Institution Name: Al Masarra Hospital					
Document Title: Policy and Procedure of Pain Management and Access Controls to Narcotic Medications					
Approval Process					
	Name	**Title**	**Institution**	**Date**	**Signature**
Written by	Policy & Procedure Team members	Pharmacy & Medical Stores	Al Masarra Hospital	26/7/2022	[signature]
Reviewed by	Najla Al Zadjali	HoD Quality Management and Patient Safety	Al Masarra Hospital	25/7/22	[signature]
Validated by	Kunooz Al Balushi	Document Manager	Al Masarra Hospital	July 2022	[signature]
Approved by	Dr. Bader Al Habsi	Hospital Director	Al Masarra Hospital	25/7/22	For [signature]

Content Table:

	Acronyms ………………………………………………………………...	3
1	Introduction ………………………………………………………..............	4
2	Scope …………………………………………………………………...	4
3	Purpose ………………………………………………………………...	4
4	Definition ………………………………………………………..............	5
5	Policy …………………………………………………….…………….	5-8
6	Procedure ………………………………………………..................	9-14
7	Responsibility ………………………………………………………..	14
8	Document History and Version Control …………………….…………	15
9	Related Documents ………………………….………………………...	15
10	References …………………………………………..……………	16
	Appendices ………………………………………………………… 17-25	
	Appendix 1. Visual Analogue Pain Scale ……………………….	17
	Appendix 2. Wong-Baker (Facial) Pain Rating Scale................	17
	Appendix 3. Pain Assessment for the Cognitively Impaired Patient ………………………………...	18
	Appendix 4. Non-opioid and Opioid Analgesic Doses………….	19
	Appendix 5. Guidelines for the Pharmacological Management of Acute and Chronic Pain in Adults	20
	Appendix 6. Neuropathic Pain Management …………………..	21
	Appendix 7. Non-opioid and Opioid Analgesic Doses................	22
	Appendix 8. Audit Tool …………………………………………….	23
	Appendix 9. Document Request Form ………………………….	24
	Appendix 10. Document Validation Checklist ……………......	25

Acronyms:

GPs	General Practitioner
CDs	Controlled Drugs
HCPs	Health Care Providers
NSAIDs	Non-steroidal Anti-inflammatory Drugs
WCDR	Ward Controlled Drugs Register
ID	Identity

Policy & Procedure of Pain Management and
Access Controls to Narcotic Medications

1. Introduction

Pain management encompasses pharmacological, non-pharmacological, and other approaches to prevent, reduce, or stop pain sensations. "Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage or both" (*International Association for the Study of Pain, 1994*). Pain serves as an alert to potential or actual damage to the body. Pain has sensory, emotional, cognitive, spiritual, and behavioral components that are interrelated with environmental, developmental, sociocultural, and contextual factors.

Al Masarra Hospital recognizes a patient's right to pain relief and supports a multidisciplinary approach to pain assessment and management. Hence, developed this document to keep up an excellence and establish standards for the assessment and management of pain especially in the field of psychiatric care management and addiction treatments.

2. Scope

This document is applicable to all the Doctors/Nurses/Pharmacy professionals/and other linked healthcare workers dealing with clinical area procedures.

3. Purpose

3.1 To recognize the right individuals to appropriate assessment and management of pain.

3.2 To support the appropriate prescribing or ordering of effective pain medications.

3.3 To educate patients, residents/training students, clients and their families about effectivepain management.

3.4 To incorporate pain management into the institution's performance measurement andimprovement program.

4. Definitions

4.1 **Neuropathic Pain:** pain sustained by injury or dysfunction of the peripheral or centralnervous system.

4.2 **Acute Pain:** recent pain that is usually transient in nature lasting for several minutes toseveral days.

4.3 **Opioids:** term preferred to narcotics. Opioids refer to morphine, codeine-like drugs andother natural, synthetic and semisynthetic drugs that relieve pain by binding to multipletypes of opioid receptors.

4.4 **Non-opioids:** term used instead of non-narcotics refers to Paracetamol and Nonsteroidalanti-inflammatory drugs (NSAIDs).

4.5 **Craving:** the intense desire for drugs.

4.6 **Pharmacological therapy**: Pharmacology is the science of drugs. The term comes fromthe Greek words *pharmakos*, which means 'medicine' or 'drug'; and *logos*, meaning 'study'. Pharmacological therapy, therefore, deals with the making and use of drugs, andespecially their effects on the body.

4.7 **Non-pharmacological therapy:** plays an important role in the treatment of pain, in particular chronic pain. Physiotherapy and various methods are used to treat pain: massage, cryotherapy (treatment with cold) or thermotherapy (treatment with heat) areparticularly used for the treatment of musculoskeletal pain.

4.8 **COX-2s:** an enzyme that acts to speed up the production of certain chemical messengers,called prostaglandins that play a key role in promoting inflammation.

4.9 **Antidote:** a medicine taken or given to counteract a particular poison.

5. Policy

5.1 Pain Assessment: All patients must be assessed for pain.

5.1.1 All sections/providing treatment/services to patients must perform appropriatescreening assessment for pain.

5.1.2 Pain intensity and pain relief must be assessed:

5.1.2.1 On admission.

5.1.2.2 After any known pain-producing event.

5.1.2.3 With each new reporting of pain.

5.1.2.4 Routinely at regular intervals as appropriate to clinical service.

5.1.3 When possible, the patient's self-report of pain should be considered as primaryindicator of pain.

5.2 Pain Scales

The following scales/methods shall be used for ratings:

5.2.1 The **0-10 numeric (Visual Analogue Pain Scale)** should be the preferred painrating measures. (See Appendix 1. Visual Analogue Pain Scale)

5.2.2 **Wong-Baker Facial Pain Scales** will be used for patients who may have difficulty in communicating their pain and require particular attention with close assessment. (See Appendix 2. Wong-Baker Facial Pain Scale)

5.2.3 The **Cognitively Impaired Nonverbal Scale** will be used for patients who are not able to communicate due to mental or physical impairment for which behaviors will be assessed to give clues about pain scales. (See Appendix 3. Pain Assessment for the Cognitively Impaired Nonverbal Pain Scale)

5.2.4 **Adult non-verbal scale** will be used for intubated patients.

5.3 Reassessment of Pain

5.3.1 Patients must be reassessed after each pain management intervention and once a sufficient time has passed for the treatment to reach effect.

5.3.2 Patients not attaining a reduction in pain must have an in-depth focused assessment of pain and appropriate action will be taken to reduce the patient.

5.4 Documentation of Pain Management

5.4.1 Pain assessment must be documented so that all members of care team will have aclear understanding of the pain.

5.4.2 All the interventions shall be documented at least every shift using the appropriatepain scale.

5.4.3 When pain management is not attained, more in-depth assessment and thedocumentation shall be done.

5.5 Options to control pain

5.5.1 Medicating prior to activity (Physical therapy etc.) to increase participation.

5.5.2 Scheduling doses on an 'around the clock' dosing schedule to maintain the levelof drug to prevent the recurrence of pain.

5.5.3 The assigned doctor/nurse should inform the patient of availability of PRN andthe need to request when pain is present.

5.6 Non-opioid analgesics and adjuvant medications

All Healthcare Providers (HCPs) must be knowledgeable about the pharmacologic alternatives to opioid analgesics and adjuvant medications that can be used to manage pain.

5.6.1 Non-steroidal anti-inflammatory drugs (NSAIDs)

5.6.2 Antiepileptic drugs

5.6.3 Antidepressants

5.6.4 Local and regional anesthetics

5.6.5 Other miscellaneous adjuvant medications

5.7 Opioid analgesics and associated risk

All Healthcare Providers (HCPs) must be knowledgeable about the risks associated withopioid analgesic use to their patients and from a public health perspective.

5.7.1 Epidemic of prescription, opioid drug abuse, and extent of the problems.

5.7.2 Most of the opioids available for misuse and abuse in the community.

5.7.3 Knowledgeable about safe opioid practices including guidelines.

5.7.4 Good knowledge about the current national policies and regulations.

5.8 Opioid analgesics and utilizing it for pain management

All HCPs must be knowledgeable about how to use opioid analgesics safely.

5.8.1 Routes of administration and formulations used in pain management.

5.8.2 Initial dosing, dose titration, dose tapering for analgesia.

5.8.3 Most common methods of opioid abuse.

5.8.4 Potential risks and benefits of opioids during pregnancy.

5.8.5 Opioids use in adults/older adults/children.

5.8.6 Sleep disorders and opioids.

5.8.7 Common and uncommon psychiatric disorders, pain, and opioids.

5.8.8 Strategies to prevent opioid overdose/death.

5.8.9 Safe storage/proper disposal of used and unused opioids.

5.8.10 Ensuring availability of Naloxone/antidote.

5.8.11 Pain management after an opioid overdose.

5.9 Initiating treatment with opioids

HCPs must be knowledgeable about the proper use of opioids in patients with acute andchronic pain. All HCPs should consider the following:

5.9.1 Patient selection – when is an opioid necessary?

5.9.2 Dosing/as needed vs. around-the-clock.

5.9.3 Matching expected duration of pain with quantity of analgesic prescribed.

5.9.4 Periodic review and monitoring for patients on opioid analgesic.

5.9.5 Screening tools for risk of abuse.

5.9.6 Warning signs and symptoms of significant respiratory depression from opioidsand monitor patients closely.

5.9.7 Required special precautions with methadone:

5.9.7.1 As it is having longer half-life than the duration of analgesia.

5.9.7.2 Dosing multiple times per day for pain results in accumulation.

5.9.7.3 Prolonged QT interval.

5.10 Side effect management

5.10.1 HCPs must assess sedation level after pain interventions.

5.10.1.1 Awake and Alert.

5.10.1.2 Dozing, easily aroused.

5.10.1.3 Dozing, aroused with difficulty.

5.10.1.4 Unresponsive.

5.10.2 HCPs must assess and observe for known side effects of pharmacologic agents.

5.10.2.1 Unstable blood pressure, urinary retention etc.

5.10.2.2 Inadequate respiratory rate and depth.

5.10.2.3 Nausea and vomiting.

5.10.2.4 Pruritus, constipation etc.

6. Procedure

6.1 Components of effective treatment plan

All HCPs must be knowledgeable about which preferred pain management therapieswill be followed and practiced:

6.1.1 Non-pharmacologic therapies – includes psychological, physical rehabilitative,complimentary therapies etc.

6.1.1.1 Psychological approaches – e.g. cognitive therapy

6.1.1.2 Physical rehabilitative approaches – e.g. Physical therapy, occupationaltherapy.

6.1.1.3 Complimentary therapies.

6.1.2 Pharmacologic therapies – Non-opioid, opioid, and adjuvant medications. **WHO Analgesic Ladder** shall be implemented:

6.1.2.1 **Step 1:** Non opioid +/- adjuvant: Paracetamol, NSAIDs/ COX-2s +/adjuvant.

6.1.2.2 **Step 2:** Opioid for mild to moderate pain +/- non-opioid +/- adjuvant:Codeine, Tramadol +/- NSAIDs/COX – 2s, +/- adjuvant.

6.1.2.3 **Step 3:** Opioid for moderate to severe pain, +/- non-opioid, +/- adjuvant:Morphine, methadone, +/- NSAIDs/COX-2s +/- adjuvant

6.4 Types of pain

Pain should be categorized into the following and will be managed as per methods:

6.4.1 Acute Pain:

6.4.1.1 Non-Pharmacological Therapies: Physical (e.g. exercise, massage, rest and physical therapy) and Psychological methods (e.g. Patient education,relaxation and supportive psychotherapy).

6.4.1.2 Pharmacological Therapies: Local anesthetic, oral non-opioid, NSAIDs,or Opioids.

6.4.2 Chronic Pain (non-cancer):

6.4.2.1 Non-pharmacological: Physical (e.g. exercise, heat massage and hydration), psychological methods (e.g. rest, exercise, relaxation anddeep breathing) and surgical.

6.4.2.2 Pharmacological Therapies: Oral non-opioid, NSAIDs, or Opioids (forshort term only).

Access to Controlled Drugs – Narcotics for In-patients

6.5 Ordering of Controlled Drugs - Narcotics by Wards/Units from the Medical Stores (*Internal*).

6.5.1 An authorized staff nurse or his/her deputy of the wards/units will fill the requisition.

6.5.2 Fill all the queries in the request form (*Annex – 5. CDs policy*).

6.5.3 An indent through the Al Shifa 3+ system will be made by the above same staffand send it to the concerned Pharmacy and Medical Stores section.

6.5.4 Request must be stamped and duly signed by the nursing In-charge or NursingSupervisor (Stamp: Hospital Stamp/hospital ward stamp).

6.5.5 Retain the original copy of request form with medical store and the other copywith receiving unit.

6.5.6 Submit the order personally to medical store while receiving the items.

6.5.7 Authorized staff will carry these to medical store while receiving items:

6.5.7.1 Original CDs request form along with the carbonized copy.

6.5.7.2 CDs register.

6.5.7.3 Prescription pad (in use) in the case of Narcotics.

6.6 Receiving of Controlled Drugs by the Wards/Units (*Internal*) from the Medical Stores

Authorized Nursing staff will:

6.6.1 Carry the relevant documents as mentioned in ordering article (Annex-5).

6.6.2 Check the quality and all specifications of the received CDs (Quantity, BatchNumber and Expiry date etc.) against the issue voucher and sign the same accordingly.

6.6.3 Update the relevant register simultaneously with the receipt of CDs.

6.7 Storage of Controlled Drugs: (*Wards/Units)*

6.7.1 CDs must be stored separately in CDs cabinet.

6.7.2 The CDs cabinet must be metallic and non-portable.

6.7.3 The CDs cabinet should be securely locked with key or coded lock.

6.7.4 Utilization of an alarm or other check system is recommended, especially forNarcotics.

6.7.5 The CDs cabinet key should always be kept separate from the CD's cabinet undercustody of the Nurse In-charge.

6.7.6 The CDs registers also should be kept in a locked secure place.

6.7.7 The CDs cabinet should not be accessible to patients or other unauthorized personnel.

6.7.8 Only controlled drugs must be stored in CD's cabinet.

6.7.9 Any split tablets/pills should be stored in an amber colored/non-transparent bottle/safe container and is to be labeled clearly with all related requirements.

6.8 Documenting in the CDs registers: *Wards/Units Authorized CDs staff from Nursing sections will follow:*

6.8.1 The wards/units shall be provided with a Ward Narcotic register in which entriesfor receipts and issues of individual CDs drugs are made.

6.8.2 To start a new register, transfer the closing stock from the old register to thebalance column of new register.

6.8.3 The name of the drug/item code should be specified at the top of each page.

6.8.4 A separate page of the register should be used for each drug and strength.

6.8.5 To start a new register, transfer the closing stock quantity from the old book to thenew register’s balance column.

6.8.6 Entries must be made in a chronological sequence.

6.8.7 **Received quantity** should be recorded by a pen with **Red** ink only.

6.8.8 All other entries must be in ink (**Blue or Black**) or otherwise indelible.

6.8.9 Entries must be made at same time of receiving and same day of the transaction.

6.8.10 Any entry in the register once made should never be erased nor corrected. Any mistake done, put a **single line cut** over it and should be corrected in the remark column and also the corrected version to be rewritten in the next line.

6.8.11 The CDs register must not be used for other purposes and kept at the premise to which it is related.

6.8.12 The CDs registers along with the Narcotic prescription pads should be secured.

6.8.13 The registers and other records should be updated and liable to be inspected at any time.

6.8.14 During the new registers collection from the CD section, Medical Stores, confirm it with an officially stamped (*MOH seal)* register and later write the name of the ward/unit clearly on the register.

6.8.15 For ease of reference, maintain an index of the register's contents at the beginningof it.

6.9 Requirements of CDs prescriptions: *Prescribers*

6.9.1 The patient's full name, hospital ID number or address, where appropriate, age or patient's sticker ID.

6.9.2 The date of the prescription.

6.9.3 The name of the medication in *Generic*, *Strength* and *dosage form* of the drug,even if only one form exists.

6.9.4 Each prescription should contain one drug.

6.9.5 The dose to be taken ('*Taken as directed'* or '*as required'* are not acceptable).

6.9.6 The total quantity of the preparation, or the number of dose units to be supplied should be written in both words and in numeric letters.

6.9.7 Prescription must be written in ink (**Blue or Black**) and be signed *(to do usual signature and this must be hand written)*, stamped *(Physician's seal)* and dated bythe Physician.

6.9.8 Any space on the prescription form that has not been written on must be kept blanked, e.g. by drawing a line through it to reduce the opportunity for fraud.

6.9.9 Any changes in the prescription, must not be erased/corrected, but only cross it and sign against it accordingly.

6.9.10 The prescriber must write the medication in the prescription's specified column only. The column specified for Pharmacy use only to be left for the Pharmacy dispensing purposes.

6.10 Procedures for Administration of CDs for In-patients: *Wards/Units*

6.10.1 Except in exceptional circumstances, the person prescribing the CDs should not personally undertake all of the following tasks: preparation, dispensing and administration etc. of the CDs.

6.10.2 A record of each administration should be documented kept in the relevant patient clinical notes. This record should specify the date, time, strength, and formof administration, dose administered as well as the name and occupation of the person administering it.

6.10.3 **Naloxone** injection, an **antidote** to opiate-induced respiratory depression, should be available in all the clinics and wards where morphine injections are stored and administered.

6.10.4 Controlled Drugs (CDs) will be administered by an authorized staff nurse andmust be checked by another registered staff nurse acting as a witness. The witnessis not a mere formal presence but to confirm that regulations are followed. Both these persons must remain present throughout the entire procedure.

6.10.5 Check if the prescription is legible and valid. In the case of Narcotic prescription,confirm both parts are countersigned by the prescriber.

6.10.6 Prepare the medicine for administration and lock the remaining CD away in theCDs cabinet.

6.10.7 Confirm the identity of the patient before administering the medication with othersupporting documents.

6.10.8 Documentation: It is necessary to put initial/sign the patient's prescription/chartby the designated/authorized nursing staff at the time of administration.

6.10.9 Authorized Staff Nurse administers medication, and witness must ensure the remaining details are recorded in the WCD Register and documented in the Nursing Kardex/Hospital Information System (*Al Shifa 3+*).

6.10.10 The Staff Nurse who administers the dose should sign the **'given by'** column and the witness in the '**witness column'** in the WCD Register.

6.10.11 Treatment with CDs to be discontinued only by the treating doctor over signature and should be dated.

6.11 Prescriptions: To the Inpatients

6.11.1 For prescribing narcotic medications, the **Pink** colored prescription books/sheets will be used.

6.11.2 In addition, clinicians shall enter CDs prescribed in individual patient's drug chart/patient file in the hospital information computer system (Al Shifa 3+).

6.11.3 The duration of an inpatient prescription for both, when necessary, medication (PRN) and a regular medication shall be for seven (7) days in Al-Shifa 3+ system in a tapering dose regimen, from the first administered dose and each dose should be written in one prescription**.**

6.11.4 If the prescribed CD is discontinued by the prescriber and the prescription is still valid, this should also be recorded on the prescription which will make it invalid for any further doses and should be clearly documented in the patient's medical file as well.

6.11.5 Cancelled Narcotics prescriptions must be kept in the prescription pad itself without tearing.

7. Responsibility

7.1 Healthcare providers (Doctors/Nurses/Pharmacy professionals) Shall:

7.1.1 Determine the nature of the pain and its impact on the patient.

7.1.2 Score the pain by using approved measuring tools.

7.1.3 Determine when to administer analgesics.

7.1.4 Assess and manage side effects of the medications.

7.1.5 Intervene to promote comfort and reduce pain.

7.1.6 Document pain assessment and interventions.

7.1.7 Monitor patient's status after administration of medications.

7.1.8 Implement the CD policy and procedure for ordering, receiving, prescribing,documenting, administering and storing of controlled drugs.

7.1.9

8. Document History and Version Control Table

Document History and Version Control			
Version	**Description of Amendment**	**Author**	**Review Date**
1	Initial Release	Policy and Procedure team (P&MS)	March 2021
2	Update and Review	Policy and Procedure team (P&MS)	July 2025
Written by	**Reviewed by**	**Approved by**	
Policy and Procedure team (P&MS)	Najla Al Zadjali	Dr. Bader Al Habsi	

9. Related Documents

9.1 General Policies and Procedures of Controlled Drugs Substances – Pharmacy Department, Al Masarra Hospital.

9.2 Medication Ordering and Review policy – Pharmacy Department – Al Masarra Hospital.

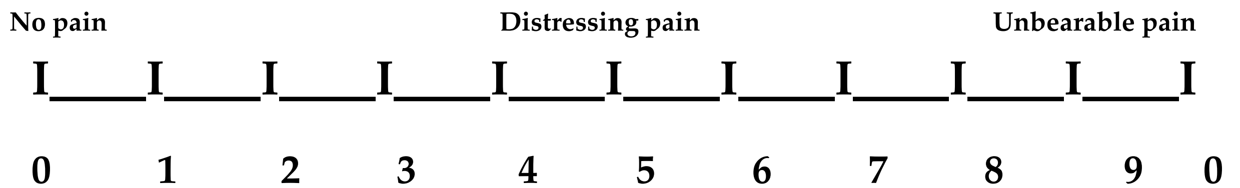
10. References:

Title of book/journal/article/Website	Author	Year of publication	Page
Pain Ladder (https://en.m.wikipedia.org)	WHO	-	
Management of patients with Pain	FDA Education Blueprint for Health Care Providers.	2017	1-8
Pain Management Documents	NHS – Wiltshire, UK	2015	1-8
Pain Management Guidelines	MoH, Rwanda	2012	1-62
Pain Management	Sacred Heart Health Care System, 421 Chew Street, Allentown.	-	

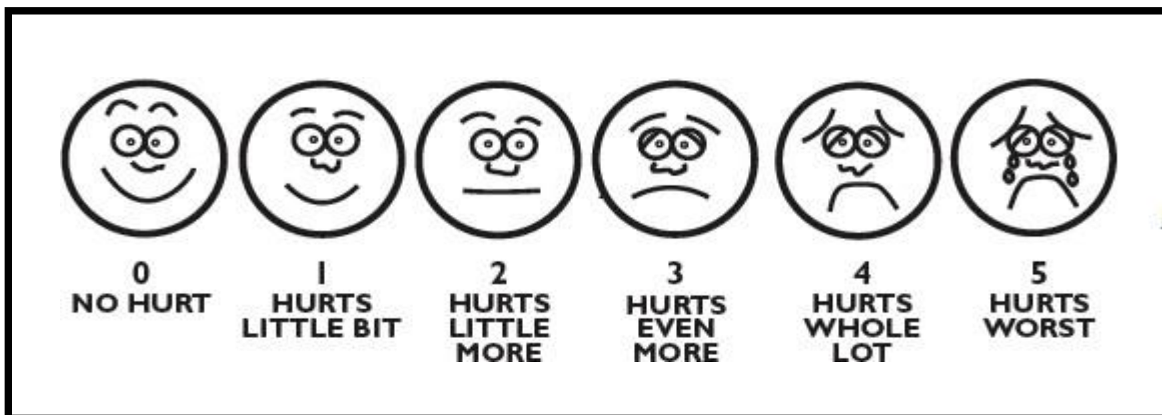
Appendices

Appendix 1. Visual Analogue Pain Scale

Choose a number from 0 to 10 that best describes your pain



Appendix 2. Wong-Baker (Facial) Pain rating scale



Appendix 3. Pain Assessment for the Cognitively Impaired Patient

Write a "0" if the behavior was not observed and a "1 if the behavior occurred even brieflyduring activity or rest.

Behavior	With Movement	Rest
Vocal complaints: non-verbal. (Expression of pain, not in words, cries, gasps, grunts etc.)		
Facial grimaces / winces (narrowed eyes, tightened lips, jaw drop, clenched teeth, distorted expression etc)		
Bracing (clutching or holding onto side rails bed, tray, tables or affected area during movement)		
Restlessness (constant or intermittent shifting of position, rocking, intermittent or constant hand motion, inability to keep motionless)		
Rubbing (massaging affected area)		
Verbal / Vocal complaints: (words expressing discomfort or pain, "ouch", cursing during movement, or exclamations of protest, e.g. Stop!, that's enough!		
Total Score		

Appendix 4. Non-Opioid & Opioid Analgesic Doses

Non-Opioid Analgesic Doses				
Medication	**Dose range/mg**	**Max/day/mg**	**Frequency**	**Considerations**
Paracetamol	500-1000	4000	4-6 hours	Light headedness Dizziness Can cause liver toxicity
Tab. Aspirin	300-900	4000	4-6 hours	Do not use in children < 12 years. Tinnitus GI disturbance Allergic reaction Blood disorders & Asthma
Tab. Ibuprofen	200-600	2400	4-6 hours	GI bleeding Severe heart failure Uncontrolled hypertension Allergic reaction Asthma
Diclofenac Sodium	50	150	8-12 hours	GI bleeding Severe heart failure Uncontrolled hypertension Allergic reaction Asthma
Tab. Mefenamic acid	500	1500	8 hours	GI bleeding Severe heart failure Uncontrolled hypertension Allergic reaction Asthma
Opioid Analgesic Doses				
Medication	**Pain Severity**	**Dose range/ mg**	**Frequency**	**Considerations**
Codeine	Mild-Moderate	30-60, max 240mg/day	6-8 hours	Children Cardio-vascular diseases Breathing problems
Morphine	Severe	5-10	4 hours	Cardiac arrhythmias GI disturbance Hypertension

Appendix 5. Guidelines for the Pharmacological Management of Acuteand Chronic Pain in Adults:

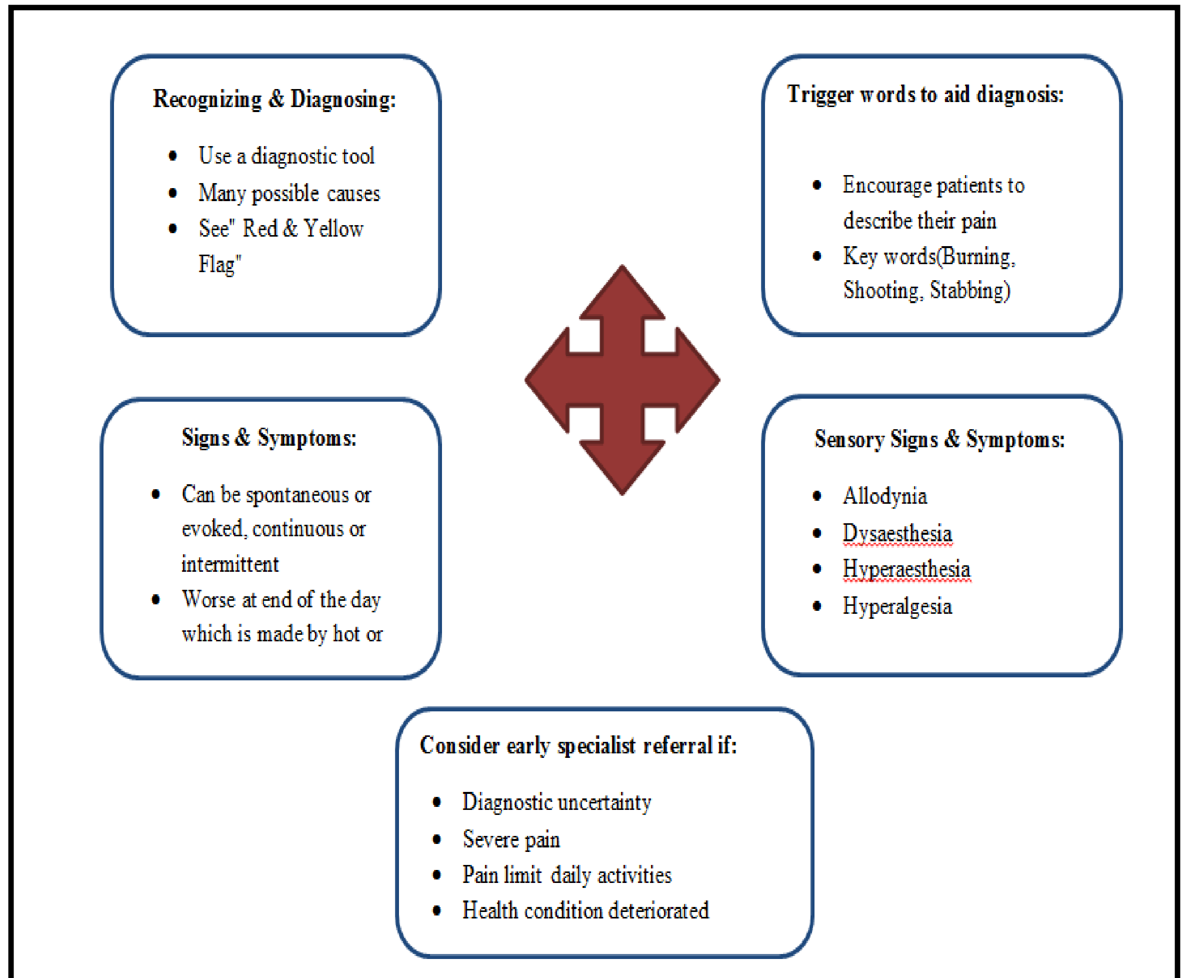
If Pain settles at any step, consider a step-wise trial of reduction of analgesia.

Check compliance every step before moving up.

Regular Paracetamol 1 g QDS throughout

1. **Assess patient using appropriate tool**
2. **Ensure patient is prescribed regular Paracetamol 1g**
3. **ADD NSAID** (Naproxen or Ibuprofen) + **PPI if necessary** (if over 45yrs old)
4. **ADD Codeine 30mg - 60mg QDS**
5. **STOP codeine / Tramadol 50mg qds**(up to 100mg qds)
6. **Re-assess patient &Consider referral to other services**
7. **STOP tramadol; ADD Morphine SR**
8. **Refer to pain management specialist**

Appendix 6. Neuropathic Pain Management



Appendix 7. Non-Opioid & Opioid Analgesic Doses

WHO Pain Ladder						
Mild pain:			Non-opioid	+	Optional adjuvant	If pain persists or increases, go to step 2.
Moderate pain:	Weak opioid	+	Non-opioid	+	Optional adjuvant	If pain persists or increases, go to step 3.
Severe pain:	Strong opioid	+	Non-opioid	+	Optional adjuvant	Freedom from pain.

Appendix 8. Audit Tool

S.N.	Audit Process	Description of Criteria	Yes	Partial	No	N/A	Comments
1	Observation Interview Document review	Does the institution have a policy about Pain Management and Access Controls to Narcotic Medications?					
2	Observation Interview	Is the Health care provider aware about the pain management policy, and management?					
3	Observation Interview	Is the Health care provider knowledgeable about the preferred pain management therapies?					
4	Observation Interview	Is the health care provider aware about the route of administration and formulation available in pain management in the institution?					
5	Observation Interview	Is the staff aware about how to use the opioid analgesics safely?					
6	Observation Interview Document review	Is a proper documentation system followed for all the pain management interventions?					
7	Observation Interview Document review	Does the institution follow any pain scale method used for rating the person who may have difficulty in communicating their pain?					
8	Observation Interview Document review	Is the health care provider aware about the non-pharmacological alternatives to opioid analgesics and adjuvant medications that can be used to manage pain? *(e.g: NSAIDS / Antidepressants / local and regional anesthetics / Physical rehabilitative approaches / Physical approaches / complimentary therapies etc.)*					

Appendix 9. Document Request Form

Document Request Form			
Section A: Completed by Document Requester			
1. Requester Details			
Name	Najla Al Zadjali	Date of Request	July 2022
Institute	Al Masarra Hospital	Mobile	95885771
Department	QMPSD	Email	–
The Purpose of Request			
☐ Develop New Document	☑ Modification of Document	☐ Cancelling of Document	
2. Document Information			
Document Title	Policy and Procedure of Pain Management and Access Controls to Narcotic Medications		
Document Code	AMRH/PHARM/P&P/013/Vers.02		
Section B: Completed by Document Controller			
☑ Approved	☐ Cancelled	☐ Forward To:……………..	
Comment and Recommendation:			
Name	Kunooz Al Balushi	Date	July 2022
Signature	[signature]	Stamp	

Appendix 10. Document Validation Checklist

Document Validation Checklist

Document Title:	Policy and Procedure of Pain Management and Access Controls to Narcotic Medications	**Document Code:** AMRH/PHARM/P&P/013/Vers.02			
No	Criteria	**Meets the Criteria**			**Comments**
		Yes	**No**	**N/A**	
1.	**Approved format used**				
1.1	Clear title – Clear Applicability	✓			
1.2	Index number stated	✓			
1.3	Header/ Footer complete	✓			
1.4	Accurate page numbering	✓			
1.5	Involved departments contributed	✓			
1.6	Involved personnel signature /approval	✓			
1.7	Clear Stamp	✓			
2.	**Document Content**				
2.1	Clear purpose and scope	✓			
2.2	Clear definitions	✓			
2.3	Clear policy statements (if any)	✓			
3.	**Well defined procedures and steps**				
3.1	Procedures in orderly manner	✓			
3.2	Procedure define personnel to carry out step	✓			
3.3	Procedures define the use of relevant forms	✓			
3.4	Procedures to define flowchart	✓			
3.5	Responsibilities are clearly defined	✓			
3.6	Necessary forms and equipment are listed	✓			
3.7	Forms are numbered	✓			
3.8	References are clearly stated	✓			
4.	**General Criteria**				
4.1	Policy is adherent to MOH rules and regulations	✓			
4.2	Policy within hospital/department scope	✓			
4.3	Relevant policies are reviewed	✓			
4.4	Items numbering is well outlined	✓			
4.5	Used of approved font type and size	✓			
4.6	Language is clear, understood and well structured	✓			

Recommendations …✓…… For implementation ………. More revision ……… To be cancelled

Reviewed by: **Kunooz Al Balushi** **Reviewed by:** **Irwin S. Rio**