

# **Assessing pain in children**

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# ABCs of Pain Management

Recommended by the Agency for Health Care Policy and Research (AHCPR), USA

- A - Ask** about pain regularly. **Assess** pain systematically.
- B - Believe** the patient and family in their reports of pain and what relieves it.
- C - Choose** pain control options appropriate for the patient, family, and setting.
- D - Deliver** interventions in a timely, logical, coordinated fashion.
- E - Empower** patients and their families. **Enable** patients to control their course to the greatest extent possible.

# Assessing pain

## **QUESTT** (*Wong et al, 1999*)

- **Q**uestion the child
- **U**se a pain rating scale
- **E**valuate the behaviour and physiological changes
- **S**ecure parents involvement
- **T**ake cause of pain into account
- **T**ake action and evaluate results

# Question the child

- Use their language (sore, ouch, hurt)
- Be developmentally appropriate
- Consider using dolls/toys as a medium
- Consider other issues
- Non-verbal children are very vulnerable to having their pain under estimated

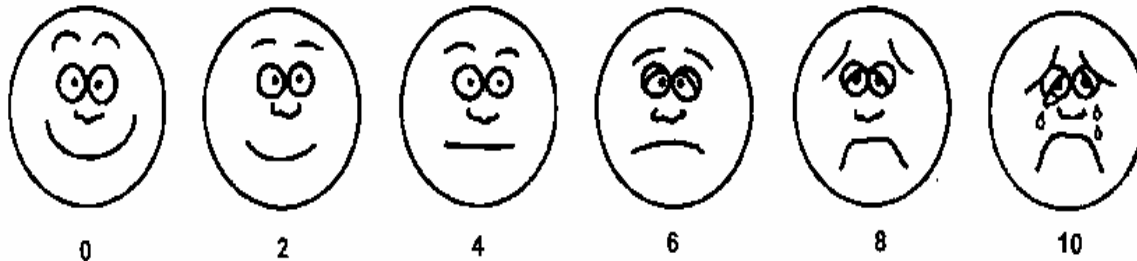
# Pain rating scales

- Faces
- Numeric
- Behavioural
- Behavioural/physiological

# Faces scale

Used at  
RCH

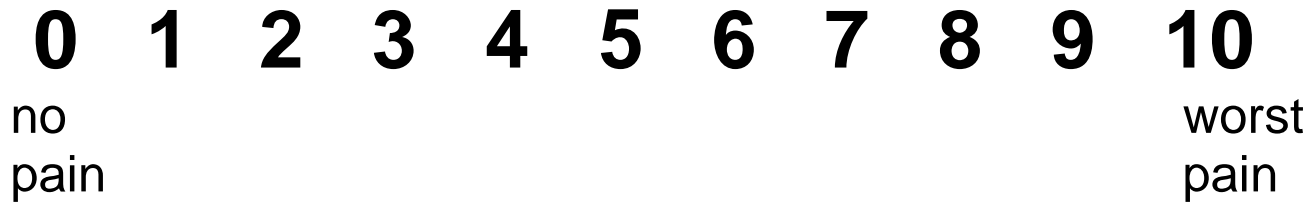
## Wong-Baker FACES Pain Rating Scale



# Numeric rating scale



## Numeric Rating Scale



**Used at  
RCH**

# Behavioural scale

## FLACC SCALE ©University of Michigan Health System

<b>Face</b>	0 No particular expression or smile	1 Occasional grimace or frown, withdrawn, disinterested	2 Frequent to constant frown, clenched jaw, quivering chin
<b>Legs</b>	0 Normal position or relaxed	1 Uneasy, restless, tense	2 Kicking, or legs drawn up
<b>Activity</b>	0 Lying quietly, normal position, moves easily	1 Squirming, shifting back and forth, tense	2 Arched, rigid, or jerking
<b>Cry</b>	0 No cry (awake or asleep)	1 Moans or whimpers, occasional complaints	2 Crying steadily, screams or sobs, frequent complaints
<b>Consolability</b>	0 Content, relaxed	1 Reassured by occasional touching, hugging or "talking to". Distractable	2 Difficult to console or comfort



**Used at  
RCH**

## PAT tool

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### Neonatal **P**ain **A**ssessment **T**ool

- Specifically developed for post-operative pain but useful for other pain
- 10 variables to maximum of 20 points
  - Physical parameters
  - Physiological parameters
  - Nurses perception

# Evaluate the behaviour and physiological changes

- Age related behavioural changes
- Physiological changes
  - altered observations (HR RR BP etc)
  - posture/tone
  - sleep pattern
  - skin colour / sweating

*These are **not** good indicators to use in isolation. They may vary enormously and can be due to fear, anger, anxiety, sepsis, hypovolaemia etc*

# Take action/evaluate results

- Administer analgesia
- Utilise other comfort measures
- Review within short period, i.e. at expected peak effect of drug
- Don't assume the analgesia has worked
- Take action if analgesia ineffective
- Document findings clearly for others

# Assessing pain in non-verbal disabled children

- no speech
- limited or absent communication
- may have cognitive impairment
- altered body movement
- other pre-existing conditions
- ask carers opinion\*\*\*

# Common problems for disabled children

- spasm / spasticity
- positioning issues
- pressure areas
- bowels
- reflux / gastritis
- surgical complications / late diagnosis
- fear / anxiety / sadness
- environment

# Optimising analgesia

- Administer analgesia
- Utilise other comfort measures
- Review within short period, eg at expected peak effect of drug
- Don't assume the analgesia has worked
- Take action if analgesia ineffective
- Document findings clearly for others

# Pain: the 5th Vital Sign at RCH

- Pain is important and should be documented
- Choose the appropriate tool
- Document on observation chart
- Consider when and how often you should assess pain

# Observation Chart

GIVEN NAME(S)

DATE OF BIRTH

AFFIX PATIENT LABEL HERE

## Legend:

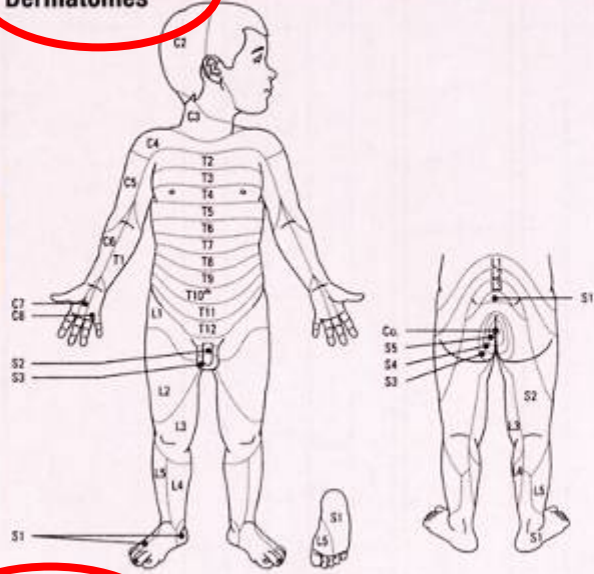
Pressure Area Care	
S=Sitting	PR=Prone
A=Ambulating	SUP=Supine
L=Left side	R=Right

## University of Michigan Sedation Score (UMSS)

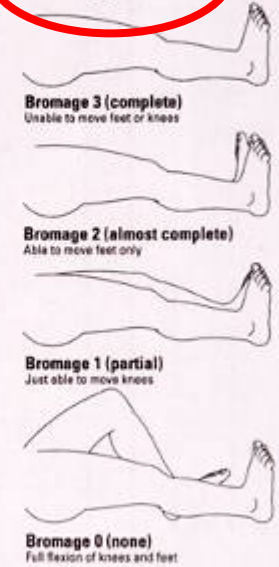
Please complete sedation checklist MR36S for procedural sedation

0=Awake and alert
1=Minimally sedated: may appear tired/sleepy, responds to verbal conversation and/or sound
2=Moderately sedated: somnolent/sleeping, easily aroused with tactile stimulation or simple verbal command
3=Deep sedation: deep sleep, arousable only with deep or significant physical stimulation
4=Unarousable
S=Patient is sleeping

## Dermatomes



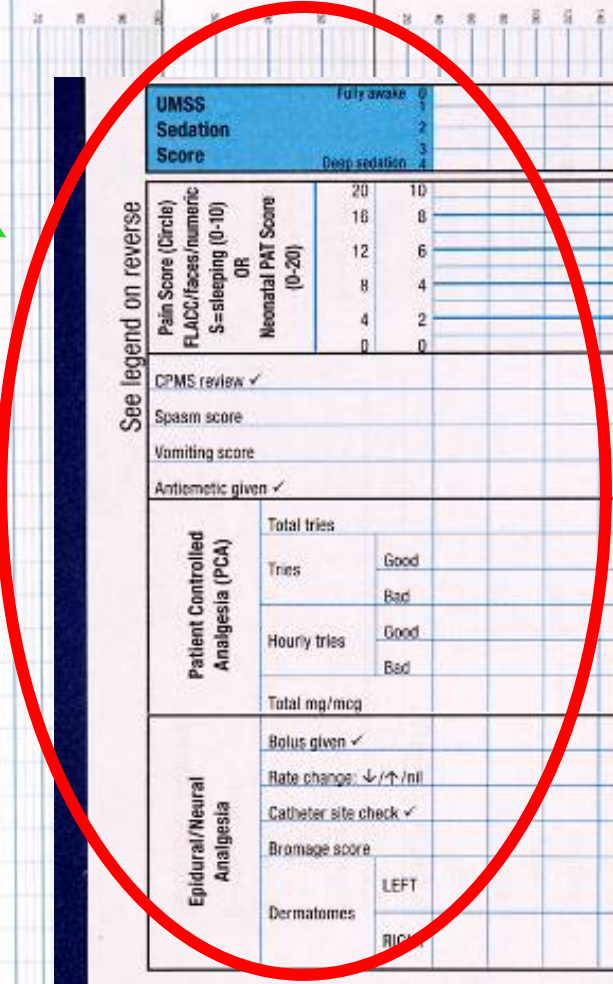
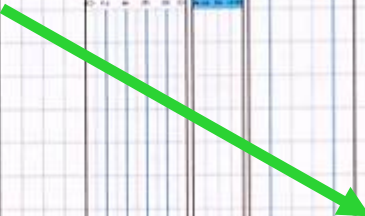
## Bromage Score



Spasm Score
0=nil
1=Present (not causing discomfort/pain)
2=Present (causing discomfort/pain)

Vomiting Score
0=nil
1=Nausea
2=Vomiting in last hour

Epidural/Neural Analgesia		Patient Controlled Analgesia (PCA)		Pain Score (Circle) FLACC/faces/numeric S=sleeping (0-10) OR Neonatal PAIN Score (0-20)		SaO2(%)		Blood Pressure (X=MAP) > X <		Respiratory Rate		Pulse Rate		Temperature <small>Indicate method if not tempax</small>	
Epidural/Neural Catheter site check Bromage score Dermatomes LEFT RIGHT	Bolus given Rate change Catheter site check Bromage score Dermatomes LEFT RIGHT	Total tries Tries: Good, Bad Hourly tries: Good, Bad Total mg/mcg	CPMS review Spasm score Vomiting score Antiemetic given	Pain Score (Circle) FLACC/faces/numeric S=sleeping (0-10) OR Neonatal PAIN Score (0-20)	20 18 16 14 12 10 8 6 4 2 0	10 8 6 4 2 0	100 90 80 70 60 50 40 30 20 10 0	180 160 140 120 100 80 60 40 20 0	220 200 180 160 140 120 100 80 60 40 20 0	40 38 36 34 32 30 28 26 24 22 20 18 16 14 12 10 8 6 4 2 0	40 38 36 34 32 30 28 26 24 22 20 18 16 14 12 10 8 6 4 2 0	40 38 36 34 32 30 28 26 24 22 20 18 16 14 12 10 8 6 4 2 0	40 38 36 34 32 30 28 26 24 22 20 18 16 14 12 10 8 6 4 2 0	40 38 36 34 32 30 28 26 24 22 20 18 16 14 12 10 8 6 4 2 0	



See legend on reverse

See legend on reverse

UMSS Sedation Score  
 Fully awake 0  
 1  
 2  
 3  
 4  
 Deep sedation

Pain Score (Circle)  
 FLACC/faces/numeric  
 S=sleeping (0-10)  
 OR  
 Neonatal PAIN Score (0-20)

CPMS review  
 Spasm score  
 Vomiting score  
 Antiemetic given

Patient Controlled Analgesia (PCA)  
 Total tries  
 Tries: Good, Bad  
 Hourly tries: Good, Bad  
 Total mg/mcg


Epidural/Neural Analgesia  
 Bolus given  
 Rate change: ↓/↑/nil  
 Catheter site check  
 Bromage score  
 Dermatomes: LEFT, RIGHT

# The 5<sup>th</sup> vital sign



# Almost finally...

Pain control must be based on scientific fact, not on personal beliefs or opinions.

A decorative graphic on the left side of the slide, consisting of a light green vertical bar and a dark blue horizontal bar with rounded ends.

Optimal pain management is  
the right of **all** patients and  
the responsibility of  
**all** health professionals.