Assessing pain in children

Children’s Pain Management Service
Royal Children’s Hospital
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

**QUESTTT** *(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

Wong-Baker FACES Pain Rating Scale

0 2 4 6 8 10
How to assess pain using-

Wong-Baker Faces Pain Rating Scale

Explain to the child that each face is for a person who feels happy because they have no pain (hurt) or sad because they have some or a lot of pain.

- **Face 0** is very happy because he doesn't hurt at all
- **Face 2** hurts just a little bit.
- **Face 4** hurts a little more.
- **Face 6** hurts even more.
- **Face 8** hurts a lot.
- **Face 10** hurts as much as you can imagine, although you don't have to be crying to feel this bad.

Ask the child to choose the face that best describes how he is feeling.

This rating scale is recommended for people age 3 years and older.
Numeric rating scale

**Numeric Rating Scale**

0  1  2  3  4  5  6  7  8  9  10
no  pain  worst  pain

Used at RCH
**Behavioural scale**

<table>
<thead>
<tr>
<th>FLACC SCALE ©University of Michigan Health System</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Face</strong></td>
</tr>
<tr>
<td>No particular expression or smile</td>
</tr>
<tr>
<td><strong>Legs</strong></td>
</tr>
<tr>
<td>Normal position or relaxed</td>
</tr>
<tr>
<td><strong>Activity</strong></td>
</tr>
<tr>
<td>Lying quietly, normal position, moves easily</td>
</tr>
<tr>
<td><strong>Cry</strong></td>
</tr>
<tr>
<td>No cry (awake or asleep)</td>
</tr>
<tr>
<td><strong>Consolability</strong></td>
</tr>
<tr>
<td>Content, relaxed</td>
</tr>
</tbody>
</table>
How to assess pain using FLACC

Face
Score 0 point if patient has a relaxed face, eye contact and interest in surroundings
Score 1 point if patient has a worried look to face, with eyebrows lowered, eyes
Partially closed, cheeks raised, mouth pursed
Score 2 points if patient has deep furrows in the forehead, with closed eyes, open
mouth and deep lines around nose/lips

Legs
Score 0 points if patient has usual tone and motion to limbs (legs and arms)
Score 1 point if patient has increase tone, rigidity, tense, intermittent
flexion/extension of limbs
Score 2 points if patient has hyper tonicity, legs pulled tight, exaggerated
flexion/extension of limbs, tremors

Activity
Score 0 points if patient moves easily and freely, normal activity/restrictions
Score 1 point if patient shifts positions, hesitant to move, guarding, tense torso,
pressure on body part
Score 2 points if patient is in fixed position, rocking, side-to-side head movement,
rubbing body part

Cry
Score 0 points if patient has no cry/moan awake or asleep
Score 1 point if patient has occasional moans, cries, whimpers, sighs
Score 2 points if patient has frequent/continuous moans, cries, grunts

Consolability
Score 0 points if patient is calm and does not require consoling
Score 1 point if patient responds to comfort by touch or talk in ½- 1 minute
Score 2 points if patient requires constant comforting or unable to console

Children's Pain Management Service, RCH, Melbourne
PAT tool

Neonatal Pain Assessment Tool

• Specifically developed for post-operative pain but useful for other pain

• 10 variables to maximum of 20 points
  • Physical parameters
  • Physiological parameters
  • Nurses perception

Used at RCH
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***

Children's Pain Management Service, RCH, Melbourne
Common problems for disabled children

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

**Legend:**

<table>
<thead>
<tr>
<th>Pressure Area Care</th>
<th>Dermatomes</th>
<th>Bromage Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>S= Sitting PR= Prone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A= Ambulating SUP= Supine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L= Left side R= Right</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**University of Michigan Sedation Score (UMSS):**

Please complete sedation checklist UMSS for procedural sedation.

**Pressure Area Care:**

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

**Spasm Score:**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Nil</td>
</tr>
<tr>
<td>1</td>
<td>Present (not causing discomfort/pain)</td>
</tr>
<tr>
<td>2</td>
<td>Present (causing discomfort/pain)</td>
</tr>
</tbody>
</table>

**Vomiting Score:**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Nil</td>
</tr>
<tr>
<td>1</td>
<td>Nausea</td>
</tr>
<tr>
<td>2</td>
<td>Vomiting in last hour</td>
</tr>
<tr>
<td>Pain Score (Circle)</td>
<td>Blood Pressure (X = MAP)</td>
</tr>
<tr>
<td>--------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>FLACC/linear</td>
<td>S x sleeping (0-10)</td>
</tr>
<tr>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Sedation Score**
- Fully awake: 3
- Deep sedation: 4

**PMR Review**
- Spasm score
- Vomiting score

**Patient Controlled Analgesia (PCA)**
- Total mg/kg
- Bolus given
- Rate change: ↓ / ↑ / rel
- Catheter site check
- Drainage score
- Dermatomes:
  - LEFT
  - RIGHT
Pain control must be based on scientific fact, not on personal beliefs or opinions.
Optimal pain management is the right of all patients and the responsibility of all health professionals.