Lucile Packard Children's Hospital AT STANFORD

HealthStream Training

Pain Assessment and Management

Physicians and Allied Health Professionals

Philosophy of Pain Management

- Adequate pain management is crucial to good patient care
- Appropriate pain management can decrease complications and facilitate healing
- Pain is the 5th vital sign (as defined by the California Health & Safety Code and the California Board of Registered Nurses)
- Pharmocologic and non-pharmocologic/ cognitive-behavioral interventions may be used
  - Choice is dependent on patient's developmental level, type and severity of pain and other factors
- Patient and the family if appropriate, will be involved in planning pain treatment as much as possible
- Goals will be set in terms of the patient's and family's background, experience and culture as well as the type and severity of pain

Pain Tools Used at LPCH

- For Infants/Children Less than 3 Years of Age
  - NPAS-Neonatal Pain and Agitation Score
    - Babies under 2 months of age
  - FLACC-(Face, Legs, Activity, Cry, Consolability)
    - Infants or children on any unit and nonverbal children/others

- For Children and Adults Over 3 Years of Age
  - Wong-Baker Faces Scale
    - Children or others approximately 3-7 years of age who can communicate intensity and location of pain but who do not understand abstract numbers
  - 0-10 Scale
    - Older than 7 years of age and adults who understand abstract numbers

* Tools are based on patient's developmental age not their chronological age

Pain Tools

For Non-Verbal Patients

FLACC Pain Scale

Categories	Scoring		
	0	1	2
Face	No particular expression or smile	Occasional grimace or frown	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans and whimpers; occasional complaint	Crying steadily, screams or sobs, 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) Cry; (C) Consolability is scored from 0-2, which results in a total score between zero and ten.

Authors: Merkel, S. Voepel-Lewis, T. Shayevitz, J.R., Malviya, S.

N-PAS
Neonatal Pain & Agitation Scale

Hummel & Puchalski, 2000

Assessment Criteria	Normal	Pain / Agitation	
	0	1	2
Crying Irritability	Appropriate crying Not irritable	Irritable or crying at intervals Consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking Constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Appropriate Relaxed	Any pain expression intermittent	Any pain expression continual
Extremities Tone	Relaxed hands and feet Normal tone	Intermittent clenched toes, fists and/or finger splay Body is not tense	Frequent clenched toes, fists and/or finger splay Body is tense
Vital Signs HR, BP, RR, O_2 Sats	Within baseline or normal for gestational age	↑ 10-20% from baseline SaO_2 ↓ to 76-85% with stimulation - quick ↑	↑ > 20% above baseline SaO_2 ↓ to ≤ 75% with stimulation - slow ↑ Out of sync with vent

Premature Pain Assessment

+ 3 if < 28 weeks gestation / corrected age
+ 2 if 28-31 weeks gestation / corrected age
+ 1 if 32-35 weeks gestation / corrected age

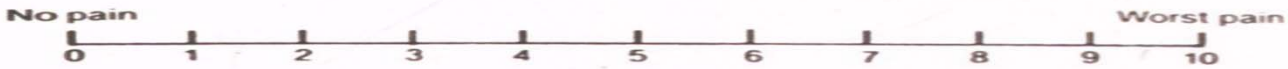
WONG-BAKER FACES PAIN RATING SCALE

0 2 4 6 8 10

Explain to the person that each face is for a person who feels happy because he has no pain (hurt) or sad because he has some or a lot of pain. **Face 0** is very happy because he doesn't hurt at all. **Face 2** hurts just a little bit. **Face 4** hurts a little more. **Face 6** hurts even more. **Face 8** hurts a whole lot. **Face 10** hurts as much as you can imagine, although you don't have to be crying to feel this bad. Ask the person to choose the face that best describes how he is feeling. *Recommended for persons age 3 years and older.*

Research reported in Wong, D., and Baker, C.: Pain in children: comparison of assessment scales. Pediatric Nursing 14(1):9-17, Jan.-Feb. 1988. This tool may be reproduced for use in the clinical setting.

NUMERIC SCALE FOR PAIN ASSESSMENT



Explain to the person that at one end of the line is a **0**, which means that a person feels no pain (hurt). At the other end is a **10**, which means the person feels the worst pain imaginable. The numbers **1-9** are for a very little pain to a whole lot of pain. As the person to choose number that best describes own pain. *Recommended for persons 7 years and older.*

This tool may be reproduced for use in the clinical setting.

Assessment/Reassessment of Pain

- Assessment of pain scores is completed:
  - upon admission
  - each time vital signs are measured (unless ordered otherwise by an MD or NP)
  - whenever a patient complains of pain
- Reassessment of pain scores is completed:
  - within an hour of a pain management intervention to assess the effectiveness of the medication and/or other relief measures

Using More than One Medication for Pain Management

- Medications are written for the patient's specific pain management needs

- If more than one medication is ordered, the nurse will provide the medications according to the evaluated pain score. If the pain score is greater than 4/10 or unacceptable to the patient, the RN will provide other interventions per orders or contact the physician/AHP for further orders
  - The medication chosen should be commensurate with the pain that's reported (e.g. Tylenol given as an adjuvant but not primary choice for a fresh postoperative patient)

Non-Pharmocologic/Cognitive-Behavioral Pain Management Interventions

- A variety of nonpharmacological and cognitive-behavioral pain management interventions are available per policy (Can we get a link here to the policy?)
- Interventions are developmentally age appropriate
  - i.e. Swaddling and Sucrose Sweeties for infants
- Some interventions require a physician/AHP order
  - i.e. Acupuncture
- Pain Service Consults are available

LPCH Policies Related to Pain Management

- Pain Management
- Neonatal Pain Management
- Clinic Pain Management

HealthStream Post Test Questions

1. Appropriate pain management can decrease complications and facilitate healing
   - True or False

2. Pain Tools used at LPCH are:
   a) NPAS, FLACC, Wong-Baker Faces and 0-10
   b) NPASS, PIPP, FLACC, Wong-Baker Faces and 0-10
   c) PIPP, FLACC and Wong-Baker Faces
   d) None of the above
   e) All of the above

HealthStream Post Test Questions

3. When is the pain assessment completed?

a) Upon admission
b) Each time vital signs are measured
c) Whenever a patient complains of pain
d) All of the above

HealthStream Post Test Questions

4. Reassessment of pain scores is completed within an hour of a pain intervention to assess the effectiveness of the medication and/or other relief measures
   - True or False

HealthStream Post Test Questions

5. A variety of nonpharmacological and cognitive-behavioral pain management interventions are available per policy.

   The interventions are appropriate for all patients and and will require an order

   – True or False

6. If more than one medication is ordered, the nurse will provide the medications according to the evaluated pain score. If the pain score is greater than 4/10 or unacceptable to the patient, the RN will provide other interventions per orders or contact the physician/AHP for further orders The medication chosen should be commensurate with the pain that's reported (i.e. Tylenol given as an adjuvant but not primary choice for a fresh postoperative patient).

   -- True or False