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Pain Assessment and Management

Policy

Boston Children's has defined criteria to screen, assess, and reassess pain that are consistent with the patient's age, condition, and ability to understand.

Screen

Clinicians develop a pain treatment plan based on evidence-based practices and the patient's clinical condition, past medical history, and pain management goals.

Assess

Inpatient

Identify and document pain intensity using the standardized pain assessment tools appropriate to the age, medical condition and level of cognitive development of the child in conjunction with the child's self-report, family member's and health professional's assessment of pain:

- On admission
- Before and after analgesic administration
- pre and post procedure where analgesia is used as pre-medication
- At a minimum of every shift
 - For patients at risk for moderate-severe pain, a minimum of every 4 hours

When there is a discrepancy between self-reported pain and clinician observations of pain, further evaluation is needed to understand the source of this discrepancy:

- For example, a patient may report a low pain score but appears to be in a lot of pain or a patient may report a high pain score but is able to move well. In these cases, the nurse may assess pain through clinician observation.
- For patients with a primary pain disorder, (such as migraines, functional abdominal pain, complex regional pain syndrome (CRPS)) that is confirmed by team impression and a prescriber order, assess pain through clinician observation rather than self-report.

The clinical team involves patients in the pain management treatment planning process through the following:

- Developing realistic expectations and measurable goals that are understood by the patient for the degree, duration, and reduction of pain
- Discussing the objectives used to evaluate treatment progress (for example, relief of pain and improved physical and psychosocial function)

- Providing education on pain management, treatment options, and safe use of opioid and non-opioid medications when prescribed

Ambulatory

Patients seen in recurrent outpatient care settings (primary care clinics, infusion centers) shall receive a screen conducted on establishment of care to identify the presence pain. If the screen is positive, then the patient shall receive an assessment to gather sufficient information to identify the pain using the standardized pain assessment tools appropriate to the age, medical condition and level of cognitive development of the child in conjunction with the child’s self-report, family member’s and health professional’s assessment of pain.

For specialty clinics no routine screening or assessment is required unless the patient indicates a pain issue or the patient is being seen for that purpose (chief complaint or reason for seeking care).

Medication Administration

When orders are written to give pain medications for anticipatory, mild/ moderate or moderate/severe pain the following order clarification will apply unless otherwise delineated by the prescriber. See exceptions above for use of clinical observation.

Name of Pain assessment tool	Anticipatory/Mild/Moderate	Moderate/Severe
FLACC	0-6	4-10
Faces	0-6	4-10
NRS/ INRS	0-6	4-10
PIPP	0-12	12-21

Administration of an analgesic medication to pre-treat for anticipated pain prior to a painful event or activity is consistent with an order for an analgesic for PRN Pain: Anticip/Mild/Mod (Score 0 – 6) or Pain: Anticip/Mild/Mod (PIPP Score 0-12). Administering an analgesic in the context of a pain score of 0 should be reserved for anticipatory pain.

- Anticipatory pain (Score = 0) is determined by the clinician’s reasonable expectation that an impending procedure or activity will result in pain. Examples include but are not limited to physical therapy, exercise, painful procedures (e.g. chest tube removal, line placement), and/or dressing changes.
- Administration of an Anticip/Mild/Mod PRN medication can also be used in the post procedural period of a patient’s care for the purpose of maintaining adequate pain relief.

If pain score ranges overlap orders for opioid and non-opioid medication, administer non-opioid first and assess response. Contact the prescriber if exceptions need to be made. If appropriate, the prescriber will modify the order.

When orders are written to give pain medication and orders for that condition exist with multiple routes of administration, administer enteral/non-parenteral doses by default first if patient is awake, tolerating other enteral medications, and is not on a structured protocol. Use of the parenteral doses should be reserved for when the patient does not meet these criteria. Non-opioid medications are considered before

opioid medications where appropriate. Consider all doses that have been administered, regardless of route, when determining the next due dose.

Reassess

The clinical team reassesses and responds to the patient's pain through the following:

- Evaluation and documentation of response(s) to pain intervention(s)
- Progress toward pain management goals including functional ability (for example, ability to take a deep breath, turn in bed, walk with improved pain control)
- Side effects of treatment
- Risk factors for adverse events caused by the treatment

Monitor

Use cardio-respiratory and oxygen saturation monitoring for:

- Patients on epidural analgesia (with or without opioids).
- Full term infants 0 to 3 months on opioids via any route (PO, IV, etc.).
- Full term infants 0 to 6 months on IV opioids.
- Former premature infants with a post-conceptual age less than 60 weeks on any opioids (PO, IV, etc).
- Patients on opioids-scheduled or PRN for less than 72 hours (opioid naïve) with continuous opioid infusions.
- Any patient with increased risk of respiratory depression. See list below for more conditions that increase risk. For more information on respiratory depression see Critical Alert below.

Note: Exception to monitoring requirement: *Cardio-respiratory monitoring may be discontinued intermittently while patient is awake and alert and when a responsible adult is present.*

Notify the appropriate clinician if the patient's pain is NOT consistent with illness or surgery or if pain is significant and unrelenting. See the Safe and Effective Pain Management reference tool and algorithm for more information.

Educate

The clinical team educates the patient and family on discharge plans related to pain management including the following:

- Pain management plan of care
- Side effects of pain management treatment
- Activities of daily living, including the home environment, that might exacerbate pain or reduce effectiveness of the pain management plan of care, as well as strategies to address these issues
- Pain medications prescribed upon discharge: usage, dosage, potential side effects, safe handling and disposal of medication.

Purpose

To decrease pain as much as possible while ensuring patient safety.

Critical Alerts

Pain NOT Consistent with Illness or Surgery

Unexpected intense pain, particularly if sudden or associated with altered vital signs such as respiratory distress, hypotension, tachycardia or fever must be evaluated by the primary service and new diagnoses such as wound dehiscence, bladder distension, ileus, compartment syndrome, tight cast or dressing, bleeding or infection should be considered. The first priority in caring for a patient with significant pain not consistent with illness or surgery is to stabilize and treat the primary cause of the pain especially if associated with altered vital signs. For additional information, refer to the following pain reference tool and algorithm: [Safe and Effective Pain Management](#).

Respiratory Depression

The least common, but most serious, side effect of opioids is respiratory depression. Monitoring of the patient's responsiveness can alert the clinician to early signs of problems. For patients with significant cognitive/developmental impairment, refer to the Nursing Inpatient Assessment History for the patient's cognitive/developmental baseline.

Increased Risk of Respiratory Depression

Selected patients with increased risk of respiratory depression may require cardio-respiratory monitoring. This includes but is not limited to the following conditions:

- Compromised airway
- Significant kidney and/or liver disease
- History of respiratory depression with opioid use
- Large opioid doses for patient's weight and/or condition
- Neurological impairment
- Opioid naïve (use of opioids-scheduled or PRN for less than 72 hours) and concurrent use of other medication capable of central nervous system depression (e.g. benzodiazepines)
- Significant lung disease in patients who are not receiving assisted ventilation
- Somnolence
- Morbid obesity
- Muscle weakness

Responsiveness Assessment (modified Ramsay)

- Awake and alert
- Easily aroused but drowsy
- Drowsy, opens eyes when name is called several times
- Hard to arouse needing tactile stimulus
- Only responds to pain
- No response

Emergency Response

Opioid related respiratory depression and serious complications requiring ventilatory support are treated by emergency response (anesthesia STAT or Code Blue), and with Naloxone (Narcan) as needed. For detailed information about Naloxone (Narcan) refer to:

- Boston Children's Hospital Formulary: Narcan
- Emergency equipment (at bedside):

- ❖ oxygen
- ❖ ambu bag
- ❖ proper size mask for patient
- ❖ suction equipment
- Naloxone (Narcan) stocked in Pyxis and in code trays

Placebos

Placebos (i.e. saline injections for analgesia) are NOT administered as a method for assessment or treatment of pain except with informed consent or in clinical trials. A placebo is defined as any medication or procedure that produces an effect in a patient because of its implicit or explicit intent and not because of its specific physical or chemical properties. Placebo use deprives the patient of appropriate treatment or diagnostic measures.

Procedure

Resources

- Pain Treatment Service (page # 7246 [PAIN])
- Patient's Pain History and an Initial Pain Assessment
- Laminated Pain Assessment tools
(Non-English versions of the Wong-Baker FACES tool are available from the Family Education Home Care Instructions area in the e-library)
- Pain Management Modules [NetLearning]
- Order sets for specific medications
- Coping Kit (located in unit treatment rooms)
- Child Life Specialist
- Pain Management Website
- Needle Pain Management (inpatient)
- Needle Pain Management for Non-Inpatient Areas

Planning

Administer therapeutic interventions per level of patient's pain and as condition warrants. Interventions may include:

- Patient and/or parent/caregiver teaching:
- Administering analgesics as ordered;
- Engaging Child Life therapists as appropriate;
- Behavioral distraction techniques; and/or
- Other pharmacologic and non-pharmacologic interventions, including needle pain interventions per the needle pain protocol, (inpatient and non-inpatient)

Assessment

1. Obtain a **Pain History** on admission.
 - In the **Ambulatory setting**, ask the patient if they are having any pain.
2. Select a pain assessment tool based on the developmental level, medical condition, patient's language preference, past experience, and patient and family choice of tool. Use a self-report tool whenever possible. Instruct patient and family on its use.

- For non-verbal patients, Use the INRS to capture the patient’s typical pain behaviors as described by the parent/guardian.
3. Assess patient receiving opioids or other sedating medications for respiratory depression and responsiveness.
 - When you obtain vital signs; and
 - Before and after administering sedating medications. Refer to the Formulary and the Patient Care Manual: Patient Controlled (PCA)/Nurse Controlled (NCA) Analgesia or Epidural Analgesia.
 4. For need pain management, consider interventions such as analgesics, topical local anesthetics, sucrose. Refer to the Needle Pain Management (inpatient) and Needle Pain Management for Non-Inpatient Areas for more information.
 5. Reassess pain and document if interventions performed do not produce the intended effect.
 6. Manage side effects of opioids.
 7. Refer to the Safe and Effective Pain Management reference tool and algorithm to communicate inadequate pain relief, change in vital signs from patient’s baseline and uncontrolled side effects to the appropriate team members.

Assessment of a Sleeping Patient

In the case of the sleeping patient, the frequency of pain assessment is based upon:

- Patient’s medical condition
- Past reports of pain
- Analgesics orders
- Consult with the family whenever possible

Pain cannot be assessed when the patient is asleep. By definition pain is awareness of an unpleasant sensory experience at the cortex level (i.e. consciousness). Therefore, when the patient is asleep, pain intensity cannot be documented, rather document observations of the patient such as vital signs. It is not always necessary to wake the sleeping patient for a pain assessment.

Evaluation

Evaluate effectiveness of the procedure and patient outcomes.

Documentation

Complete patient care documentation as described in the Patient Care Manual. In addition, document specific Pain Assessment and Management information as follows:

Pain History and Initial Assessment Form	Obtain a pain history for every patient from the patient and/or family/caregivers upon admission and an Initial Pain Assessment when clinically indicated.
Patient Care Flow Sheet/ Electronic Documentation	Document the selected pain tool or by clinician observation for patients with a primary pain disorder (chronic pain) Record the pain assessment a minimum of once per shift for all patients. Record the Responsiveness Assessment as indicated. Record all changes in pain management plan, and communication of unexpected outcomes (unsatisfactory pain relief, significant side effects, dose changes, etc.) along with response to changes.

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Document Attributes

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