Northwestern Medicine

PROCEDURE

Title: **Assessment and Management of Pediatric Pain**	Page **1 of 7**	Procedure # CDH/DEL D 15 Version: **X.0**
Department: **NM CDH and NM Delnor Pediatrics**	Revision of:	Effective Date: 04/07/2020
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(Can be adapted to include other sections as appropriate for procedure content)

SCOPE: Applies to entities indicated below as well as their subsidiaries and affiliates

☐ **NM – Northwestern Memorial Hospital**	☐ **NM – Lake Forest Hospital**
☐ **NM – Northwestern Medical Group**	☒ **NM – Central DuPage Hospital**
☐ **NM – Regional Medical Group**	☒ **NM – Delnor Hospital**
☐ **NM – Kishwaukee Hospital**	☐ **NM – Valley West Hospital**
☐ **NM – Marianjoy Rehabilitation**	☐ **NM – Centegra Physician Care**
☐ **NM – Marianjoy Medical Group**	
☐ **NM – Huntley /** ☐ **NM – McHenry /** ☐ **NM – Woodstock Hospitals**	
☐ **NM – Other **See "Scope / Areas / Persons Affected" section below****	

I. PURPOSE:

To provide guidelines for the assessment and management of pain in pediatric patients, and for the evaluation of the therapeutic interventions that are employed in the management of patients in pain.

II. SCOPE / AREAS / PERSONS AFFECTED:

Pediatric patients at NM Central DuPage Hospital and NM Delnor Hospital

III. INDICATIONS FOR USE: n/a

IV. EQUIPMENT : n/a

V. GENERAL INFORMATION / SPECIAL INSTRUCTIONS:

A. Definitions:

1. **Pain**: An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. Whatever the experiencing person says it is, existing whenever and wherever they say it does.
2. **Pasero Opioid Sedation Scale** (POSS): Scale used to assess level of sedation related to administration of opioids. Nursing assessment and corresponding interventions are included based on the level of sedation to guide the nurse to provide safe analgesic care.
3. **Patient Comfort Function-Activity Goal** (CFG): Describes the patient's numeric pain goal or activity goal for the shift. Pain relieving interventions should provide sufficient comfort to allow the patient to participate in the identified activities or support progress

towards numeric goal. Activity examples include: up in halls, up to bathroom, up to playroom, repositioning, up to chair, sitting at edge of bed, and cough/deep breathing exercises.

B. All patients, regardless of age, developmental level, cognitive level or diagnosis will be assessed for pain on admission and presentation to the ED or clinic (clinic specific).

C. Pain management requires an individualized and developmentally appropriate approach utilizing pharmacologic and non-pharmacologic regimens.

D. The patient and family are integral to the development of a pain management plan. Past experiences of pain and current pain management expectations must be explored.

E. Evaluate each patient for the presence of a Comfort Plan. Explore opportunities to establish or revise the Comfort Plan. Ensure necessary Comfort Plan alerts (EMR and CDH inpatient room signage) is present.

F. The patient, family and healthcare team identify an acceptable intensity of pain (comfort function goal) that allows the child to participate in routine activities.

G. The patient and family will:
   1. Be informed of their right to receive effective pain management
   2. Understand pain and pain prevention measures
   3. Participate in development a pain management plan
   4. Indicate the presence and intensity of pain
   5. Have the pain reassessed following pain-related intervention
   6. Indicate satisfaction with pain relief in accordance with comfort function goal

H. The CDH Interprofessional Pediatric Pain Committee is responsible for monitoring and recommending effective patient/family centered pediatric pain care delivery throughout the hospital and pediatric subspecialty clinics.

VI. PROCEDURE - ASSESSMENT:

A. Pain assessment includes: intensity rating utilizing the appropriate age related or cognitive scale, location, quality, satisfaction as reported by the patient and/or parent. A more comprehensive assessment may be necessary on admission and as needed, should include: pain type, onset, duration, clinical progression, frequency, and effect on daily activities.
   1. Question the child and parents.
      a. Ask the toddler and preschool patient if they “hurt” or have an “owie” and ask them to point or tell you where it hurts.
      b. Ask the school age and adolescent patient if they have pain. If they report pain ask about additional pain descriptors including: location, onset (“when did the pain start?”), progression (“what makes the pain worse and what makes the pain better?”), quality (“are there words to describe your pain?”), and effect on daily activities (“does the pain stop you from doing things you normally do?”).
      c. Ask the patient/parent if they are satisfied with the current level of pain.

   2. Assist the patient/parent in determining an appropriate CFG.

3. Assess behavior and physiologic responses to pain.

4. Use appropriate pain rating tools.
   a. Pain can be assessed using self-report, behavioral observation, or physiologic measures, depending on the age of the child and his or her cognitive abilities.
   b. Self-report is the most reliable indicator of pain.
   c. Nurses and providers are encouraged to utilize consistent appropriate methods of assessment (i.e. inconsistent methods: FACES utilized on day shift and r-FLACC utilized on evening shift). Consistent means of assessment allows for trends over time.
   d. The patient and/or caregiver should be taught how to use the pain scale using visual and verbal instruction (utilize translated materials as appropriate).
   e. Assessing the patient while sleeping: if utilizing self-report scales-document sleeping; if utilizing observational scales-document pain score.
   f. Pediatric patients will be assessed for pain using the following scales (Appendix A):
      i. N-PASS: infants less than 3 months of age
      ii. R-FLACC: infants greater than 3 months to 3 years, those with cognitive impairment, those older children unable to use a self-report scale due to clinical condition.
      iii. Faces: age 3 and older
      iv. Visual or verbal analogue scale: age 8 and older. Note the child must demonstrate an understanding of more/less-addition/subtraction to cognitively understand the use of this scale. If the school-age or adolescent prefers or is having difficulty using the visual or verbal analogue scale the Faces scale may be used.

5. Assess pain minimally every four hours and prior to and within 60 minutes of pain-related intervention (consider intervention specific peak time of effectiveness, i.e. 30 minute reassessment following IV intervention)

6. Patients are at risk for opioid-induced respiratory depression. Therefore, sedation assessment, using the POSS, must be performed prior to opioid administration and as part of pain reassessment.

VII. PROCEDURE – MANAGEMENT:

A. Assessment data is used to develop an individualized plan to manage the patient's pain.

B. Utilize the patient CFG and patient/parent level of satisfaction as a guide in developing the pain management plan for the shift.

C. Consideration is given to all patients, and family's preference when determining pain management therapeutic treatment modalities.

D. Take cause of pain into account (i.e. nociceptive, neuropathic, and procedural) when selecting interventions.

E. Provide patient and/or family education specific to appropriate pain management strategies.

F. Patients receiving neuromuscular blocking agents still experience pain, sensation, apprehension and anxiety. Sedatives and analgesics should be administered with a paralyzing agent.

G. Placebos are not used without the patient's informed consent.

H. Incorporate patient specific Comfort Plan components into pre-procedural planning and procedural support.

I. Pharmacologic and/or non-pharmacologic pain interventions are used prior to procedures including, but not limited to: phlebotomy, IV insertion, lumbar puncture, and bone marrow aspiration.

J. It is within the scope of professional nursing practice to determine a safe and effective intervention based on the current provider orders. The patient's pain intensity rating/score is only one component of the nurse's decision-making process. Other important considerations include opioid tolerance, previous response, age, organ function, comorbidities, and use of other sedating agents.

K. Provide/offer appropriate multi-modal pain relief measures in response to the patient's pain,
   1. Utilize non-pharmacologic interventions for all levels of pain
      a. Encourage patient and/or family participation in non-pharmacologic interventions.
      b. Physical massage, positioning, application of heat or cold, swaddling, immobilization, therapeutic exercises, oral sucrose, reduction of stimuli (noise control, dim lights, group care to decrease number of interactions)
      c. Cognitive/Behavioral
         i. Reassurance, information giving, offer choices/control
         ii. Relaxation: Deep breathing, mindful meditation
         iii. Distraction: CDH Pediatric Comfort Cart, art, play, role play, modeling, child life activities and music.
         iv. Guided imagery
         v. Pet therapy
      d. Child Life Specialist: consultation to assist with coping strategies and/or diversional activities.
      e. Psychological Evaluation: to assess if patient is a candidate for psychological interventions and/or possible self-regulatory strategies.

   2. Utilize, a multi-step approach to treating pain, such as the World Health Organization (WHO) analgesic ladder, as a guide for initiating analgesic drugs and dosages that correspond to the patients reported level of pain.
      a. Select progressively stronger analgesics based on the child's pain level (mild [1-3], moderate [4-6] and severe [7-10])
      b. Recommended doses for analgesics are based on the clinical condition of the patient in conjunction with established guidelines.
      c. Patients who require opioid analgesics benefit from continued doses of acetaminophen or NSAID's as appropriate.
      d. Analgesics should be administered on a regular schedule based on drug duration and severity of pain rather than on an as needed basis

e. Scheduled administration provides consistent pain relief whereas intermittent dosing requires the patient first experience pain before drug administration. Anticipate higher doses of analgesics required to provide relief to a patient with existing or breakthrough pain
f. Consider as needed dosing if pain reports are intermittent and unpredictable
g. Oral and intravenous (IV) administration of analgesics are the preferred routes
h. Patient will be transitioned to oral administration as soon as they can tolerate oral intake
i. Intramuscular injections should be avoided unless absolutely necessary. All patients receiving IV opioids must receive minimal pulse oximetry monitoring as follows:
    i. IV prn doses: continuous monitoring for 24 hours and if no signs of respiratory distress and no evidence of dose escalation, may discontinue monitoring. Reinitiate monitoring in response to changes in patient condition.
    ii. Administration via a PCA or continuous infusion: continuous monitoring.

L. Notify the provider to discuss alternative therapies if the goal is consistently not achieved.

M. If pain management interventions are not effective, the nurse or healthcare team member pursues other available options:

1. Notify, the provider, a unit-based Pain Resource Nurse, Pharmacist or Child Life Specialist to serve as a resource for pain management intervention/options.
2. In conjunction with the care team, consider pain physician consultation, as appropriate
3. Arrange for an interprofessional health team conference, as appropriate

VIII. DOCUMENTATION:

A. Routine pain assessment and reassessment post intervention
    1. Pain scale/score
    2. Patient or parent satisfaction with pain
    3. Comfort Function Goal: Minimally document once a shift
    4. If pain present
        a. Pain location: Document unable to determine as appropriate
        b. Pain quality: Document unable to describe as appropriate
        c. Pain interventions as offered/provided
        d. Sedation scale assessment pre- and post-opioid intervention.

B. In the ambulatory setting if the patient reports pain that is unrelated to the current illness or clinic visit, a treatment plan should be documented during the visit (i.e. referral to primary care physician or another specialty physician).

IX. REFERENCES / RELATED DOCUMENTS:

NM CDH/DEL PEDS D 15: Assessment and Management of Pediatric Pain, Appendix A: Pain Scales - FORM
https://nm.ellucid.com/documents/view/3417

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Zernikow, B., Smale, H., Michael, E., Hasan, C., & Jorch, N. (2006). Pediatric cancer pain management using the WHO analgesic ladder. *European Journal of Pain, 10*, 7, 587-595.

NM CDH/DEL PCS: Adult Pain Management - POLICY
https://nm.ellucid.com/documents/view/2288

NM CDH/DELPCS: Patient Controlled Analgesia - POLICY
https://nm.ellucid.com/documents/view/359

X. APPROVALS:

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