC : 5.6 PAIN AS 5TH VITAL SIGN	**DATE: 15 JAN 2026**
DOCUMENT NO : E5 AF 5.6 Pind.1/2026	

OBJECTIVES

1. To meet objectives of the Pain Free Hospital Concept of the Ministry of Health.
2. To keep patients pain free or keep pain to a minimal level to promote patient comfort.
3. To assess pain for all patients correctly, accurately and enhance patient mobility

STANDARD : >95% compliance to standard of managing pain as 5th vital sign

Date of Audit : .....

Locality : .....

Auditor : .....

Auditee : .....

N.B. Instructions for Auditors

1. To tick [√] at appropriate column.
2. S/ T/ D indicate soft skill/ technical skill/ documentation respectively.

S/N	ITEM	SOURCE OF INFORMATION	YES	NO	N/A
S1	Does the nurse greet patients before starting any assessment?	Listen & Observe nurse			
T2	Does the nurse correctly identify the appropriate pain scale based on the patient's condition?	Observe nurse & Check document			
S3	Does the nurse explain the pain assessment Tools to the patient or caregivers (if applicable)?	Listen & observe nurse			
T4	Does the patient understand how to rate his/ her pain on a scale?	Listen & observe			
T5	Does the nurse repeat or explain information in a different way if the patient seems confused?	Listen & observe nurse			
S6	Does the nurse reassure the patient when they express pain or discomfort?	Listen & observe nurse			
	Pain Score < 4 (0-3)				
T7	Does the nurse provide appropriate non-pharmacological interventions (e.g., repositioning, comfort measures) for patients with mild pain?	Listen & Observe nurse			
T8	Does the nurse manage pain in accordance with scope of practice and institutional policy,	Listen & Observe nurse			

	with appropriate referral to medical officers for pharmacological management?				
D9	Does the nurse document the pain score or/ and any interventions taken for mild pain in the patient's records?	Observe & check document			
T10	Does the nurse follow up with the patient after administering any interventions to see if their mild pain improves?	Observe & check document			
	If pain score is ≥ 4 (4-10)				
T11	When a patient In moderate/severe pain, does the nurse acknowledge the level of discomfort and offer appropriate interventions?	Observe & check document			
T12	Does the nurse verify the doctor's pain medication prescription and check the time of the last analgesic dose before administration?	Observe & check document			
T13	Does the nurse report to the doctor if no analgesic is prescribed for a patient in pain?	Listen & Observe nurse			
T14	Does the nurse administer pain medication as prescribed or implement appropriate nursing interventions when medication is not indicated?	Observe nurse			
D15	Does the nurse document the analgesics administered and	Observe & check document			

	reassess the patient's pain score within 30 minutes to 1 hour after administration?				
T16	Does the nurse advise the patient to inform them if the pain is not relieved after medication is given?	Listen / Observe Nurse			
D17	Does the nurse accurately record the reassessed pain score and ensure complete documentation of pain management?	Observe & check document			

AUDIT REPORT

(Please [√] the appropriate box)

Pain score ≤ 4

Rating:

Criteria	Item	Conformance	Non conformance
Technical	6		
Documentation	1		
Soft skill	3		
Total	**10**		

Pain score ≥ 4

Rating:

Criteria	Item	Conformance	Non conformance
Technical	8		
Documentation	2		
Soft skill	3		
Total	**13**		

Calculation: _____ X 100% = _____

REMARKS:

Auditor (name and signature) : …….

*Calculation: $\frac{\text{Total conformance of items}}{\text{Total number of items – Total number of items marked as NA}}$ X 100%

9. REFERENCES

International Association for the Study of Pain (IASP). (2020, July 16). Revised IASP definition of pain: IASP's 50th anniversary – Working together for pain relief throughout the world. IASP Press.

Ministry of Health Malaysia. (2018). *Pain as the 5th vital sign guideline* (3rd ed.). Medical Development Division, Ministry of Health Malaysia.

Ministry of Health Malaysia. (2023). *Pain Free Program: Pain Free Manual* (3rd ed.). Clinical Audit Unit, Medical Care Quality Section, Medical Development Division. ISBN 978-967-2469-52-0.

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