ACUTE PAIN MANAGEMENT 2026

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Abbreviations

The following abbreviations and acronyms are used throughout this guideline.

Abbreviation	Full Form
ACS	Acute Coronary Syndrome
BPI	Brief Pain Inventory
BPS	Behavioural Pain Scale
CBT	Cognitive Behavioural Therapy
Cox-2	Cyclooxygenase-2
CPOT	Critical-Care Pain Observation Tool
DH	District Hospital
EMLA	Eutectic Mixture of Local Anaesthetics
ESPB	Erector Spinae Plane Block
FLACC	Face, Legs, Activity, Cry, Consolability (scale)
FPS-R	Faces Pain Scale – Revised
IASP	International Association for the Study of Pain
ICD-11	International Classification of Diseases, 11th Revision
IGMH	Indira Gandhi Memorial Hospital
IM	Intramuscular
IN	Intranasal
IV	Intravenous
LAST	Local Anaesthetic Systemic Toxicity
MPQ	McGill Pain Questionnaire
NIPS	Neonatal Infant Pain Scale

Abbreviation	Full Form
NRS	Numeric Rating Scale
NSAID	Non-Steroidal Anti-Inflammatory Drug
PAINAD	Pain Assessment in Advanced Dementia (scale)
PO	Per Os (Oral)
PR	Per Rectum (Rectal)
SC	Subcutaneous
TAP (block)	Transversus Abdominis Plane (block)
TENS	Transcutaneous Electrical Nerve Stimulation
VAS	Visual Analogue Scale
WHO	World Health Organization

1.0 Introduction

Acute pain is a sudden, sharp or intense unpleasant sensation, often associated with injury, surgery, illness or trauma, and it serves a protective function. In the ICD-11 classification developed jointly by the IASP and the World Health Organization, pain persisting or recurring for longer than three months is classified as chronic; acute pain is therefore pain of less than three months' duration, and it usually resolves once the underlying cause has been treated (World Health Organization, 2019).

Commonly encountered examples of acute pain include trauma and injury leading to abrasions and lacerations, sprains and other soft tissue injuries, and fractures; burns; pain following medical, surgical and dental procedures; and acute illness such as sore throat, body aches and acute abdominal pain (Mariano et al., 2022).

Acute pain is the most common and is often the primary reason individuals seek medical attention. In the Maldives, healthcare facilities at all levels receive patients requiring acute pain care. Acute flare-ups of chronic pain conditions should be managed as acute pain, and these guidelines therefore apply to those conditions as well (American Pain Society, American Society of Regional Anesthesia and Pain Medicine, & American Society of Anesthesiologists, 2016).

2.0 Scope of the Guideline

This guideline covers adults and children presenting with acute pain and are designed for use across primary, secondary, and tertiary care, with recommendations scaled to the management capacity at each level. Details of special categories of patient’s neonates, adults with cognitive impairment and individuals under critical care are beyond the scope of this practical guideline and need specialist consultations for management of their acute pain conditions.

Intended users: all registered medical and dental practitioners, nurses, community health workers, emergency medical technologists.

3.0 Definitions

Pain as defined by International Association for the Study of Pain (IASP) is “An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage.” IASP also defines acute pain as “Acute pain is of recent onset and limited duration. It usually has an identifiable temporal and causal relationship to injury or disease.” Acute pain serves as a warning for underlying illness or injury (Treede et al., 2019).

Key Principles in Acute Pain Management

1. *Address the underlying cause of pain:* Acute pain is frequently a manifestation of an underlying disease process or injury. Appropriate diagnostic investigations should be undertaken to identify the cause of pain, and definitive management of the underlying condition should proceed concurrently with symptomatic pain treatment.
2. *Conduct a comprehensive patient assessment:* A detailed clinical history should be obtained whenever feasible. This should include an assessment of relevant medical and psychological comorbidities, concurrent medications, history of chronic pain, substance use disorders, and previous postoperative or trauma-related pain management strategies and outcomes. Such information is essential for developing an individualised pain management plan.
3. *Use validated pain assessment tools:* Pain intensity and its impact should be assessed using a validated pain assessment tool at presentation and reassessed regularly thereafter to guide treatment decisions and evaluate response to therapy. The frequency of assessment should be guided by the response and adequacy of pain control.
4. *Implement a multimodal analgesic strategy:* Multimodal pain management should be offered whenever appropriate and should include non-pharmacological interventions, non-opioid analgesics, regional analgesic techniques, and other pharmacological modalities. Opioids should be reserved for situations in which pain remains inadequately controlled despite optimised non-opioid therapies. In tertiary centers where specialist consultation or pain services are available, a more liberal opioid prescription could be employed, guided by the institutions’ opioid stewardship protocols.
5. *Promote responsible opioid use:* Healthcare institutions should establish and maintain opioid stewardship programs aimed at minimising opioid overuse, misuse, and associated harms while ensuring adequate pain relief. Appropriate clinical monitoring should be ensured when parenteral opioids are prescribed and administered.
6. *Regularly review and optimise treatment:* The pain management plan should be continuously reassessed and adjusted according to the patient's response, adequacy of analgesia, functional outcomes, and the presence of adverse effects.

7. *Provide patient and family education:* Patients and their families should receive clear and comprehensive information regarding the pain management plan, expected outcomes, potential adverse effects, and the range of available treatment options. Shared decision-making should be encouraged whenever possible.
8. *Consider specialist consultation when indicated:* Referral to, or consultation with, a pain specialist should be considered when pain remains inadequately controlled despite available therapies or when management is complicated by factors such as opioid tolerance, substance use disorders, or complex pain syndromes. Consultations by Anaesthesiologist, critical care physicians and emergency physicians should be undertaken when specialist pain teams are not available.

4.0 Pain Assessment and Monitoring

1. *Use validated pain assessment tools:* A validated pain assessment tool should be used to quantify pain at presentation. The Numeric Rating Scale (NRS) and Visual Analogue Scale (VAS) are appropriate for most acute pain scenarios and patient populations. However, specialised validated assessment tools should be used when indicated for specific patient groups, such as children, older adults with cognitive impairment, or patients with communication difficulties.
2. *Perform regular and proactive pain reassessment:* Pain should be assessed proactively and at regular intervals until adequate pain control is achieved. Pain reassessment should be performed following every clinical encounter and therapeutic intervention to evaluate treatment effectiveness and guide subsequent pain management decisions.
3. *Undertake a comprehensive pain assessment:* Pain assessment should extend beyond pain intensity scores and include evaluation of physiological and functional parameters, such as heart rate, blood pressure, level of activity, mobility, and ease of movement. The impact of pain on function and recovery should also be considered.
4. *Monitor for adverse effects of treatment:* Patients should be monitored proactively for adverse effects associated with pain management interventions. Potential complications should be identified early and managed promptly to optimise patient safety and treatment outcomes.
5. *Respect individual beliefs and cultural values:* Pain is a subjective experience, and individual pain beliefs develop according to patients' life experiences, thus assessment and management should be patient-centered and culturally sensitive. Patients' beliefs, preferences, cultural values, and expectations regarding pain and its treatment should be acknowledged and respected throughout the care process.

Pain Assessment Tools *

Pain assessment tool	Appropriate age group	Example
Verbal rating Scale	>7 years	Self rated pain scale using common words describing pain intensity. (No pain, Mild, moderated, severe and excruciating pain)
Numeric rating scale	>7 years	Self rated pain scale. Patient rates their pain with a number between 0-10.
Visual analogue scale (VAS) - Linear scale	>7 years	Self rated pain scale. Patient is asked to draw a straight line between two points hundred millimetres apart. The length of the line denotes the pain score.
Faces pain scale revised (FPS-R)	3-18 years	Child self-rates their pain by pointing to the face that matches their perceived pain intensity
Wong-Baker FACES® scale	3-18 years	Child self-rates their pain *Revised Faces Pain Scale addresses some limitations in this pain tool
Faces legs activity cry consolability (FLACC)	2 months to 7 years	Clinician assessment Add scores of five assessments (faces, legs, activity, cry, consolability) for a score 0-10

* In addition to unidimensional pain assessment scales, multidimensional assessment tools may be used to evaluate the broader impact of acute pain on patients. Instruments such as the Brief Pain Inventory (BPI) and the McGill Pain Questionnaire (MPQ) can provide valuable information regarding the sensory, affective, and functional dimensions of pain and may be particularly useful in selected clinical situations.

Special patient populations may require the use of validated, population-specific pain assessment tools. Examples include the Neonatal Infant Pain Scale (NIPS) for neonates, the Pain Assessment in Advanced Dementia (PAINAD) scale for individuals with cognitive impairment, and the Critical-Care Pain Observation Tool (CPOT) or Behavioral Pain Scale (BPS) for mechanically ventilated, or otherwise non-communicative patients. Selection of the assessment tool should be tailored to the patient's age, cognitive status, communication ability, and clinical condition.

Numeric rating Scale (Bijur et al., 2003)

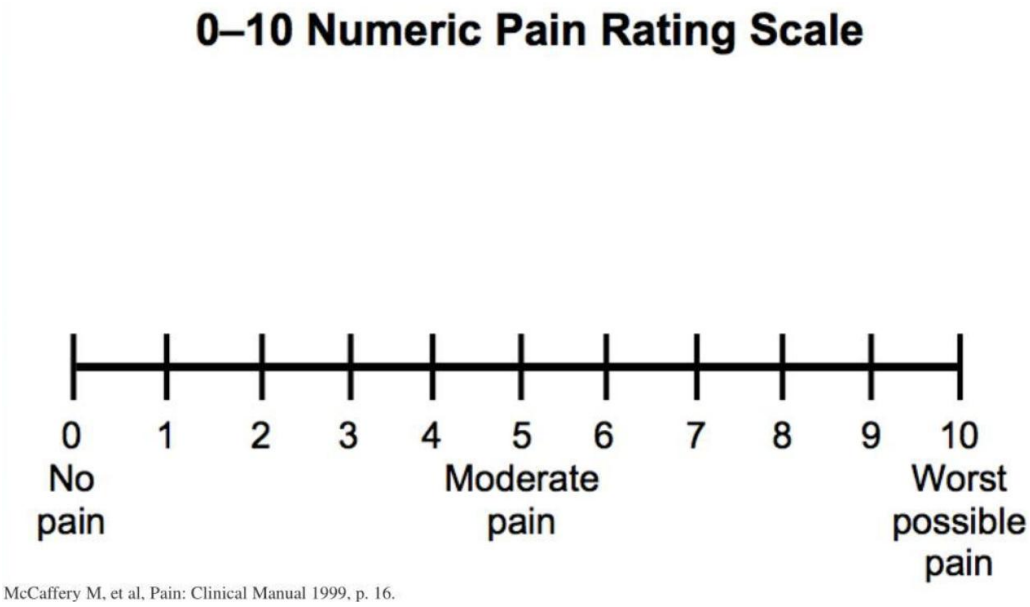


Figure 1. Numeric Rating Scale (NRS) for pain intensity.

How to use: Ask the patient: *"On a scale of 0 to 10, where 0 means no pain and 10 means the worst pain imaginable, how would you rate your pain right now?"* The patient selects a whole number from 0–10. The score should be documented and reassessed after an analgesic intervention and at regular intervals according to the clinical situation. The NRS is suitable for adults and children who can understand and reliably communicate a numerical rating.

Parameters:

- 0: No pain
- 1–3: Mild pain
- 4–6: Moderate pain
- 7–10: Severe pain

Note: These severity bands are commonly used clinically, but the patient's reported pain and functional impact should guide management rather than the numerical category alone.

Visual Analogue Scale (Hjermstad et al., 2011)

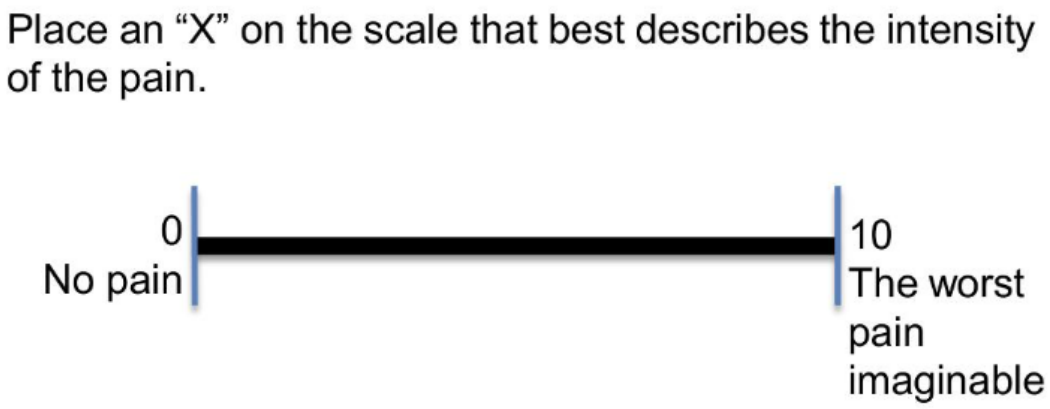


Figure 2. Visual Analogue Scale (VAS) for pain intensity.

How to use: Present the patient with a 10-cm (100-mm) horizontal line anchored by *“No pain”* at one end and *“Worst pain imaginable”* at the other. Ask the patient to mark the point that best represents their current pain intensity. The distance from the “No pain” end to the patient's mark is measured in millimetres or centimetres and recorded as the VAS score. The VAS should preferably be presented in the same format at subsequent assessments to allow comparison over time.

Parameters:

- 0 mm: No pain
- 1–30 mm: Mild pain
- 31–69 mm: Moderate pain
- 70–100 mm: Severe pain

Important: The 10-cm/100-mm length and two endpoint anchors are the key parameters of the traditional VAS; avoid adding multiple intermediate numbers or tick marks if you want to use a true VAS.

Faces Pain Scale- Revised (Hicks et al., 2001)

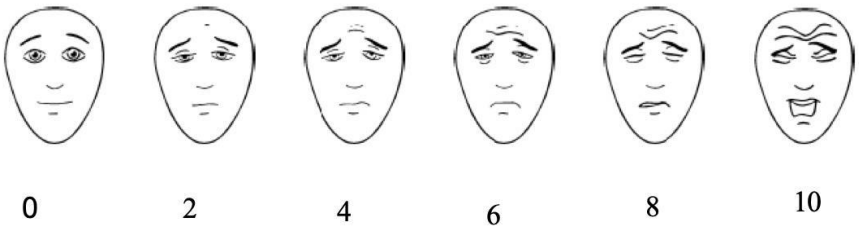


Figure 3. Faces Pain Scale – Revised (FPS-R).

How to use: Ask the child to select the face that best represents how much pain they have right now. Explain that the faces range from no pain on the left to very much pain on the right; the facial expressions should not be described as happy or sad. The selected face corresponds to a score of 0, 2, 4, 6, 8, or 10. The FPS-R is particularly useful for children who can self-report pain but may have difficulty using numerical scales.

Parameters:

- 0: No pain
- 2: Mild pain
- 4: Mild–moderate pain
- 6: Moderate–severe pain
- 8: Severe pain
- 10: Very severe/worst possible pain

Clinical point: The FPS-R is a self-report scale, so the child's selection should be respected as the primary indicator of pain intensity when the child can reliably use the scale.

FLACC Scale (Merkel et al., 1997)

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

Figure 4. FLACC behavioural pain scale scoring chart.

The FLACC (Face, Legs, Activity, Cry, Consolability) scale is a behavioural observational tool for patients who cannot reliably self-report pain, particularly young children and some non-verbal or cognitively impaired patients. When reliable self-report is possible, a self-report scale such as the NRS should be preferred.

Scoring

Total score = 0–10

Total score	Interpretation
0	No pain / relaxed
1–3	Mild discomfort
4–6	Moderate pain
7–10	Severe pain / significant distress

How to use: Observe the patient and score each of the five behavioural categories—Face, Legs, Activity, Cry, and Consolability (FLACC)—from 0 to 2. Add the five scores to obtain a total score between 0 and 10. The assessment should be repeated after analgesic or other pain-relieving interventions to evaluate response.

Clinical note: The FLACC score should be interpreted alongside the patient's clinical condition and observed behaviour; a high score may reflect pain as well as other causes of distress.

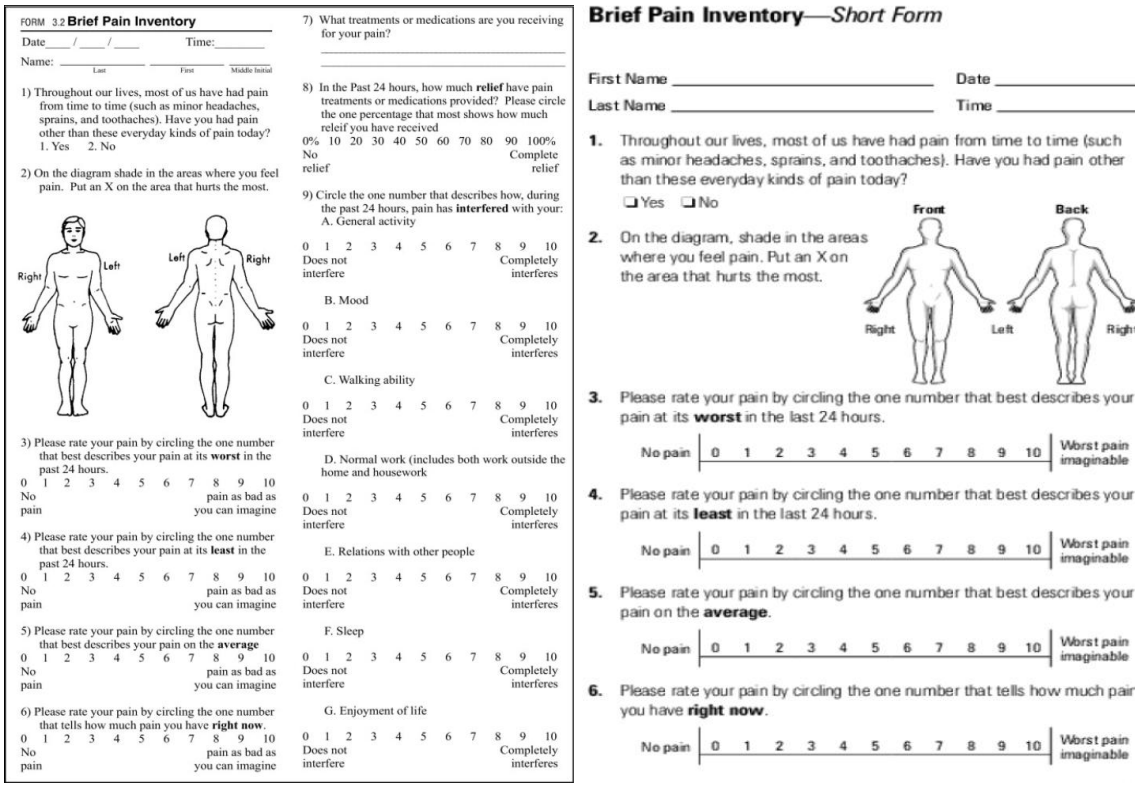
4.1 Multidimensional Pain Measurement

Pain is a complex and multidimensional experience that extends beyond intensity alone. Multidimensional pain assessment tools evaluate different aspects of the pain experience, including its sensory and emotional characteristics, functional impact, and interference with daily activities. These tools may be considered when a more comprehensive assessment is required, particularly in patients with complex, persistent, or difficult-to-assess pain.

In routine acute pain management, the NRS or VAS should generally be used for regular assessment of pain intensity. The other tools may be considered when a more comprehensive assessment of pain characteristics, functional interference, or the broader impact of pain is required.

4.2 Brief Pain Inventory (BPI)

Brief Pain Inventory (BPI) is a multidimensional pain assessment tool that evaluates both pain severity and the impact of pain on daily functioning. It assesses pain at its worst, least, average, and current intensity, as well as the extent to which pain interferes with activities such as general activity, mobility, work, mood, sleep, relationships, and enjoyment of life. It can therefore provide a broader assessment of the patient's pain experience beyond pain intensity alone (Cleeland & Ryan, 1994).



FORM 3.2 **Brief Pain Inventory**

Date____/____/____ Time:_____

Name: _____ _____ _____
Last First Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?
1. Yes 2. No

2) On the diagram shade in the areas where you feel pain. Put an X on the area that hurts the most.

3) Please rate your pain by circling the one number that best describes your pain at its **worst** in the past 24 hours.
0 1 2 3 4 5 6 7 8 9 10
No pain — pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its **least** in the past 24 hours.
0 1 2 3 4 5 6 7 8 9 10
No pain — pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the **average**
0 1 2 3 4 5 6 7 8 9 10
No pain — pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have **right now**.
0 1 2 3 4 5 6 7 8 9 10
No pain — pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

_____

_____

8) In the Past 24 hours, how much **relief** have pain treatments or medications provided? Please circle the one percentage that most shows how much releif you have received
0% 10 20 30 40 50 60 70 80 90 100%
No relief — Complete relief

9) Circle the one number that describes how, during the past 24 hours, pain has **interfered** with your:
A. General activity
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

B. Mood
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

C. Walking ability
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

D. Normal work (includes both work outside the home and housework
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

E. Relations with other people
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

F. Sleep
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

G. Enjoyment of life
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

Brief Pain Inventory—*Short Form*

First Name _____ Date _____

Last Name _____ Time _____

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?
❑ Yes ❑ No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.

3. Please rate your pain by circling the one number that best describes your pain at its **worst** in the last 24 hours.
No pain | 0 1 2 3 4 5 6 7 8 9 10 | Worst pain imaginable

4. Please rate your pain by circling the one number that best describes your pain at its **least** in the last 24 hours.
No pain | 0 1 2 3 4 5 6 7 8 9 10 | Worst pain imaginable

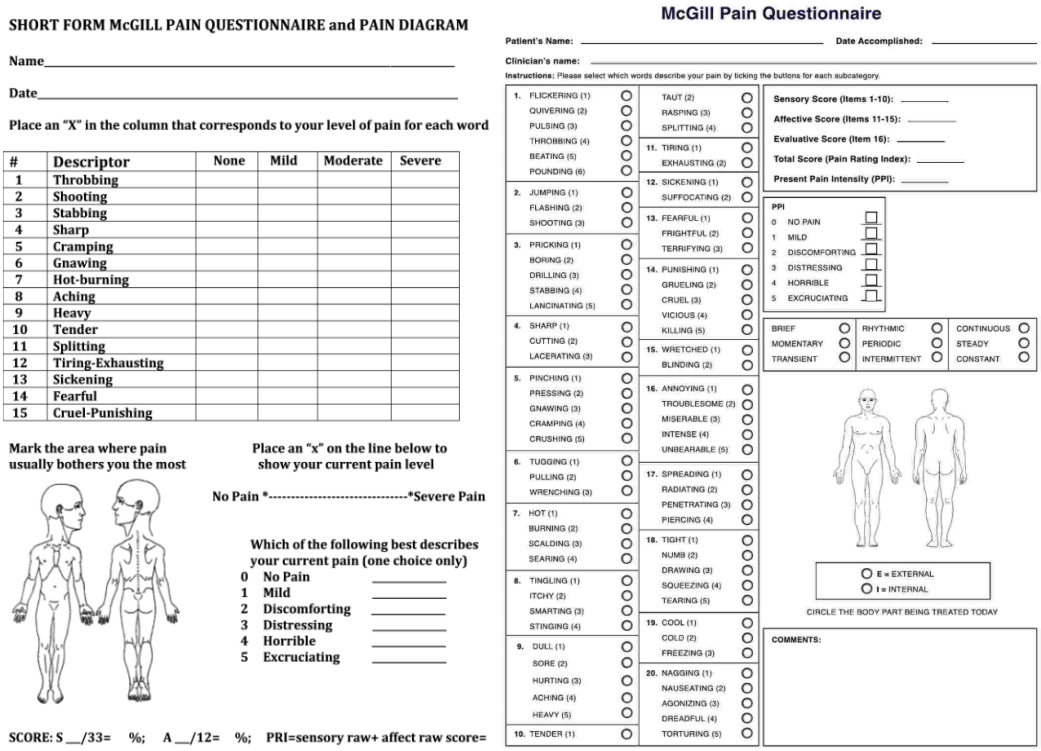
5. Please rate your pain by circling the one number that best describes your pain on the **average**.
No pain | 0 1 2 3 4 5 6 7 8 9 10 | Worst pain imaginable

6. Please rate your pain by circling the one number that tells how much pain you have **right now**.
No pain | 0 1 2 3 4 5 6 7 8 9 10 | Worst pain imaginable

Figure 5. Brief Pain Inventory (BPI), short form.

4.3 McGill Pain Questionnaire (MPQ)

McGill Pain Questionnaire (MPQ) is a multidimensional tool designed to assess the quality and characteristics of pain. It allows patients to describe their pain using a range of sensory and affective descriptors and also incorporates an assessment of pain intensity. It may be particularly useful when a more detailed understanding of the nature and emotional impact of pain is clinically relevant (Melzack, 1975).



SHORT FORM McGILL PAIN QUESTIONNAIRE and PAIN DIAGRAM

Name_____

Date_____

Place an "X" in the column that corresponds to your level of pain for each word

#	Descriptor	None	Mild	Moderate	Severe
1	Throbbing				
2	Shooting				
3	Stabbing				
4	Sharp				
5	Cramping				
6	Gnawing				
7	Hot-burning				
8	Aching				
9	Heavy				
10	Tender				
11	Splitting				
12	Tiring-Exhausting				
13	Sickening				
14	Fearful				
15	Cruel-Punishing				

Mark the area where pain usually bothers you the most

Place an "x" on the line below to show your current pain level

No Pain *----------*Severe Pain

Which of the following best describes your current pain (one choice only)

0 No Pain _____
1 Mild _____
2 Discomforting _____
3 Distressing _____
4 Horrible _____
5 Excruciating _____

SCORE: S __/33= %; A __/12= %; PRI=sensory raw+ affect raw score=

McGill Pain Questionnaire

Patient's Name: _____ Date Accomplished: _____

Clinician's name: _____

Instructions: Please select which words describe your pain by ticking the buttons for each subcategory.

1. FLICKERING (1), QUIVERING (2), PULSING (3), THROBBING (4), BEATING (5), POUNDING (6)
2. JUMPING (1), FLASHING (2), SHOOTING (3)
3. PRICKING (1), BORING (2), DRILLING (3), STABBING (4), LANCINATING (5)
4. SHARP (1), CUTTING (2), LACERATING (3)
5. PINCHING (1), PRESSING (2), GNAWING (3), CRAMPING (4), CRUSHING (5)
6. TUGGING (1), PULLING (2), WRENCHING (3)
7. HOT (1), BURNING (2), SCALDING (3), SEARING (4)
8. TINGLING (1), ITCHY (2), SMARTING (3), STINGING (4)
9. DULL (1), SORE (2), HURTING (3), ACHING (4), HEAVY (5)
10. TENDER (1), TAUT (2), RASPING (3), SPLITTING (4)
11. TIRING (1), EXHAUSTING (2)
12. SICKENING (1), SUFFOCATING (2)
13. FEARFUL (1), FRIGHTFUL (2), TERRIFYING (3)
14. PUNISHING (1), GRUELING (2), CRUEL (3), VICIOUS (4), KILLING (5)
15. WRETCHED (1), BLINDING (2)
16. ANNOYING (1), TROUBLESOME (2), MISERABLE (3), INTENSE (4), UNBEARABLE (5)
17. SPREADING (1), RADIATING (2), PENETRATING (3), PIERCING (4)
18. TIGHT (1), NUMB (2), DRAWING (3), SQUEEZING (4), TEARING (5)
19. COOL (1), COLD (2), FREEZING (3)
20. NAGGING (1), NAUSEATING (2), AGONIZING (3), DREADFUL (4), TORTURING (5)

Sensory Score (Items 1-10): _____
Affective Score (Items 11-15): _____
Evaluative Score (Item 16): _____
Total Score (Pain Rating Index): _____
Present Pain Intensity (PPI): _____

PPI
0 NO PAIN
1 MILD
2 DISCOMFORTING
3 DISTRESSING
4 HORRIBLE
5 EXCRUCIATING

BRIEF, MOMENTARY, TRANSIENT | RHYTHMIC, PERIODIC, INTERMITTENT | CONTINUOUS, STEADY, CONSTANT

E = EXTERNAL
I = INTERNAL

CIRCLE THE BODY PART BEING TREATED TODAY

COMMENTS:

Figure 6. McGill Pain Questionnaire (MPQ), short form.

4.4 Pain Assessment in Special Patient Populations

4.4.1 Neonatal Infant Pain Scale (NIPS)

Parameter	0	1	2
Facial expression	Relaxed	Grimace	—
Cry	No cry	Whimper	Vigorous cry
Breathing pattern	Relaxed	Change in breathing	—
Arms	Relaxed	Flexed/extended	—
Legs	Relaxed	Flexed/extended	—
State of arousal	Sleeping/awake	Fussy	—

The Neonatal Infant Pain Scale (NIPS) is a behavioural pain assessment tool designed for newborn and young infants, particularly those who are unable to provide a reliable self-report of pain. It assesses six behavioural and physiological indicators: facial expression, cry, breathing pattern, arms, legs, and state of arousal (Lawrence et al., 1993).

Scoring:

NIPS score	Interpretation
0	No behavioural signs of pain
1–2	Possible/mild pain-related behaviour
≥3	Suggestive of clinically significant pain

Total score 0–7. A higher score indicates greater pain or distress. NIPS should be used before and after painful procedures or analgesic interventions to assess changes in the infant's behavioural response.

4.4.2 Pain Assessment in Advanced Dementia (PAINAD)

Parameter	0	1	2
Breathing	Normal	Occasional laboured breathing	Noisy laboured breathing
Negative vocalisation	None	Occasional moan/groan	Repeated distressed calling/moaning
Facial expression	Smiling/neutral	Sad/frightened/frown	Facial grimacing
Body language	Relaxed	Tense/distressed	Rigid, striking out, pulling away
Consolability	No need to console	Distracted/reassured by voice or touch	Unable to console

The Pain Assessment in Advanced Dementia (PAINAD) scale is designed to assess pain in patients with advanced dementia who are unable to communicate their pain reliably. It evaluates five behavioural domains: breathing, negative vocalisation, facial expression, body language, and consolability (Warden et al., 2003).

Scoring:

PAINAD score	Interpretation
0	No behavioural indicators of pain
1–3	Mild behavioural indicators
4–6	Moderate behavioural indicators
7–10	Severe behavioural indicators

Total score 0–10. Increasing scores suggest increasing likelihood or severity of pain. The score should be interpreted together with changes from the patient's usual behaviour and clinical context.

4.4.3 Critical-Care Pain Observation Tool (CPOT)

Parameter	0	1	2
Facial expression	Relaxed, neutral	Tense	Grimacing
Body movements	No movement/normal position	Protection	Restlessness/agitation
Muscle tension	Relaxed	Tense/rigid	Very tense or rigid
Ventilator compliance / vocalisation	Tolerating ventilator or normal speech	Coughing but tolerating ventilator / moaning	Fighting ventilator / crying out

The Critical-Care Pain Observation Tool (CPOT) is used primarily for critically ill patients who are unable to reliably self-report pain, including mechanically ventilated patients. It assesses four behavioural domains: facial expression, body movements, muscle tension, and compliance with the ventilator or vocalisation (Gélinas et al., 2006).

Scoring: Total score 0-8.

CPOT score	Interpretation
0	No behavioural signs of pain
1–2	Mild behavioural signs
3–4	Moderate behavioural signs
5–8	Severe behavioural signs

An increase in score from baseline or a score suggestive of clinically significant pain should prompt clinical assessment and consideration of appropriate analgesic intervention. CPOT should be reassessed after an intervention to evaluate response.

4.4.4 Behavioural Pain Scale (BPS)

Parameter	Score
Facial expression	
Relaxed	1
Partially tightened	2
Fully tightened	3
Grimacing	4
Upper limb movements	
No movement	1
Partially bent	2
Fully bent with finger flexion	3
Permanently retracted	4
Compliance with mechanical ventilation	
Tolerating movement	1
Coughing but tolerating ventilation	2
Fighting ventilator	3
Unable to control ventilation	4

The Behavioural Pain Scale (BPS) is a behavioural assessment tool used primarily in critically ill patients who are unable to communicate their pain, particularly mechanically ventilated patients. It assesses facial expression, upper limb movements, and compliance with mechanical ventilation (Payen et al., 2001).

Scoring:

BPS score	Interpretation
3	No behavioural evidence of pain
4–5	Increasing behavioural response
≥6	Suggestive of clinically significant pain

Total score 3–12. A higher score indicates greater behavioural evidence of pain. BPS should be used alongside clinical assessment and reassessed following analgesic interventions.

5.0 Management

Key Principles in acute pain management

1. **Multimodal analgesia:** Pain management modalities should include non-pharmacological strategies and pharmacological options to minimise reliance on single agent and to reduce adverse effects. Combine drug classes (paracetamol, NSAIDs and local anaesthetics) as they may provide a synergistic pharmacological effect. Regional analgesic techniques with local anaesthetics (administered as field blocks, nerve blocks, regional blocks, fascial plane blocks or neuraxial anaesthesia)
2. Provide analgesic medication at **regular 'round the clock' intervals** whenever possible rather than waiting for the pain to become severe. As needed medications can be added for breakthrough pain episodes.
3. Promote **responsible use of opioids.** Healthcare institutions should establish and maintain opioid stewardship programs aimed at minimising opioid overuse, misuse, and associated harms while ensuring adequate pain relief. Use opioids only for moderate to severe or refractory pain. If required, prescribe the lowest effective dose for the shortest duration (typically ≤ 3 - 7 days). Appropriate clinical monitoring should be ensured when parenteral opioids are prescribed and administered.
4. **Non-Pharmacological Modalities**: Incorporate physical therapies like ice, Transcutaneous electrical nerve stimulation (TENS) and psychological coping techniques (e.g., distraction methods, deep breathing, mindfulness) to enhance overall efficacy.
5. Regularly **review and optimise** treatment: The pain management plan should be continuously reassessed and adjusted according to the patient's response, adequacy of analgesia, functional outcomes, and the presence of adverse effects.
6. **Patient education:** Patients and their families should understand their pain management plan, expected outcomes, potential adverse effects, and the range of available treatment options. Shared decision-making should be encouraged whenever possible.

5.1 Non-Pharmacological Management of Acute Pain

1. Incorporate non-pharmacological interventions as part of multimodal pain management: Non-pharmacological strategies should be considered as part of a comprehensive, multimodal approach to acute pain management whenever appropriate.
2. Manage pain associated with trauma and injuries: Trauma and injury account for a substantial proportion of acute pain presentations. Supportive measures such as ice application, heat therapy, elevation, rest, immobilisation, and protection of the injured area should be considered when clinically indicated to reduce pain and facilitate recovery.
3. Provide appropriate burn care: In patients with burn injuries, appropriate wound care and dressing techniques should be employed according to the severity, depth, extent, and

location of the burn. Effective burn management can significantly reduce pain and improve healing outcomes.

4. Promote activity and rehabilitation where indicated: Exercise therapy, mobility training, and early functional rehabilitation may be beneficial in selected acute pain conditions, particularly musculoskeletal disorders such as acute low back pain. Interventions should be tailored to the patient's condition and functional status.
5. Consider physical and manual therapies: Manual therapies, including massage, mobilisation, manipulation, acupuncture, and dry needling, may provide benefit in selected musculoskeletal pain conditions. These interventions should only be performed by appropriately trained and qualified healthcare professionals.
6. Utilise psychological and behavioural strategies: Psychological interventions can complement other pain management strategies and improve coping with acute pain. These may include distraction techniques, music therapy, relaxation training, mindfulness-based interventions, and other supportive therapies. Cognitive behavioural therapy (CBT) techniques may help patients identify and modify maladaptive thoughts and behaviours that contribute to pain-related distress and disability.
7. Provide age-appropriate non-pharmacological interventions for children: In children, parental or caregiver presence, comforting touch, consoling behaviours, and tactile stimulation should be incorporated whenever possible. Distraction techniques are particularly effective and may include videos, music, toys, storytelling, bubble blowing, counting exercises, games, or other age-appropriate activities. These interventions should be used routinely alongside pharmacological pain management when indicated.

5.2 Pharmacological Methods

Non-opioid analgesics form the foundation of pharmacological management for most cases of acute non-cancer pain. Paracetamol (acetaminophen) and non-steroidal anti-inflammatory drugs (NSAIDs) are effective first-line agents and should be considered whenever not contraindicated.

Paracetamol is generally well tolerated and can be administered orally, intravenously, or rectally depending on the clinical situation and patient factors. NSAIDs may be administered orally, intravenously, or topically. Topical NSAIDs are particularly useful for localised musculoskeletal pain, providing analgesic benefits while minimising systemic adverse effects.

Adjuvant medications may be considered in selected patients to enhance analgesia and address specific pain mechanisms. These include muscle relaxants for acute musculoskeletal conditions, gabapentinoids for selected neuropathic pain syndromes, and antihistamines when clinically indicated. The use of adjuvant therapies should be guided by the underlying cause of pain, patient characteristics, and the risk-benefit profile of each medication.

Opioids should generally be reserved for patients with moderate to severe acute pain or for pain that remains inadequately controlled despite optimised non-opioid and non-pharmacological therapies. When opioids are used, the lowest effective dose should be prescribed for the shortest appropriate duration, with regular reassessment of efficacy, adverse effects, and ongoing need.

The selection and escalation of pharmacological therapy should be guided by pain severity, functional impairment, the underlying diagnosis, patient comorbidities, and the individual's response to treatment. Pharmacological interventions should be incorporated into a multimodal pain management strategy whenever possible.

5.3 WHO Analgesic Ladder

The WHO Analgesic Ladder was originally developed by the World Health Organization in the 1980s as a framework for the management of cancer-related pain. Owing to its simplicity and effectiveness, the principles of the ladder have subsequently been adapted and applied to the management of other acute and chronic pain conditions. A modified four-step analgesic ladder is commonly used in contemporary acute pain management.

- Step 1: Mild Pain: For mild pain, non-opioid analgesics are recommended as first-line therapy. This typically includes paracetamol (acetaminophen), with or without non-steroidal anti-inflammatory drugs (NSAIDs), unless contraindicated. Opioids should generally be avoided in patients with mild pain.
- Step 2: Mild to Moderate Pain: If pain is inadequately controlled with non-opioid analgesics alone, a weak opioid may be added as part of a multimodal analgesic regimen while continuing non-opioid therapy where appropriate.
- Step 3: Moderate to Severe Pain: For moderate to severe pain, a strong opioid may be added to non-opioid analgesics. Opioid therapy should be individualised, regularly reassessed, and used in conjunction with opioid stewardship principles to minimise adverse effects and misuse.
- Step 4: Interventional Pain Management: Interventional pain management techniques may be considered when pain is inadequately controlled with pharmacological therapies or when such interventions are expected to improve analgesia and reduce systemic medication requirements. Examples include regional anaesthesia, peripheral nerve blocks, neuraxial techniques, and other specialist pain procedures. Although depicted as the fourth step of the ladder, interventional modalities may be incorporated at any stage of pain management when clinically indicated.
- Application in Acute Pain Management: Unlike chronic cancer pain, acute pain management often requires rapid escalation of therapy. In patients presenting with severe acute pain, treatment may commence at Step 3 and subsequently be de-escalated as pain improves. Therefore, the analgesic ladder should be viewed as a flexible framework that supports individualized, patient-centred care rather than a rigid stepwise progression

5.3.1 Local analgesia (some selected regional techniques in acute pain)

Context	Suggested topical agent
Local Applicants	• Oral/ mucosal local anaesthetic application is oral ulcers, gingivosomatitis • Topical eye drops • Ear/ Nose drops for localised pain due to foreign bodies in ear or nose respectively • Local perianal application/ Sitz bath in anal fissure / haemorrhoids
Topical cream prior to IV cannulation/ needle puncture	• EMLA cream applied prior to skin puncture in children helps reduce pain and distress
Local infiltration (field blocks)	• Can be employed when the offending area is relatively small. Especially useful in surgical procedures like suturing/ dressing small woulds
Peripheral Nerve blocks	• When pain arises from a lesion in the area of a locatable nerve, the nerve can be identified and blocked. Eg: Femoral nerve block, median nerve block
Regional blocks	• When pain arises from a lesion in the area of a nerve plexus or multiple nerves in close proximity, a regional block can be employed. Eg: Brachial plexus block, Ankle block
Fascial Plane blocks	• When pain arises from a lesion in the area of a nerve plexus or multiple nerves in close proximity running though a facial plane, infiltration of the plane with local anaesthetic can block sensation Eg: Erector Spinae Plane Block (ESPB) , Transversus Abdominis Plane block (TAP)
Neuraxial Anaesthesia	• Local Anaesthetic given in epidural or intrathecal space can have very potent analgesic effect. Should be carried out only by trained healthcare professional. Eg: Labour Epidural Analgesia

* Regional analgesia techniques should be performed only by healthcare professionals who have received appropriate training and demonstrated competency. Ultrasound guidance is recommended when performing these techniques. Epinephrine may be added to the local anaesthetic at a concentration of 2.5-5 mcg/mL to reduce systemic absorption. Patients should be monitored for local anaesthetic systemic toxicity (LAST) whenever large doses of local anaesthetic are used. Institutions should establish guidelines for the monitoring and management of LAST and ensure that lipid emulsion is readily available wherever regional techniques are performed

5.4 Systemic analgesia

All pain management should begin with an assessment and pre-emptive escalation through the flowchart based on the severity of pain.

Ongoing reassessment is essential, particularly to assess intervention and whether further analgesia is required.

Drug	Drug Class	Route	Dose	Notes / Onset of Action
Paracetamol	Non-opioid analgesic / antipyretic	**PO (Oral)**	15 mg/kg (max 1 g) 4–6 hourly	Onset: ~30 minutes. Oral route preferred. Dose on ideal body weight. Administer commercial syrup carefully as available in several concentrations.

Drug	Drug Class	Route	Dose	Notes / Onset of Action
		PR (Rectal)	15–20 mg/kg (max 1 g) 6 hourly	If not tolerated orally. Rectal absorption can be delayed and erratic. Dose on ideal body weight. 125 mg, 250 mg and 500 mg suppositories available. Avoid PR medication in immunocompromised children.
		IV (Intravenous)	**<1 month:** 10 mg/kg 6 hourly. **>1 month:** 15 mg/kg (max 1 g) 6 hourly	Onset: 5–10 minutes. If PO/PR not tolerated. More expensive. Dose on ideal body weight. Dose (mg) and volume (mL) errors have caused significant overdoses in young children.
Ketorolac	NSAID (Non-steroidal anti-inflammatory drug)	**IV (Intravenous)**	>12 years: 10–30 mg 6 hourly	Should be limited to <5 days. Should not exceed 120 mg/day.
Diclofenac (Adults only)	NSAID	**PO (Oral)**	75 mg 12 hourly or 50 mg 8 hourly	Consider gastrointestinal, renal and cardiovascular risks.
		IM (Intramuscular)	75 mg once	Avoid repeated IM administration where possible.

Drug	Drug Class	Route	Dose	Notes / Onset of Action
		Topical	1% gel/cream	Apply according to product instructions. Useful for localised musculoskeletal pain.
Naproxen (Adults)	NSAID	**PO (Oral)**	250–500 mg 8 or 12 hourly	Onset: 30–60 minutes. Renal impairment is a concern.
Ibuprofen	NSAID	**PO (Oral)**	>3 months: 10 mg/kg (max 400 mg) 6–8 hourly with food	Onset: ~30 minutes. Precautions include renal impairment, dehydration, bleeding and anticoagulant use. Asthma is not an absolute contraindication. Administer commercial syrup carefully as available in several concentrations.
Morphine	Strong opioid analgesic	**IV (Intravenous) / SC (Subcutaneous)**	**<1 month:** 0.025 mg/kg, repeat as needed. **1–12 months:** 0.05 mg/kg. **>12 months:** up to 0.2 mg/kg (max 5–10 mg)	Rapid onset. Peak effect: 5–10 minutes. Higher or more frequent dosing may be used in hospital settings with appropriate monitoring. Monitor for respiratory depression and sedation.

Drug	Drug Class	Route	Dose	Notes / Onset of Action
Fentanyl	Strong synthetic opioid analgesic	**IV (Intravenous)**	>12 months: 1.5 mcg/kg (max 100 mcg) for first dose; 0.75 mcg/kg for subsequent doses after 10 minutes	Rapid onset: ~5 minutes. Monitor for respiratory depression and sedation.
Tramadol	Atypical opioid / centrally acting analgesic	**PO (Oral) / IV (Intravenous)**	>12 years: 0.5–1 mg/kg (max 100 mg) 6 hourly	Onset: 30–60 minutes. Can give up to 2 mg/kg if no risk of sleep apnoea or respiratory depression. Avoid in epilepsy. Avoid with SSRIs where possible because of serotonin syndrome risk.
Naloxone	Opioid antagonist / opioid reversal agent	**IV (Intravenous) / IM (Intramuscular) / SC (Subcutaneous)**	Titrate according to age, clinical condition and local protocol; repeat doses may be required	IV onset: 1–2 minutes. Used for opioid-induced respiratory depression/toxicity. Titrate to restore adequate ventilation. Monitor for recurrence of respiratory depression.

Drug	Drug Class	Route	Dose	Notes / Onset of Action
		IN (Intranasal)	According to locally available formulation and protocol	Useful when IV access is not immediately available. Repeat dose may be required. Monitor airway and ventilation.

5.5 Selected Analgesics

Abbreviations

PO	Oral
PR	Rectal
IV	Intravenous
IM	Intramuscular
SC	Subcutaneous
IN	Intranasal
NSAID	Non-steroidal anti-inflammatory drug

5.6 Other Considerations

Significant ongoing pain

- Consider combination medications. Opioids should be considered if multimodal analgesia with non-opioidal medication doesn't relieve the pain adequately
- Consider management plans for ongoing medical or surgical condition
- Consider use of regional analgesic techniques early

Renal Impairment

- Renal dosing of medication should be considered. Reduce dose where appropriate.
- Avoid morphine or adjust dose accordingly
- Monitor for opioid toxicity
- Selective Cox-2 inhibitors are more kidney safe than traditional non-selective NSAIDS.

Consider transfer when

Analgesic requirements and care are above the level of comfort of the local centre

Consider discharge

Patients should be considered for discharge:

- Clinically stable: Vital signs should be appropriate for patients baseline with no evidence of an evolving medical or surgical condition.
- Pain Control: Pain or distress is appropriately controlled or acceptable to the patient.
- Functional status: Patient
  Anticipated pain is appropriately considered

6.0 Discharge criteria:

Discharge Criteria for Patients Managed for Acute Pain

Patients may be considered suitable for discharge when all of the following criteria are met:

Clinical Stability

- Vital signs are stable and appropriate for the patient's baseline.
- No evidence of an evolving medical or surgical condition requiring inpatient care.
- No significant adverse effects from analgesic therapy (e.g., excessive sedation, respiratory depression, uncontrolled nausea or vomiting, or allergic reaction).

Pain Control

- Pain is adequately controlled with oral analgesics or the planned outpatient regimen.
- Pain intensity is acceptable to the patient and permits safe discharge, recognizing that complete pain relief is not always achievable.
- The patient demonstrates improved functional ability appropriate to their condition (e.g., able to mobilize safely or perform essential activities).

Functional Status

- The patient can ambulate safely or has an appropriate mobility plan.
- Oral intake is tolerated if clinically indicated.

- Any regional anesthesia or procedural sedation effects have resolved sufficiently for safe discharge.

Medication Plan

- An individualized multimodal analgesic regimen has been prescribed when appropriate.
- Opioids, if prescribed, are limited to the lowest effective dose and shortest appropriate duration.
- The patient has received counseling regarding medication use, potential adverse effects, safe storage, and disposal of opioids.

Patient Education

The patient (and caregiver when appropriate) understands:

- The expected course of pain and recovery.
- How and when to take prescribed medications.
- Non-pharmacological pain management strategies.
- Red flag symptoms requiring urgent medical review (e.g., increasing pain despite treatment, fever, new neurological deficits, uncontrolled bleeding, signs of infection, or medication-related adverse effects).

Follow-up

- Appropriate follow-up has been arranged or clearly advised.
- The patient knows how to access medical care if pain worsens or complications develop.

Social Considerations

- The patient has adequate support, transportation, and the ability to obtain prescribed medications.
- Where sedation or opioids have been administered, discharge is consistent with local policy regarding supervision, driving restrictions, and return to work or hazardous activities.

1.Pain control: managed with oral meds, function manageable

2. Cause of pain addressed: diagnosis confirmed

3. No Red Flags at Discharge: document absence of - Hemodynamic instability, Increasing pain, Neurological deficit, Signs of infection/sepsis, Surgical emergency features

4. Red Flag Education Given: Patient must be told to return if - Pain worsens or changes character, Fever develops, Vomiting persists, New neurological symptoms, Unable to control pain with meds

5. Follow up plan given

Rule out red flags first:

If any present then escalate to reach diagnosis

Pain out of proportion

Hemodynamic instability

Acute abdomen / peritonitis

Chest pain suspicious of ACS

Limb ischemia / compartment syndrome

Neurological deficit

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