Advocate Health Care	**Title: ACH Pediatric Pain Management**
	☒ Policy ☐ Procedure ☐ Guideline ☐ Other:
	Scope: ☐ System ☒ Site: ACH Department: Pediatric

I. PURPOSE

The purpose of this policy is to set the standard of care for pain management in pediatrics and to provide professional staff with a guide to assist in the recognition, assessment, and treatment of children experiencing pain.

II. POLICY

Patients will receive prompt assessment, treatment, evaluation and re-evaluation of their pain. Advocate Children's Hospital will monitor the quality of the pain management program through the performance improvement department, using ongoing data collection, aggregation, and analysis. Patient assessments, reassessments, interventions, and responses to interventions will be documented.

The physician, nurse, and other healthcare professionals (e.g. Child Life therapists, pharmacists, respiratory care practitioners, and physical therapists) will collaborate to manage pain in the child.

III. DEFINITIONS/ABBREVIATIONS

Pain – May be defined as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage." Pain is always subjective.

Acute Pain – Follows injury to the body and generally disappears when the bodily injury heals.

Chronic Pain - Persists beyond the expected healing time and often cannot be described to the effects of a specific injury.

Cancer Pain – May be acute, chronic, or intermittent, and it often has a definable etiology, usually related to tumor recurrence or treatment.

Opioids – Refers to codeine, morphine, and other natural semisynthetic and synthetic drugs that relieve pain by binding to multiple types of opioids receptors in the nervous system. This term is referred to as "narcotic."

Adjuvant Drug – Drugs with other specific indications that have been found to be effective analgesics for selected types of pain.

IV. PROCEDURE

A. Assessment of Pain

1. Patients, upon arrival, will be assessed by a registered nurse (RN) for the presence, absence or history of pain, pain's effect on ADLS and pain goal if applicable.

2. The admission assessment will include: The use of a developmentally appropriate pain measurement scale, which should be used consistently by all health care professionals caring for the child to document intensity of pain.

   a. Numeric Rating Scale (NRS)

      i. Use for children greater than or equal 5 years old who can self-report. 0-10 scale whereas 0 = no pain and 10 = worst pain ever.

   b. NPASS (Neonatal, Pain, Agitation, and Sedation Scale)

      i. Use for Neonates, birth to 28 days. Five category scale which accounts for prematurity. A lower number represents less pain and/or increased sedation. A higher number represents increased pain and less sedation.

      ii. NPASS should be used for an entire SCN & ICN admission.

   c. FLACC (Face, Legs, Activity, Cry, Consolability)

      i. Use for infants, toddlers, children with developmental delay, or any child who is unable to use a self-report scale (NRS or Bieri Faces). A higher score indicates a higher intensity of pain.

   d. Bieri Faces Pain Scale

      i. Use for children ≥ 3 years old if they are able to self-report. The numeric value of the chosen face indicates the patient's pain intensity with a higher score indicating a higher intensity of pain.

e. Location of pain
f. Onset and Duration of pain
g. Description of Pain
h. Alleviating and aggravating factors
i. Past interventions and responses
j. Effects of pain on activities of daily living (ADL's)
k. Function, sleep, appetite, relationships with others, emotions, concentration, etc.
l. Patient's pain goal and goals related to function IF the patient is able to verbally communicate said goal.
m. Physical exam/observation of site of pain.
n. Pain assessments will be primarily based on self-report; however, consideration should be given to reports from family, patient behavior, and pathology associated with the condition or disease.

3. Ongoing Assessments

a. Pain intensity and will be reassessed at a minimum of once every 4 hours and with each new report of pain. Pain location will be documented with each report of a new pain location.

b. The following assessments will be reported to the primary physician/Advance Practice Clinician:

- The presence of pain reported by the patient as greater than 5 on a scale of 0 to 10, two consecutive times over a 24-hour period.
- The patient is not satisfied with pain management.
- The patient is experiencing excessive side effects.

c. Sedation scores should be documented, along with pain scores, prior to administration using the Opioid Sedation Score Scale on the computer flow sheet. For patients using a PCA, epidural analgesia, or any continuous narcotic infusion, sedation scores will be documented every 4 hours. Sedation scores that are consistently a level 2 or higher must be reported to the physician caring for the patient.

d. Patients are not to be awakened for pain assessments unless requested by the patient, family or physician. Coordinate pain assessments and interventions with other care whenever possible.

e. If patient is sleeping, document Unable to Assess on flow sheet and add a comment, "patient is sleeping."

B. Interventions

1. Interventions should be considered when

   a. The verbal or behavioral pain scale is greater than the patient's comfort goal.
   b. An increase in activity is anticipated.
   c. Treatments that may exacerbate pain are anticipated (i.e. procedures, dressing changes etc.).
   d. A child is unable to sleep for 2 hours at a time.
   e. A child is unable to take deep breaths.
   f. A child is unable to perform ADL's.
   g. A child is experiencing unacceptable side effects.

2. Chose a therapeutic intervention based on the initial pain assessment and discussion with the patient and family, as available. Therapeutic interventions may include:

   - Child-parent teaching
   - Distraction/relaxation techniques
   - Milieu management
   - Analgesics
   - Procedural Sedation
   - Child Life referrals
   - PT/OT referrals
   - Pain Service referral
   - Palliative Care Service referral when applicable

3. Pharmacological Management

   a. ACH recommends following the World Health Organization's Analgesic Ladder as follows. Refer to Pediatric Analgesic and Sedation Dosing Guidelines

      Step 1 Mild Pain: Acetaminophen and/or Ibuprofen
      Step 2 Moderate to Severe Pain: Opioid as clinically appropriate
      Subjective pain score should not be the sole determination of medications or interventions provided for pain relief. Other objective findings should include but not limited to:
         - Affect
         - Heart Rate
         - Respiratory Rate

      Body positioning

   b. Administration routes

- Utilize the oral route of administration whenever possible.
- Utilize the IV route as the parenteral route of choice.
- Intramuscular injections (IMs) are strongly discouraged, will be avoided and will only be used in extraordinary circumstances (if no other route is available.). IMs are painful, and create fear and anxiety in children, which may result in avoidance of pain medication.

c. Use equianalgesic dose when converting from parenteral to oral.

d. When appropriate, provide analgesics on an around-the-clock basis, with doses as needed for break-through pain. Monitor level of sedation and report a sedation score of 3 or more; do not administer an opioid without notifying the physician.

e. PRN dosing is appropriate for:

- Intermittent pain (including break-through or activity related pain)
- Pain that is escalating or decreasing rapidly
- Initiating opioid analgesic therapy in patients with moderate or severe pain.

f. Monitor for and minimize drug-induced adverse effects

g. Patient Controlled Analgesia (PCA) and Epidural Analgesia (PCEA) should be considered for appropriate patients. The following are indications for these:

- Patients requiring opioids for greater than 24 hours
- Postoperative pain control
- Patients with moderate-severe pain unrelieved with IV analgesia.
- Refer to: Epidural Analgesia (Adult, Non-OB and Pediatrics), Pediatric Patient Controlled Analgesia (PCA) and Authorized Agent-Controlled Analgesia policies

h. Placebos should not be administered for the assessment or treatment of pain without informed consent of the patient.

i. A pulse oximeter will be used for children less than 6 months of age receiving IV opioids. A pulse oximeter may be used for older children as well, per physician order. Capnography is also available for high risk patients receiving opioids at physician discretion (OSA, obesity)

4. Non-Pharmacological Management

a. Most pain can be treated with a combination of pharmacological and non-pharmacological approaches. For mild to moderate pain, non-pharmacological techniques alone may provide sufficient relief. Select the non-pharmacological technique based on developmental age of the child; effectiveness of prior use; pain and anxiety level or the patient and family; and ability of the patient and family to follow instructions. The family can encourage and help facilitate effective use of these strategies:

- Education
- Distraction
- Art therapy • Play therapy
- Psychotherapy (Cognitive Behavioral Therapy)
- Low stimulus environment
- Hot and/or cold packs
- Relaxation and controlled breathing exercises
- Guided imagery and visualization
- Exercise, rest, and immobilization
- Transcutaneous Electrical Nerve Stimulation (TENS)
- Physical therapy
- Acupuncture
- Massage

b. For infants: pacifiers, swaddling, holding, rocking, minimizing stimulation and gentile tactile stimulation

5. Specialized Services

a. A pain service consultation is required when:

- An epidural is ordered for a patient

b. A pain service consultation is required when:
    - A Parent/Guardian Driven Authorized Agent Controlled Analgesia (AACA) is requested
    - Patients on a sedation wean on the general pediatric floor
    - Exemption: patients being care for by the Palliative Care Team

c. A pain service consultation is required when:
    - A Narcan® infusion is ordered for reducing or eliminating opioid induced side effects
    - Entrance into either the opioid tolerant or palliative libraries on PCA
    - A RN Driven Authorized Agent Controlled Analgesia is being requested
    - Ketamine infusions when utilized for pain management, please refer to Subanesthetic Ketamine for Pediatric Pain Management Policy
    - When patient is discharged from the PICU with any of the following: Narcan® infusion, Ketamine infusion, PCA, and/or methadone/Ativan wean either Pediatric Pain Service or Palliative Care Service will be notified as appropriate by PICU attending physician
    - Exemption: patients residing in the PICU and/or patients being care for by the Palliative Care Team

d. A pain service consultation is encouraged when:

    - Pain remains uncontrolled (greater than 5) despite interventions.
    - Assistance is needed for equianalgesic conversion from one opioid to another or change in route of administration.
    - Frequent dosing (Q 2 hour) of opioid pain medications

C. Patient and/or Family Education

1. Patients and families are provided with education and instruction regarding:

    - The nature of pain
    - Their role in pain control
    - Informing staff when experiencing pain and to quantify pain intensity on the NRS when possible.

2. Communicating to clinicians when an acceptable and unacceptable level of pain relief exists.

3. Inclusion of families and significant others in the education process is encouraged:

   - Incorporate rehearsal into the education process
   - Parent training

V. CROSS REFERENCE

Not Applicable

VI. REFERENCES

Refer to Lippincott for procedures:
Lippincott - Pain assessment-pediatric

American Pain Society Task Force on Pain in Children (2000). The Assessment and Management of Acute Pain in Infants, Children, and Adolescents.

Drendel, A.L., Kelly, B.T., & Ali, S. (2011). Pain assessment for children overcoming challenges and optimizing care. *Pediatric Emergency Care*, 27(8), 773-781.

Howard, R.F., & Liossi, C. (2014). Pain assessment in children. *Archives of Disease in Childhood*, 99(12), 1123-1124.

Joestlein, L. (2015). Pain, pain, go away! Evidence-based review of developmentally appropriate pain assessment for children in a postoperative setting. *Orthopedic Nursing,* 34(5), 252-259.

Schecter, N.L., Berde, C. B., Yaster, M. (2003). Pain in Infants, Children, and Adolescents. (2nd Ed.) Philadelphia: Williams & Wilkins.

World Health Organization. (2012). WHO guidelines on the pharmacological treatment of persistent pain in children with medical illnesses. Geneva: World Health Organization.

VII. RELATED DOCUMENTS/RECORDS

A. Sedation Assessment Tool
B. Pediatric Pain Assessment Tool
C. Pediatric Analgesic and Sedation Dosing Guidelines