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

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

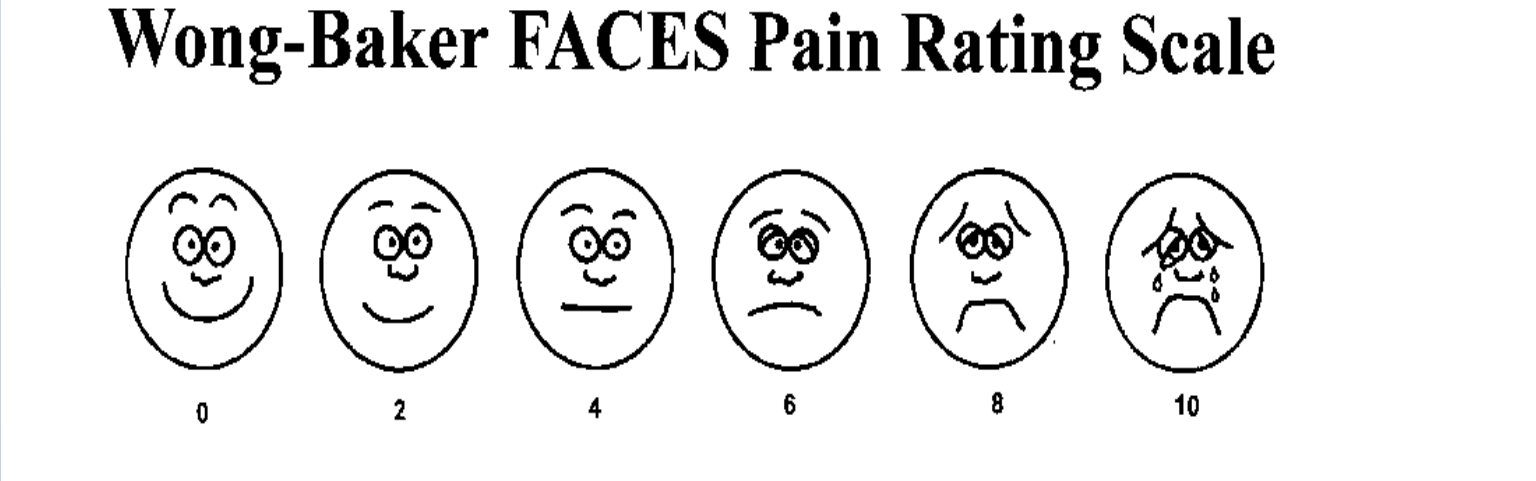
- Use their language (sore, ouch, hurt)
- Be developmentally appropriate
- Consider using dolls/toys as a medium
- Consider other issues
- Non-verbal children are very vulnerable to having their pain under estimated

Pain rating scales

- Faces
- Numeric
- Behavioural
- Behavioural/physiological

Faces scale

Used at RCH



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 has 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

Used at RCH

Numeric Rating Scale

0 1 2 3 4 5 6 7 8 9 10

no pain — worst pain

Behavioural scale

FLACC SCALE **©University of Michigan Health System**

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Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin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

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
- **L**egs
- 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
- **A**ctivity
- 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
- **C**ry
- 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
- **C**onsolability
- 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

PAT tool

Used at RCH

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

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

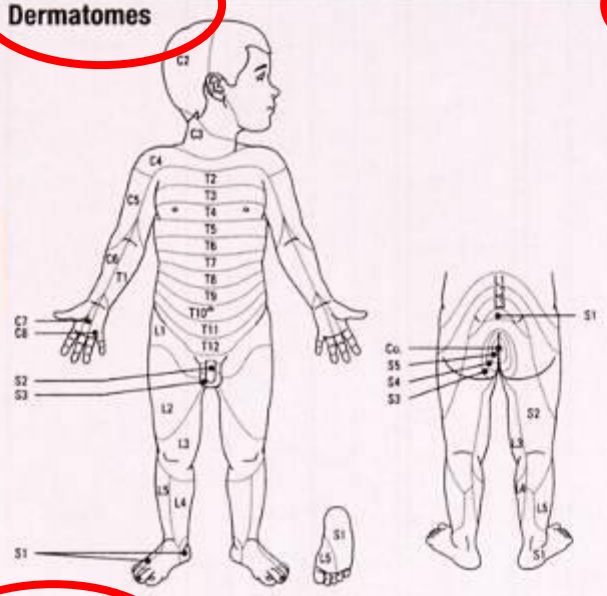
AFFIX PATIENT LABEL HERE

Legend:

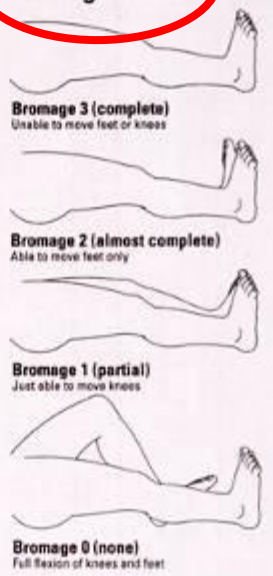
Pressure Area Care	
S=Sitting	PR=Prone
A=Ambulating	SUP=Supine
L=Left side	R=Right

University of Michigan Sedation Score (UMSS) Please complete sedation checklist MR56S 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 comand
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

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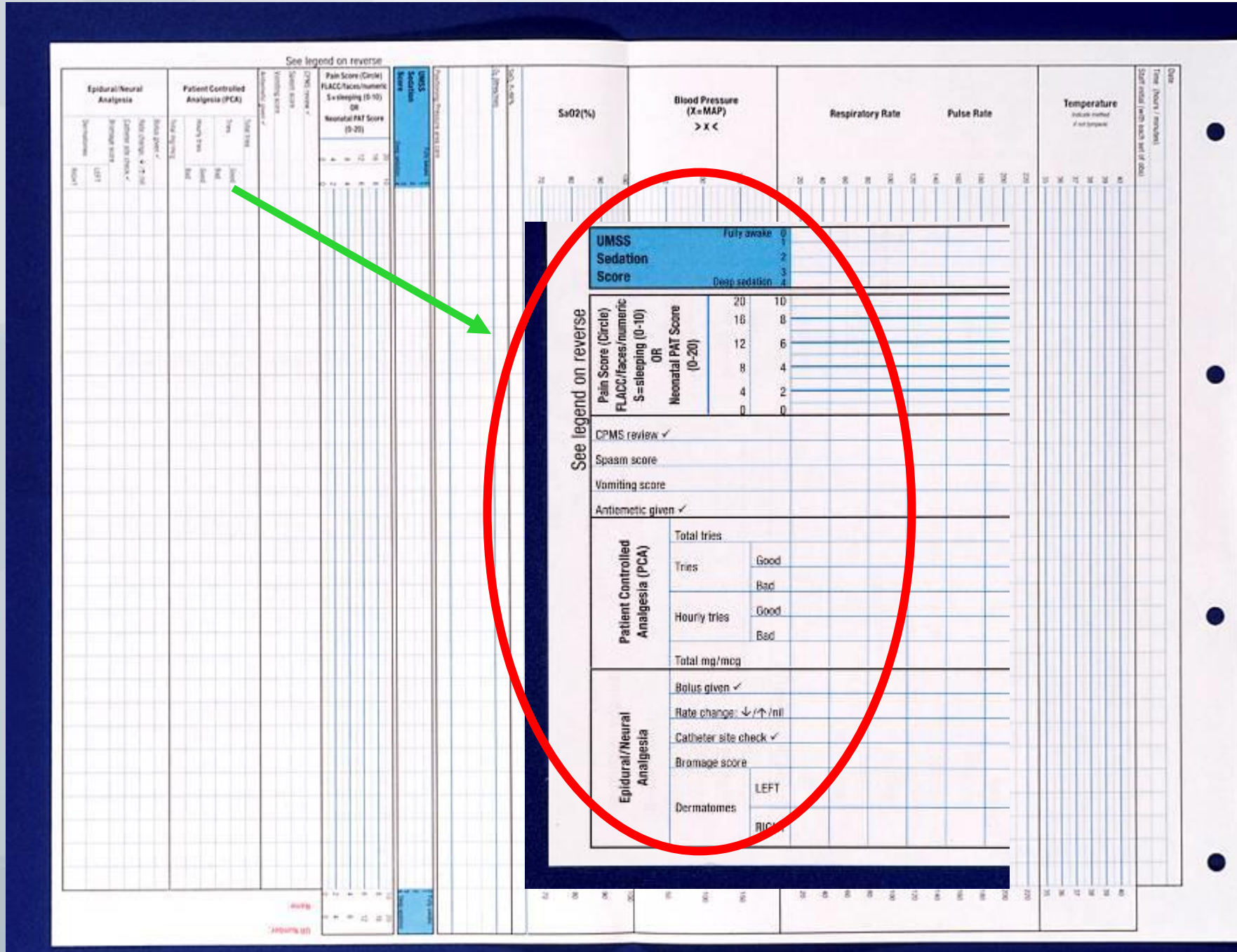
See legend on reverse
Epidural/Neural Analgesia
Patient Controlled Analgesia (PCA)
Pain Score (Circle) FLACC/faces/numeric S=sleeping (0-10) OR Neonatal PAT Score (0-20)
UMSS Sedation Score
SaO2(%)
Blood Pressure (X=MAP)
Respiratory Rate
Pulse Rate
Temperature
Date
Time (hours / minutes)
UMSS Sedation Score
Fully awake 0 1 2 3 Deep sedation 4
Pain Score (Circle) FLACC/faces/numeric S=sleeping (0-10) OR Neonatal PAT Score (0-20)
20 16 12 8 4 0
10 8 6 4 2 0
See legend on reverse
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

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.