Paediatric Acute Pain Policy

Assessment and management of pain in children and young people

This procedural document supersedes: PAT/MM 6 v.2 – Paediatric Acute Pain Policy - Assessment and management of pain in children and young people

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Executive Sponsor(s):	Moira Hardy, Director of Nursing, Midwifery and Allied Health Professionals
Author/reviewer: (this version)	Lorraine Robinson - Lead Specialist Nurse In-patient Pain Team
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Approved by:	Drugs and Therapeutics Committee
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Target audience:	Clinical Staff Trust-wide

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 3	7 January 2019	• Updated Trust name and logo throughout • References updated	Lorraine Robinson
Version 2	6 January 2015	• New Trust format • References updated • Changes throughout the document, please read in full	Lorraine Robinson
Version 1	May 2012	• This document has been reviewed, without change.	Lorraine Robinson
Version 1 **(PAT/MM 6 v.1)**	December 2011	This document has been transferred from 'Treatment/Investigation' (PAT/T 27 v.1) to **'Medicines Management' (PAT/MM 6 v.1).** • Title change. • Aim of document changed to purpose. • Acute pain team, 1st paragraph removed. • 2nd paragraph amended, to include pain score >1. • Reference to Patient Group Direction No 75 included. • Inclusion of Equality Impact Assessment. • Inclusion of monitoring and compliance. • Duties and responsibilities changed - please read. • New section added – frequency of pain assessment. • RCN reference updated. • Hyperlink to RCN clinical guidelines/pain. • IV Paracetamol infusion included.	Lorraine Robinson
Version 1 **(PAT/T 27 v.1)**	January 2009	This is a new procedural document	Lorraine Robinson/ Michelle Veitch

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1. INTRODUCTION

The goal of pain assessment is to ensure that effective procedures and processes are instituted to prevent or minimise pain. Pain assessment is a pre-requisite to optimal pain management in children and should involve the child, their parent / carer and the use of an age and context appropriate pain measurement tool.

There can be particular difficulties in inferring the sensory and emotional experience of pain in children, especially in young children. Children vary greatly in their cognitive and emotional development, medical condition, response to painful interventions and to the experience of pain, as well as in their personal preferences for care.
THIS POLICY IS NOT APPLICABLE TO NEONATAL SERVICES.

2. PURPOSE

To improve the way in which health professionals recognise, assess and treat pain in children.

3. DUTIES AND RESPONSIBILITIES

All health professionals providing care to children have a responsibility to learn the language of child pain expression, to listen carefully to children's self-reports of pain and to attend to behavioural cues in partnership with the child's parent/carer.

3.1 In-Patient Pain Team

Are responsible for supporting staff in the clinical areas where a child has a continued pain scores of 2 or more despite analgesia, for more than 3 hours or if the child has a Patient Controlled Analgesia (PCA) pump.

In-patient pain team can be contacted:
DRI - Bleep 1449 Monday – Friday 8 – 4 / Out of hours/Bank Holidays 2nd on call anaesthetist
BDGH - Bleep 3107 Monday – Friday 7.45 - 15.45 / Out of hours/Bank Holidays on call anaesthetist via switchboard.

3.2 Registered Nurses, Doctors and Allied Healthcare Professionals

It is the responsibility of doctors, nurses and Allied Healthcare Professionals involved in the assessment and management of children's pain to understand and incorporate pain assessment into routine observations (as the 5th vital sign – temperature, blood pressure, pulse, respiration and pain). Following assessment appropriate management of pain must be undertaken and effectiveness evaluated within the hour.

3.3 Ward Managers

Are responsible for ensuring newly appointed staff receives training and awareness on polices, pain tools, documentation and audit. Ward managers are also responsible for monitoring practice and audit within their area of responsibility.

3.4 Healthcare Support Workers

It is the responsibility of healthcare support workers to use pain assessment tools with children, document scores and report scores of 2 or more to the registered nurse.

3.5 Ward Managers beyond Children's In-Patient Areas

It is the responsibility of doctors, nurses and Allied Healthcare Professionals involved in the assessment and management of children's pain to understand and incorporate pain assessment into routine observations (as the 5th vital sign – temperature, blood pressure, pulse, respiration and pain). Following assessment appropriate management of pain must be undertaken and effectiveness evaluated within the hour.

4. PROCEDURE

Pain Assessment
Assessment of a child's pain should be undertaken as soon as possible from admission or when the condition allows. Pain assessment should be a routine integral part of every child's care. Accurate and timely pain assessment is a key factor for improving pain management for children.

4.1 Pain Assessment Tools

Pain assessment tools should be used to determine the level of pain experienced by the child. The score obtained will determine the intervention required.

A suitable pain tool should be selected on admission based on the age, development and clinical condition of the child. It is important that continuity is maintained by using the same tool throughout the child's stay in hospital. Effective communication is therefore required to ensure that all staff involved in the child's care are aware of the selected tool.

The use of a pain tool must be explained to the child, if possible, and the parent / carer. This policy advocates the use of the following assessment tools:

- Smiley faces
- FLACC
- Verbal descriptive scale e.g. none, mild, moderate or severe pain (0-3). The numbers are purely for documentation purposes, the words are to be used when assessing pain.

It is imperative that the pain scores are clearly documented on the child's Paediatric Advanced Early Warning (PAWS) observation chart.

Pain assessment should be carried out:

- Using a validated pain assessment tool
- Observing the child's behaviour and physiological signs
- Involving the parent(s) / carer (where appropriate)
- Taking into account the contextual factors and the cause of pain

4.2 Frequency of Pain Assessment

General Assessment
All children will have their pain assessed / documented, alongside observations and recorded on the appropriate documentation, on admission to hospital and throughout their stay.
Changes in clinical observations i.e. increased heart rate, respiratory rate, blood pressure and decrease in oxygen saturations, may indicate the presence of pain.

Post-operative Pain Assessment
1 hourly for 4 hours
4 hourly thereafter

Re-Evaluation of pain following action
Severe pain - documented evidence of action taken within 30 minutes
Moderate pain - documented evidence of action taken within 60 minutes

4.3 Behaviour

Changes in behaviour i.e. crying, facial expressions, bodily movements, and sleep patterns, may also indicate the presence of pain. Any changes in such behaviour should be discussed with the carer and documented in the child's notes.

4.4 Self-Report

Self-report is usually possible by 4 years of age but will depend on the cognitive and emotional development of the child. At 4 to 5 years of age child can differentiate 'more', 'less' or the 'same' and can use smiley faces assessment tool.

4.5 Children and Young People with Special Needs

In children with special needs i.e. cognitive impairment and / or communication problems, assessment of pain is difficult and can contribute to inadequate analgesia (Stevens et al 2003). In

these cases, clinical observations and changes behaviour are important along with parent / carer involvement. In addition to this, the **FLACC** pain assessment tool can be used. **FLACC** is an acronym for: Face, Legs, Arms, Cry, Consolability (see appendix 4)

4.6 Process of Pain Assessment

- Introduce pain tool of choice to child and carer on admission or as early as condition allows and document which pain tool (a, b or c) has been used
- Undertake and record pain assessment
- Monitor and document clinical observations for signs of pain
- Monitor and document changes in behaviour for signs of pain
- Administer intervention if required – e.g. pharmacological and / or non-pharmacological
- Evaluate intervention(s) by repeating pain assessment and document the score on the physiological observation chart
- Assess pain on movement and re-assess following interventions
- Always record pain scores and re-assessment score on physiological observation chart.

4.7 Analgesic Options

Basic principles of analgesic treatment include type of analgesia, dose, timing and routes of delivery. Pain management encompasses the use of different types of drugs including opioids (i.e. Morphine) and non-opioids (i.e. Paracetamol and Non-Steroidal Anti-inflammatory Drugs (NSAID's) such as Ibuprofen. The use of non-opioids can reduce the amount of opioids required (Verghase & Hannallah 2010) therefore reducing potential opioid side effects.
Give analgesia regularly, not PRN, to maintain baseline analgesia.

NB: All analgesic / non-drug interventions must be used in conjunction with the pain assessment tool.

5. TRAINING/ SUPPORT

On commencement of employment staff working in areas that will be assessing pain of children will receive training in assessment and management. This will be in line with practice within the clinical areas.

The training requirements of staff will be identified through a training needs analysis. Role specific education will be delivered by the service lead.

6. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

The senior nurse (ward manager) in charge of each clinical area is responsible for ensuring that the standard of pain assessment in their clinical area is audited for compliance with this document at least annually. Action plans should be developed to address areas scoring <90%.

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Pain assessment is carried out	Clinical Educator /Ward manager	Monthly via Releasing Time to Care observation audit	Ward meetings
Incidents relating to pain assessment and treatment	Ward Manager	On an individual basis	Via the Datix reporting system and reported to Clinical Governance
Complaints relating to poor pain management	Ward manager and Matron	On an individual basis	Local Clinical Governance Group

7. DEFINITIONS

Pain is unpleasant, delays recovery and adds to the trauma of illness, injury and clinical procedures.

Acute Pain
Pain, which subsides as healing, takes place, e.g. it has a predictable end and it is of brief duration (less than 3 months). Acute pain is commonly associated with surgical or other procedures.

Procedural Pain
Procedure related pain could be a frequent and distressing aspect of care. The aim of procedural pain management is to minimise physiological discomfort and psychological affects (Howard et al 2012). Children and parents should receive appropriate information about what to expect and appropriate preparation about how to minimise distress. The treatment approach should be multimodal and meet the child's needs e.g. the use of Ametop, Equanox/Entonox, sucrose, relaxation, distraction, play therapy and other cognitive strategies.

8. EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4). The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. See Appendix 5.

9. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

Equality Analysis Policy - CORP/EMP 27
Fair Treatment for all - CORP/EMP 4
Medical Equipment Training for Trust Staff – CORP/RISK 2
Privacy and Dignity Policy - PAT/PA 28
Physiological Observations for Paediatric Patients (excluding neonates) 2016 CW01.1

10. REFERENCES

Howard R et al (2012) *Good Practice in Postoperative and Procedural Pain Management – A Guideline of the Association of Paediatric Anaesthetists of Great Britain and Ireland,* 2nd edition. *Pediatric Anesthesia;* 22(Suppl 1): 1-79.

Verghase, S. Hannallah, R (2010). Acute Pain Management in children. Journal of Pain Research;3 :105-123

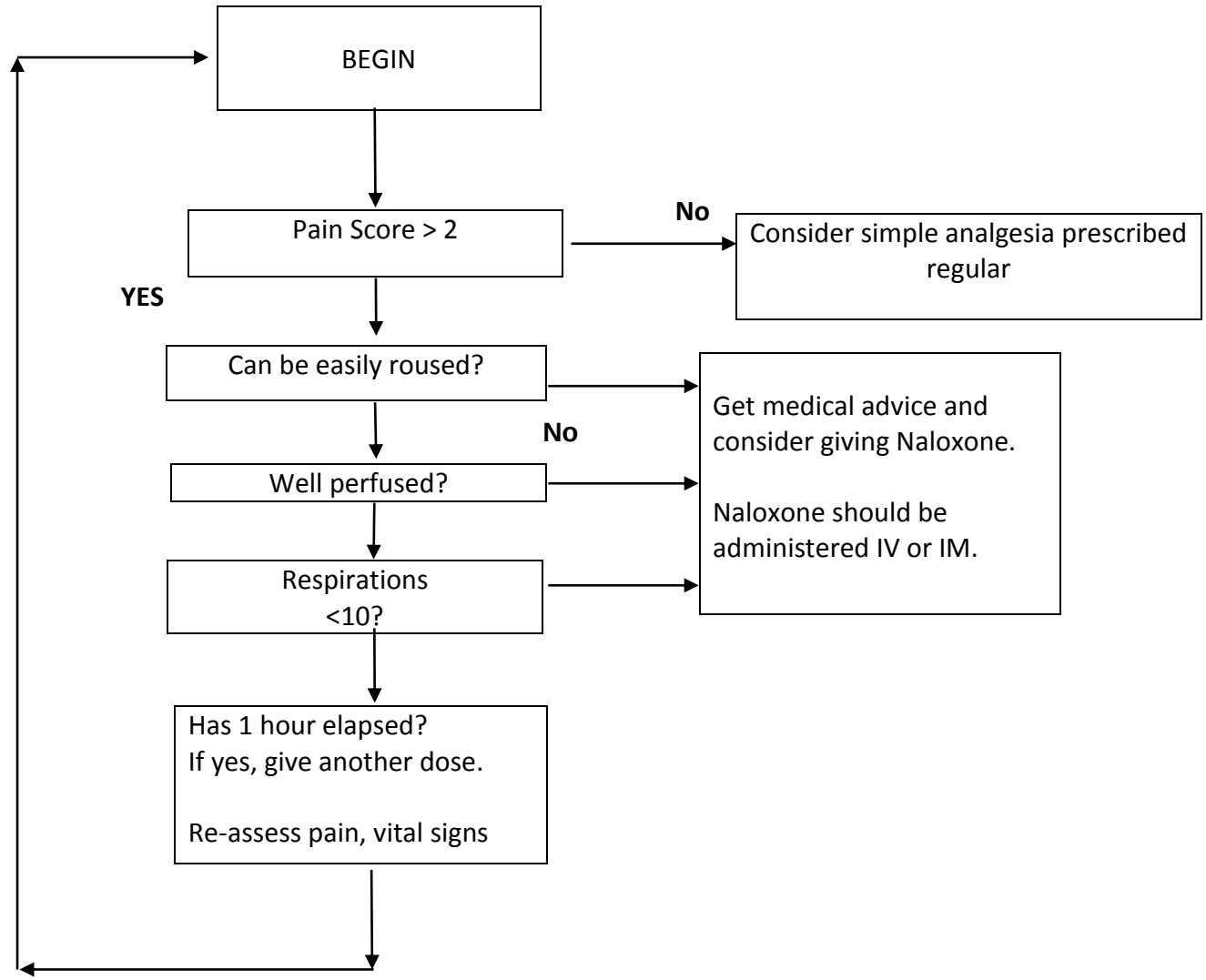
APPENDIX 1 - ORAL MORPHINE SOLUTION

Oral morphine solution 10mg/5ml in Children with Acute Pain

If two consecutive doses are given without analgesic effect then seek a medical review.

Nausea and vomiting can be treated with cyclizine. If ineffective then seek a medical review.

Recommended Doses	
10-20kg	2.5-5mg
21-30kg	7.5mg
31-50kg	10mg
51-65kg	15mg
>65kg	20mg



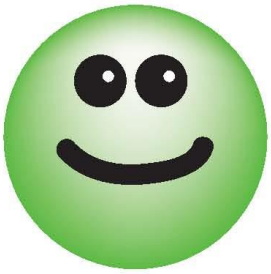
APPENDIX 2 - PAIN ASSESSMENT TOOL A - SMILEY FACES

We Care Tool A

NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

3 = This is the worst pain I have had

2 = It hurts quite alot



1 = I have a little bit of pain

0 = I have no pain at all

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APPENDIX 3 - PAIN ASSESSMENT TOOL B - SMILEY FACES

Tool B

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

3 = This is the worst pain I have had

2 = It hurts quite alot

1 = I have a little bit of pain

0 = I have no pain at all

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APPENDIX 4 - PAIN ASSESSMENT TOOL C - FLACC

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Pain Tool 'C'

SCORE			
CATEGORIES	0	1	2
Face	Patient smiling or no particular facial expression	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity/ask the relative/carer	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 complaint	Crying steadily, screams or sob, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort

Each of the five categories: (F) Face; (L) Legs; (A) Activity; (C) Consolability is scored from 0 - 2 add all the scores together and convert using the scale below

0 = no pain 1 - 3 = mild pain 4 - 7 = moderate pain 8 - 10 = severe pain

Merkel et al (1997)

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APPENDIX 5 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/ Project/Strategy	Division/ Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Policy	Children & Family	Lorraine Robinson	Existing policy	14/12/2018

1) Who is responsible for this policy? Surgical Care Group / Children & Family Services

2) Describe the purpose of the service / function / policy / project/ strategy? Is it intended to benefit children and young adults to ensure their pain is assessed and treated

3) Are there any associated objectives? No

4) What factors contribute or detract from achieving intended outcomes? Pain not being assessed

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –

6) Is there any scope for new measures which would promote equality? No

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: September 2021

Checked by: **Lesley Musk** **Date: 18/12/2018**