Regional Paediatric Pain Assessment Guide

Pain Assessment at regular intervals with age-appropriate tools, is essential in managing all types of pain in children.

- Verbal and non-verbal assessment may be used with the help of Behavioural and Self-report tools. Can my patient self-report and have I asked for carers opinion?
- Each of the scales is scored in a range of 0-10 with 0 representing no pain.
- A child's developmental level determines which scale is most appropriate.
- Use age only as a guide.

CRIES
Observational assessment tool. Suggested age group: NEONATES

Crying - Characteristic cry of pain is high pitched.
0 - No cry or cry that is not high-pitched
1 - Cry high pitched but baby is easily consolable
2 - Cry high pitched but baby is inconsolable

Requires O_2 for SaO_2 <95% - Babies experiencing pain manifest decreased oxygenation. Consider other causes of hypoxemia, e.g. oversedation, atelectasis, pneumothorax.
0 - No oxygen required
1 - <30% oxygen required
2 - >30% oxygen required

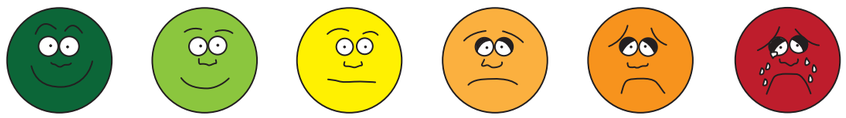
Increased vital signs (BP* and HR*) - Take BP last as this may awaken child making other assessments difficult.
0 - Both HR and BP unchanged or less than baseline
1 - HR and BP is increased but increase is <20% of baseline
2 - HR and BP is increase >20% of baseline

Expression - The facial expression most often associated with pain is a grimace. A grimace may be characterised by brow lowering, eyes squeezed shut, deepening naso-labial furrow, or open lips and mouth.
0 - No grimace present
1 - Grimace alone is present
2 - Grimace and non-cry vocalisation grunt is present

Sleepless - Scored based upon the infant's state during the hour preceding this recorded score
0 - Child has been continually asleep.
1 - Child has awakened at frequent intervals
2 - Child has been awake constantly

WONG AND BAKER
Self-reporting tool. Suggested age group: 4 years and upwards

Wong-Baker FACES® Pain Rating Scale



Instructions for Usage
Explain to the person that each face represents a person who has no pain (hurt), or some, or a lot of pain.

Face 0 doesn't hurt at all. Face 2 hurts just a little bit. Face 4 hurts a little bit more. Face 6 hurts even more. Face 8 hurt a whole lot. Face 10 hurts as much as you can imagine, although you don't have to be crying to have this worst pain.

Ask the person to choose the face that best depicts the pain they are experiencing.

REVISED FLACC
Observational assessment tool. Suggested age group: 2months - 7year and children with cognitive impairment.

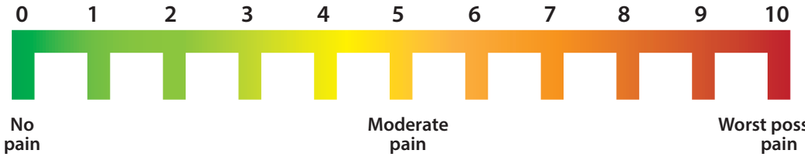
Categories	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested appears sad or worried	Frequent to constant frown, clenched jaw, quivering chin Distressed looking face; expression of fright or panic
Individual Behaviours			
Legs	Normal position or relaxed; usual tone and motion to limbs	Uneasy, restless, tense; occasional tremors	Kicking, or legs drawn up; marked increase in spasticity, constant tremors or jerking
Individual Behaviours			
Activity	Lying quietly, normal position, moves easily; Regular, rhythmic respirations	Squirming, shifting back and forth, tense or guarded movements; mildly agitated (eg. Head back and forth, aggression); shallow, splinting respirations, intermittent sighs	Arched, rigid, or jerking; severe agitation, head banging, shivering (not rigors); breath-holding, gasping or sharp intake of breaths; severe splinting
Individual Behaviours			
Cry	No cry/verbalisation (awake or asleep)	Moans or whimpers, occasional complaint; occasional verbal outburst or grunt	Crying steadily, screams or sobs, frequent complaints; repeated outbursts, constant grunting
Individual Behaviours			
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort; pushing away caregiver, resisting care or comfort measures
Individual Behaviours			

Please use single sheets to record individual revised FLACC behaviours

VISUAL ANALOGUE
Self-reporting tool. Suggested age group: 8 years and upwards

Pain score

0 - 10 Numeric Pain Rating Scale



Please document pain scores on Early Warning Score Charts and any interventions in nursing / medical notes

Developed by HSC Paediatric Collaborative version 1.0

When should I assess pain?

On admission

On a change in child behaviour

Activity levels

Vital signs

Pre and post procedure

At regular intervals

NON PHARMACEUTICAL INTERVENTIONS

INFANTS	CHILDREN	ADOLESCENTS
Pacifier	Art and Play	Guided Imagery
Sucrose	Role Play	Video Game
Massage / Touch	Books	Deep Breathing
Positioning	Games	Information
Music / Distraction	Choices / Control	Choice
Favourite Toy / Blanket	Give Information	Headphones
Noise Reduction	Heat / Cold	Relaxation

What should I do if...

CHECK ALL OK

PAIN SCORE 0-4

- Check position
- Check favourite toy
- Check distraction / non pharm intervention
- Does the child need medication?
- Is it time for regular pain medication?

DO SOMETHING

PAIN SCORE 5-7

- Intervene with medication
- Is the dose appropriate?
- Check for hunger/spasm/nausea
- Ask the care givers opinion
- Consider breakthrough analgesia from another drug class

GET HELP

PAIN SCORE 8-10

- Child needs reviewed by medical team
- Consider additional or stronger medication
- Continue assessment and interventation until pain controlled

For Pharmaceutical Interventions check "British National Formulary" for children (BNFC) (Pain Management Section).