

Assessment of Healthcare Professionals' Skills in pain management in Meru Teaching and Referral Hospital and St Theresa Mission Hospital Kiirua, Kenya

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ABSTRACT

Keywords:

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Background: Pain is a public health problem and affects millions of people globally. According to Bisher et al (2023), analysed medical literature reveals a concerning gap of up to 30% of healthcare professionals lack training in pain assessment and management. Effective pain management is essential and possible through comprehensive pain management guidelines, trained healthcare professionals and adequate facilities. Studies suggest that health care professionals often demonstrate varying skills in pain assessment and management and consequently inadequately managed pain. Therefore, this study aimed to assess the healthcare professionals' Skill in pain management in Meru Teaching and Referral hospital and St Theresa Mission hospital Kiirua. Methods: Design was a Cross-sectional study carried out from 23rd March to 5th May, 2025). Participants included 154 Health care professionals (HCPs- 22 doctors, 33 clinical officers, 99 nurses). Tool Used was Adopted KASRP questionnaire and modified practice questions from literature review and a checklist to validate skill practice. Ethical approval from MIRERC, NACOSTI, Meru County Research office and a consent from participants were sought. Analysis was by descriptive, Chi-square, logistic regression, and multinomial logistic regression at a Significance set at $p < 0.05$. Results: $N = 135$. 17(89.5%) out of 19 questions assessing the HCPs skills in pain management were answered correctly. 129(95.6%) participants reported to often follow guidelines to effectively manage pain in their unit and 56 (41.5%) of healthcare professionals reported to use the pain assessment tool every time they meet the patients. Inferential statistics found lack of significant pairwise differences in practice by designation. Mean Differences = 0.15079, Sig. = 0.992 Mean Difference = -1.37143, Sig. = 0.444. There was a significant difference between the KASRP score, sample characteristics and the checklist results where ($p < 0.001$). 48 (100%) of the sampled patient files had a prescription of pain medication, only 11(22.9%) of the files had pain classification and only 2 (4.2%) had finding according to assessment scale documented. Conclusion: All pairwise comparisons show significance levels greater than 0.05, this means that, there are no significant differences in the mean total pain management skill score based on professional designation. With these findings, HCP have good knowledge of what to practice in pain management but the evidence of their practice was lacking through documentation. The study recommends formation of quality improvement teams to train and audit practice.

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Introduction

Globally, pain affects billions of people daily with one in every five patients experiencing pain (Anekar et al., 2024). Twenty percent of the adult population in the developed countries suffer from chronic pain while in developing countries, the prevalence ranges from 13 % to 51 % (Saxena et al., 2018). In sub-Saharan Africa, a pain prevalence of 83% was reported (Ayano et al., 2023). Untreated pain causes human suffering, prolonged hospital stays and financial strain on patients and families (Lies et al., 2020). Various studies by (Kent et al., 2017; Santos et al., 2021; Saxena et al., 2018; Vittori et al., 2023), have shown that, despite the availability of pain guidelines, pain management remains inadequate. Twenty percent of patients globally still experience undertreated pain making it imperative for healthcare professionals to possess a comprehensive pain management skills (Bisher et al., 2023). Limited staff training, insufficient knowledge on the part of nurses and physicians, unhelpful staff and patient attitudes, fear of analgesic side effects, lack of accountability, are factors responsible for inadequate pain management. More studies by (Alkhatib et al., 2020; Ayano et al., 2023; IASP, 2021; Saxena et al., 2018; Scher et al., 2018; WHO, 2020), attributed the inadequacy to healthcare professional's limited competence. In Kenya, a study done in Kericho county hospital, found 91% of clinicians to possess inadequate knowledge and negative attitudes towards pain management (Rop, 2023). Due to the complexity of pain, it is recommended to use a multimodal approach to manage pain. Effective treatment modalities for acute, chronic, centralized, or neuropathic pain are often different (Dydyk & Grandhe, 2024; Lijew et al., 2020). Optimal pain relief begins with initial pain assessment then identification and administration of analgesic agent, followed by continued prompt assessment, and non-pharmacologic interventions during the course of care to safely achieve pain intensities that allow patients to meet their functional goals with relative ease, (Hinkle & Cheever, 2022).

According to Bisher et al (2023), analysed medical literature reveals a concerning gap of up to 30% of healthcare professionals lack training in pain assessment and management. A reconnaissance survey in Meru Teaching and Referral hospital surgical ward, in the period between September and November 2023, records showed of 374 patients admitted,

the 30 randomly sampled medical files lacked documentation as evidence of pain assessment yet all the patients were on pain medication. There was also no evidence of utilizing other pain relief strategies. This raises doubts about the HCPs' capacity to effectively manage pain for patients. Therefore, this study aims to illuminate on the capacity for pain management by investigating on the skills of HCPs in the management of pain.

General objective

To assess the skills in pain management among healthcare professionals in Meru Teaching and Referral hospital and St Teresa mission hospital Kiirua

Specific objectives

To describe healthcare professionals' skills in pain management in Meru teaching and referral hospital and St Teresa mission hospital Kiirua.

Research question

How do healthcare professionals apply strategies of pain management at MeTRH and STMHK?

Methods

A cross-sectional study was carried out from March to May 2025 at two level five hospitals (Meru Teaching and referral hospital – [MeTRH] and St Theresa Mission Hospital Kiirua-[STMHK] in Meru County.

The study included full-time registered doctors, clinical officers, and nurses from two hospitals. A total sample of 140 healthcare professionals was determined using Fisher's formula (95% confidence level, population of 454. Stratified sampling method to group participants by cadre and work area. Simple random sampling was done at the unit level using a raffle system (1 = included, 0 = excluded). Eligible and willing participants signed a consent form before receiving the questionnaire. 48 patient files from A&E, OPD, surgical, and medical wards were simple randomly selected and reviewed using a standardized checklist.

The questionnaire consisted of 2 main parts: the demographic and participants' data, and participants' practices for pain management. 21 statements for the participants' perspectives on the practice of pain management were modified from "The Knowledge and Attitudes Survey Regarding

Pain (KASRP)," developed by Ferrel and McCaffery, revised in 2014, to assess their practices based on the literature review on skills in pain management. The tool's content was based on the standards of pain management such as the American Pain Society and the World Health Organization guidelines to assess their practices based on the literature review on skills in pain management. Internal consistency reliability for this tool was established ($\alpha r > 0.7$). In the study, the participants were asked to select the available pain assessment scales and how often they utilize the scale when managing patients with pain. The 15 practice statements were assessed based on the response provided by the healthcare professionals as either TRUE/FALSE AND NOT SURE and 4 statements on shared decision making required a YES and NO response. Consequently, the final questionnaire consisted of 28 items and demographic information. It was checked by a senior medical officer/physicians, senior nurses, and academicians to ensure clarity and suitability in MeTRH and STMHK healthcare system. Piloting of the questionnaire was conducted among 11 healthcare professionals: 2MOs, 3 RCOs and 7 Nurses at consolata hospital Nkubu. The questionnaire was examined for reliability, and its internal consistency was established. Data collection was done from March 2025 to May 2025. Permission to collect data was sought from the CEOs of the respective hospitals. Healthcare professionals working full time in hospitals, registered in respective professional councils, and consented to participate in the study were enrolled. The questionnaires were distributed by researcher, received by in-charges and collected weekly by researcher. Data from the filled questionnaires were checked for completeness and accuracy, Coded and entered into IBM SPSS Statistics for Windows, version 29.0. Frequencies and descriptive statistics were used to describe the sample characteristics and responses to each item of KASRP and the practice-based question. Chi square was used to determine the distribution of sample population; logistic regression was used to establish predictors of skills in pain management and multinomial logistic regression to examine the association between demographic and professional variables and level of skills in pain management. A one-way ANOVA was conducted to compare the mean Total scores on Skills in Pain management across different professional designations. A p-value

of <0.05 was considered significant for all statistical tests.

Ethical Considerations

Ethical approval for the study was obtained from MIRERC no. 050/2024, NACOSTI/P/25/415318 and Meru County research office and Permission to collect the data was obtained from institutional management office of the respective hospitals. All participants were requested to sign an informed.

Findings

The results provide an interpretation of the statistical analysis conducted on a dataset from two locations, MeTRH and STMHK. 135 out of 154 questionnaires were received giving 87.6% total response rate distributed as; doctor 18(81.8%), clinical officers 30(90.9%) and Nurses 87(85.3%) for each cadre.

The age distribution shows that the largest group was between 31 and 40 years old, representing 44.4% of the sample. Following closely are those aged 21-30 years, making up 33.3%, and individuals aged 41-50 years, accounting for 22.2%. The most frequent category is 1-5 years, encompassing 41.5% of the sample. Participants with 6-10 years of experience constitute 25.9%, while those with more than 11 years represent 22.2%. A smaller group has less than 1 year of experience (9.6%). On educational attainment, majority of participants held a Diploma (62.2%). Bachelor's degrees 17.8% of the sample, and Higher National Diplomas (17.0%). A small proportion, 3.0%, had obtained a Master's degree. Participants are distributed across various work areas. Surgical and Medical areas each account for roughly 23.0% and 22.2% of the sample, respectively. Accident & Emergency (A&E) and Outpatient Department (OPD) areas are slightly more represented, each making up 27.4% of the participants.

Finally, when asked about prior training, a significant majority of participants (58.5%) reported that they had not taken a pain management course. Only 41.5% indicated that they had taken such a course

Application of Pain Management Strategies

On the question of how do healthcare professionals apply strategies of pain management at MeTRH and STMHK? The section had 21 questions, two questions were on the pain assessment scales and

Age in years	Gender	Designation	Years of exp(YOE)	Education level	work area	Pain mx course
N=135	(f)	(f)	(f)	(f)	(f)	(f)
	(%)	(%)	(%)	(%)	(%)	(%)
21-30 45 (33.3%)	M- 71 (52.6)	Mo- 18 (13.3)	<1yr- 13 (9.6)	Dip- 84 (62.2)	Surg- 31 (23.0)	Yes-56(41.5)
31-40 60 (44.4%)	F- 64 (47.4)	Co- 30 (22.2)	1-5yrs- 56 (41.5)	Hnd- 23 (17.0)	Med- 30 (22.2)	No- 79(58.5)
40-50 30 (22.2%)		NO- 87 (64.4)	6-10yrs 35 (25.9)	Bsc- 24 (17.8)	A&E- 37 (27.4)	
			>11yrs- 30 (22.0)	Msc- 4 (3.0)	OPD- 37 (27.4)	

Table 1: Demographic and Professional Characteristics of the Sample

19 which concentrated on HCPs practice divided into clinical skills and collaborative skills.

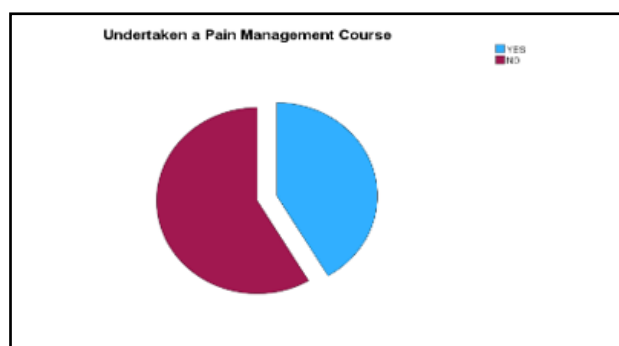


Figure 1: Pie chart on pain management course attendance

Tools as Coded	YES	NO
NRS	116(85.9%)	17(12.6%)
VAS	67(49.6%)	66(48.9%)
FPS	62(45.9%)	71(52.6%)
McGILL	10(7.4%)	123(91.1%)
PAINAD	11(8.1%)	122(90.4%)
PACSLAC	1(0.7%)	131(97.0%)

Table 2: Frequency table on available pain measurement scales

Available pain assessment scales

The Numeric Rating Scale (NRS) was available to majority (85.9%), while the Pain Assessment in Advanced Dementia Scale (PAINAD) was available to only 8.1% of participants. The Pain Assessment Checklist for seniors with Limited Ability to Communicate (PACSLAC) had the lowest reported encounter at 0.7%.

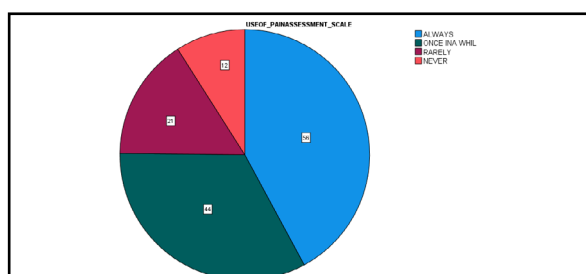


Figure 2: Pie chart on use of pain assessment scale utilization

Utilization of pain assessment scale

Overall, 56(41.5%) of respondents reported always using a pain assessment scale as seen in the pie chart, 79 (58.5%) utilized it sometime or never utilized.

Chi square results

Fifty-six of participants reported to always use a pain scale, forty-four use once in a while twelve HCPs have never used a pain scale. Clinical officer uses it more than doctors and nurses.

The cross tabulations examine the relationship between 'Designation' and various pain assessment practices and communication items. For many pain scales (NRS, VAS, FPS, PAINAD, PACSLAC), there was no statistically significant association with designation based on the Pearson Chi-Square test ($p > .05$). However, the relationship between designation and the use of the McGill pain scale was highly statistically significant (Pearson Chi-Square $p < .001$), suggesting its use varies significantly by designation as doctors reported to use it than the other two cadres.

Total Score On Skills in Pain Management

New variables were computed to represent different aspects of pain management skill. The Total score in skills in pain management is computed by summing up the recoded variables. The clinical skill and collaborative skill. The clinical skill score was a sum of fifteen recorded variables, primarily related to knowledge of clinical practices about pain management. Collaborative score was a sum of four variables about participation in multidisciplinary team.

Frequency Analysis

The total number of responses was 135. Other responses had 132 valid cases (2.2% missing), where hcp identify patient as key person had only 124 re-

			ALWAYS	ONCE INA WHILE	RARELY	NEVER	Total
DESIGNATION	Count		5	9	4	0	18
	DOCTOR	% within DESIGNATION	27.8%	50.0%	22.2%	0.0%	100.0%
	Count		16	10	2	2	30
	CLINICAL OFFICER	% within DESIGNATION	53.3%	33.3%	6.7%	6.7%	100.0%
	Count		35	25	15	10	85
NURSE	% within DESIGNATION		41.2%	29.4%	17.6%	11.8%	100.0%
	Count		56	44	21	12	133
Total	% within DESIGNATION		42.1%	33.1%	15.8%	9.0%	100.0%

Table 3: Cross tabulation to describe designation versus use of pain scale

Item description N=135	True(2) Freq (%)	False(0) Freq (%)	Not sure(1) Freq (%)
Clinical skill			
You always consider pain treatment modalities to be often different T)	130(96.3%)	2(1.5%)	3(2.2%)
You often follow pain guidelines for prescription and administration. (T).	129(95.6%)	2(1.5%)	
You understand that, the term 'equianalgesia' means approximately equal analgesia and always use it (T)	118(87.9%)	10(7.4%)	5(3.7%)
You frequently determine pain treatment methods specific according to the patient's pain intensity. (T)	122(90.4%)	9(6.7%)	3(1.5%)
You use Pain management index (PMI) as a tool that correlates an individual patient's pain intensity to the appropriateness of the prescribed analgesics. (T)	105(77.8%)	16(11.9%)	12(8.9%)
You always consider that opioids can be more or less addictive in a short time. (T)	96(71.1%)	29(21.5%)	8(5.9%)
You often consider that elderly patients cannot tolerate opioids for pain relief.(F)	44(32.6%)	78(57.8%)	11(8.1%)
You prefer to give narcotics on a regular schedule than 'p.r.n." schedule for continuous pain. (T)	81(60.0%)	43(31.9%)	9(6.7%)
You often consider the time to peak effect for morphine given IV to be 15 min when prescribing and administering medication.(T)	95(70.4%)	30(22.2%)	8(5.9)
You always combine analgesics that work by different mechanisms for better control(T).	109(80.7%)	18(13.3%)	6(4.4%)
You ensure that stable analgesics blood levels are maintained through around-the-clock dosing(T).	101(74.8%)	22(16.3%)	10(7.4%)
In your practice, you adjust subsequent opioid doses according to the individual patient's response. (T)	116(85.9%)	8(5.9%)	9(6.7%)
You consider anti-convulsant drugs such as gabapentin (Neurontin) to produce optimal pain relief after a single dose. (T)	46(34.1%)	72(53.3%)	15(11.1%)
Benzodiazepines are not effective pain relievers unless the pain is due to muscle spasm.(F)	73(54.1%)	52(38.5%)	8(5.9%)
You use distraction, for example, use of music or relaxation, to alter the perception of pain. (T)	116(85.9%)	6(4.4%)	11(8.1%)
Collaborative skill	Yes (1)	No(0)	Not Sure(1)
In your unit, Nurses, clinical officers and the doctors all know what has been explained to a patient about his/her condition or treatment of pain. (Y)	100(74.1%)	28(20.7%)	5(3.7%)
In your unit, Nurses, clinical officers and the doctors share information to verify the effect of pain management.(Y)	103(76.3%)	23(17.0%)	7(5.2%)
In your unit, Nurses, clinical officers and the doctors have the same understanding of the future direction of the patient's pain management.(Y)	83(61.5%)	43(31.9%)	7(5.2%)
In your unit, Nurses, clinical officers and the doctors identify the patient as the key person in pain management.(Y)	90(66.7%)	34(25.2%)	9(6.7%)

Table 4: Frequency of Individual response for assessing skills in pain management

Source: Researcher (2025)

sponses (8.1% missing). The missing values were treated as system-defined missing.

These frequencies indicate varying levels of endorsement or demonstrated skill/knowledge across the specific items. Some areas, like applying different treatments, following guidelines, using combined analgesics, stable analgesics, subsequent opioids, and distraction, show high frequencies in the '2.00' category (potentially indicating higher proficiency or agreement). 79(58.8%) disagreed elderly patients being able to tolerate pain', while 72(53.3%) also disagree with use of anticonvulsants, and benzo-diazepines in pain treatment. However most 116 (85.9%) will consider distraction as a method of pain management

One-Way ANOVA

A one-way ANOVA was conducted to compare the mean total scores on skills in pain management across different professional designations. The Designation has three categories: Doctor, Clinical officer, and nurse. The F-test ANOVA table presented the Sum of Squares between Groups is 39.123 with 2 degrees of freedom (df). The Sum of Squares within Groups (Residual) is 2790.468 with 117 df. The Mean Square between Groups was 19.562, and the Mean Square within Groups was 23.850. The F-statistic was calculated as the ratio of the mean squares, resulting in $F = 0.820$. The significance level for this F-statistic is 0.443 was greater than the conventional alpha level of 0.05. This indicated that there was no statistically significant difference in the mean total score on skill in pain management among the different designation groups (doctor, clinical officer, and nurse).

Mean differences in skills between designation

Post hoc tests using Tukey's HSD (honestly significant difference) were used to explore pairwise differences if the overall ANOVA was significant. Since the overall ANOVA was not significant ($p = 0.443$). The sample sizes for each group (Clinical officer $n=25$, nurse $n=77$, doctor $n=18$) and their respective means (28.2000, 29.5714, 29.7222). The post hoc test results confirmed the lack of significant pairwise differences. Doctor vs clinical officer: mean difference = 1.52222, sig. = 0.573, doctor vs nurse: mean difference = 0.15079, sig. = 0.992 and clinical officer vs nurse: mean difference = -1.37143, sig. = 0.444.

all pairwise comparisons show significance levels greater than 0.05, supporting the conclusion from the ANOVA that there are no significant differences in the mean total pain management skill score based on professional designation

Results from the Observation Checklist to Validate Pain Management Practice

48 files of patients were audited using a checklist with 10 checkpoints. 24 files were studied from each facility from the four units under the study setting as shown above.

All (100%) of the files had patient's identification details and diagnosis well documented and all the patients of the sampled files had a prescription of pain medication. Only 11(22.9%) of the files had pain classification and only 2 (4.2%) had finding according to assessment scale documented. The observation checklist result showed that HCPs in the two hospitals are well versed with theory but no evidence of their exact practice.

However, more detailed pain documentation was often missing, and the pain assessment tools were not available. Differences exist between the two data settings (MeTRH and STMHK) for specific pain documentation practices like indicating pain classification, writing assessment time, and documenting communication about pain. Despite these individual differences related to data setting, the overall average documentation score does not significantly differ across the various hospital units.

Discussion

The sample was predominantly within the 31-40 age range, with 1-5 years of professional experience, holding Diplomas, and working across Surgical, Medical, A&E, and OPD areas. A majority (58.5%) of participants had not undertaken a pain management course.

Pain assessment scales is an objective way to measure and manage pain effectively. The study found that the Numeric Rating Scale (NRS) was commonly used by majority (85.9%) of healthcare, this agrees with several studies (Bakir et al., 2023; Cooney & Quinlan-Colwell, 2020; Saleh, 2023). The studies found NRS to be the most common assessment scale used in pain management by all cadres of healthcare professionals, this could be attributed to its simplicity and easy-to-use. However, the findings

	Hospital	Surgical unit	Medical unit	Accident & emergency	Outpatient	Totals
Data setting	MeTRH	7	5	5	7	24
	STMHK	4	9	4	7	24
Totals		11	14	9	14	48

Table 7: Cross tabulation of frequencies for the source of data

Item being checked	Yes (1)	No(0)
Patient's identification details were written.	48(100%)	0(0%)
Patients' diagnosis was clearly documented.	48(100%)	0(0%)
Patient prescription had pain medication.	48(100%)	0(0%)
Pain classification was well indicated.	11(22.9%)	37.(977.1%)
Time of pain assessment was written.	5(10.4%)	43(89.6%)
Pain assessment tool used to assess pain was written.	1(2.1%)	47(97.9%)
Pain assessment findings according to scale were documented.	2(4.2%)	46(95.8%)
Communication about patients' pain among HCPs	23(52.1%)	25(47.9%)
Nursing care plan has a pain diagnosis.	7(14.6%)	41(85.4%)
Available pain assessment scale in each unit N= 8	0	8(100%)

Table 8: observation checklist result

that qualify the availability of this tool at both hospitals were not elicited. Pain Assessment in Advanced Dementia Scale (PAINAD) was available to only 8.1% of participants. Majority of whom were doctors or have more years of experience, same to the Pain Assessment Checklist for seniors with Limited Ability to Communicate (PACSLAC) had the lowest reported encounter at 0.7%.

This study also found that, majority 77(57%) of HCPs did not use the assessment scales once in a while or never in their practice, agreeing with several studies (Awe & Owoyemi, 2024; Santos et al., 2021; Thapa et al., 2022). This could be attributed to the unavailability of pain assessment scales. A study in Nepal on Assessment of the practice of 332 healthcare professionals on pain management revealed that only 96 (29%) of them used the pain assessment tool every time during their consultation. Since the scales were reported to be available and HCPs knowledge about them, their disuse could be attributed to other factors rather than skills and practice or perhaps the scales were unavailable based on the checklist findings.

The healthcare professional's skills were assessed by qualifying the statement on what they do rather

than observing their actions. The total score skill in pain management was computed by summing up several recoded variables that represent different components related to pain management practices. The two sub-scores: clinical skills and collaborative skills in pain management were established. Because, the study was to assess the skills, these steps used indicated an intention to analyze not just an overall skill score but also potentially distinct domains of clinical skills and collaborative practice. Majority of questions on clinical skills were answered correctly, giving an impression of good practice in pain management, however, inferential statistics to compare and correlate the answers on skills to characteristics showed contrary results. This finding agrees with several studies (Awe & Owoyemi, 2024; McCabe et al., 2023; Santos et al., 2021; Scher et al., 2018) that found healthcare professionals to effectively manage pain. ANOVA showed no differences in the mean total pain management skill score based on professional designation hence no difference in skills application across all cadres under study.

Collaborative decision making involves multidisciplinary teams working together towards the same goal. In this context it involved different cadres working together and making decisions that will

benefit the patient as regards pain management. The findings showed that less than half of the participant shared information about the patient, their pain and pain management plan. The results indicated that, only few of only a few of the nurses, clinical officers and the doctors all knew what was explained to a patient about his/her condition or treatment of pain, less than a third of the participants shared information to verify the effect of pain management, they had the same understanding of the future direction of the patient's pain management and identified the patient as the key person in pain management. Half of the participants who attended pain management course could participants in multi-disciplinary decision making, this concurred with a study in Canada to assess the role of different cadres and found that, different health care professionals play a variety of important roles in MPTF in Canada. However, less than 20% are involved on a full-time basis and the extent to which pain is assessed and treated in a truly multidisciplinary manner was questionable (Peng et al., 2018; Penlington et al., 2024). The study also found that, less than 50% of the nurses and the physicians had a mutual understanding of the reasons for the change of pain management, they checked with each other concerning whether a patient has any signs of side effects or complications on pain management, shared information about a patient's reaction to explanations of his/her disease status and treatment methods, and that they had the same understanding of the patient's wish for cure and care. This finding are contrary to the standard by pain association that effective pain management requires multi-disciplinary team (International Association for the study of pain (IASP), 2021).

The data suggests that basic patient identification, diagnosis, and medication documentation are consistently performed however, there was insufficient documentation of pain assessments. Study consistently showed low adoption of standardized pain assessment tools and poor communication of pain scores in patient files reports, which negatively impacts patient care by leading to prolonged pain and delayed recovery. Since more than half of participants had not attended a pain management course, it may be linked to inadequate training and lack of formal organizational support to provide assessment tools.

Conclusions

The HCPs at MeTRH and STMHK are well versed with clinical skills for effective pain management. They purport to apply strategies of pain management by following guidelines, utilize pain assessment scales, however there were variations in actual practice with missing evidence of collaboration and communication. This study highlights the need of improvement in skills in pain management among healthcare professionals at MeTRH and STMHK. To improve these skills, continuous professional development, enhanced organizational support for pain management initiatives, and stronger institutional guidelines are crucial. Formation of quality improvement teams within each hospital will help with audits and reduce pain documentation gaps.

Recommendation

The researcher recommends the MeTRH and STMHK administration to form quality improvement teams that will audit and organize continuous medical education with regards to pain management and emphasize on documentation

Disclosure

The author reports no conflicts of interest in this work. This is my original work and has never been published.

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