LEGACY HEALTH

PATIENT CARE
Practice Guideline: 912.5007
Origination Date: MAR 2000
Last Revision Date: NOV 2023

SECTION: FUNDAMENTAL PROCEDURES
TITLE: PAIN MANAGEMENT FOR HOSPITALIZED PEDIATRIC AND NEONATAL PATIENTS

FACILITY:

☒ Legacy Emanuel Hospital and Health Center
(as applicable: ☒ LEMC only ☐ RCH only ☐ Unity only)

☒ Legacy Good Samaritan Medical Center	☒ Legacy Meridian Park Medical Center
☒ Legacy Mount Hood Medical Center	☒ Legacy Salmon Creek Medical Center
☒ Legacy Silverton Medical Center	☐ Legacy Visiting Nurse Association (Hospice)
☐ Legacy Medical Group	☐ Legacy Lab Services
☐ Administrative/System Support Services	☐ Legacy Research Institute
☐ Legacy Urgent Care	☐ Other:

POPULATION: ☐ Adult ☒ Pediatric ☒ Neonate
(Adult > 18 years of age; Pediatric 0-18 and adult patients under care of a pediatric specialty physician at RCH; Neonate 0-28 days and continued hospitalization in the NICU)

PURPOSE:
1. To describe developmentally appropriate pain assessment scales, interventions, monitoring and teaching guidelines.
2. Define a systematic approach for titration of approved PRN range medications. (See 900.3233 Medications: Orders, for policy information on approved PRN range medications and 900.3102 Medications: Administration)

POLICY STATEMENT:
The goal of pain management therapy is not to completely eliminate pain but to effectively control pain for patient comfort so that the patient can engage in developmentally appropriate therapeutic activities.

Key Point: For patients receiving only comfort measures refer to *912*.1018

RESPONSIBLE STAFF: All members of the healthcare team who provide direct clinical care per their scope of practice.

PRACTICE GUIDELINE:

ASSESSMENT:

1. Routine pain assessments will be completed per SOC.

2. Pain reassessments will be completed per SOC.

3. Developmentally and clinically appropriate validated pain scales should be used to assess pain.

Pediatrics	Neonates
• 0-10 Pain Rating Scale • Wong-Baker Faces • Comfort Behavior Scale	• NPASS (Neonatal Pain, Agitation and Sedation Scale) • FLACC (Face, Legs, Activity, Cry, Consolability Scale)

INTERVENTIONS

1. Utilize age-appropriate nonpharmacologic and/or pharmacologic methods of pain control.
    a. Nonpharmacologic interventions include but are not limited to:
        i. Ice
        ii. Heat
        iii. Distraction
        iv. Comfort positioning
2. Consider premedicating prior to pain producing activity or procedures such as (e.g. chest tube insertion, circumcision, etc.)
    a. Topical anesthetic (i.e.lidocaine, J-tip, cold spray)
    b. Intrademal anesthetic (i.e. bacteriostatic saline)
    c. Sucrose
    d. Non-opioid analgesics
    e. Opioid analgesics
3. Administer pharmacologic interventions for pain.

MONITORING

1. For all patients, consideration of patient history, co-morbidities and other medications received will guide the nurse in selection of increasing levels of monitoring above the applicable standards of care. Recognize that changes in patient condition and response to treatment may also increase the level of monitoring required.
2. Patients receiving continuous IV opioids, including patient-controlled analgesia (PCA), will be monitored with continuous pulse oximetry or via centralized monitoring of pulse oximetry, or End Tidal CO_2, where available.
3. Patients receiving intermittent IV opioids and at risk of CNS depression should be placed on continuous pulse oximetry

DISCHARGE INFORMATION

1. Assess pain status at time of discharge and type of intervention needed.
2. Assess barriers to participation in pain management plan.
3. Provide patient/family and/or caregiver with information about how to obtain medications, renew prescriptions, store
   and monitor medication supply after discharge, and appropriate disposal of opioids when no longer needed.

DOCUMENTATION:

1. Document in the electronic health record (EHR).
    a. Pain assessment on admission, per SOC
    b. Pain assessment following each PRN pain management intervention once enough time has elapsed for the treatment to reach peak effect.
    c. Administration of analgesic medication and non-pharmacological pain management interventions in the MAR and/or appropriate flowsheets

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Key Words: PAIN MANAGEMENT, adult pain management, PRN pain medications, range order titration, dose ranges, pediatric pain management, sucrose, NPASS, FLACC, nonpharmacologic

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Replaces: 900.2359
Approval: CSR
P&T
NEC
MEC
MQ&C
Originators: Standardizing Pain Assessment and Management Process Improvement Team

Attachment 1

Wong-Baker FACES® Pain Rating Scale

0	2	4	6	8	10
Non fa per niente male	Fa male solo un pochino	Fa male un po' di più	Fa ancora più male	Fa tanto male	Fa un male incredibile
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

Attachment 2

CLINICIAN CUES

VERBAL PATIENTS

1. Where is your pain/aching/discomfort? - Location
2. Do you have pain/aching/discomfort anywhere else?
3. Intensity -use the following anchor words to help as needed:

1= barely noticeable	6= disturbing
2= noticeable	7= distressing
3= there but able to ignore	8= horrible
4= beginning uncomfortable	9= almost out of control
5= uncomfortable	10= out of control, intolerable

4. What is an acceptable level of pain/aching/discomfort?
5. Duration -
   - How long have you had this pain/aching/discomfort?
   - How much of your day are you spending in pain/aching/discomfort?
6. What words would you use to describe your pain/aching/ discomfort? - examples

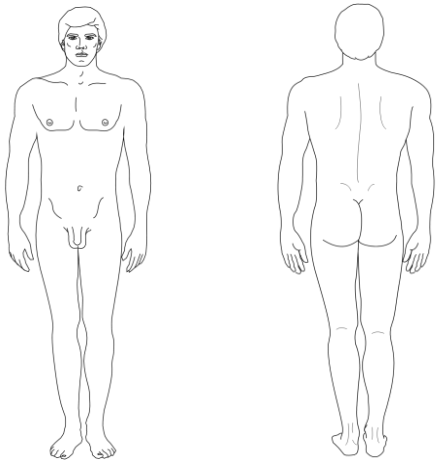
Incisional	Neuropathic	Somatic/Visceral	Muscular	Bone
Hot	radiating	crushing	soreness	sharp
itchy	shooting	generalized	tenderness	localized
sore	stabbing	tenderness	grabbing	aching
smarting	tingling	dull	ripping	dull
cutting	burning	ache	aching	heavy
pulling	numbness	pressure	shooting	pain
tugging		radiating	exhausting	with
cold-piercing			nauseating	movement
tight squeezing				
stretching				
throbbing				

NONVERBAL PATIENTS

Ask family and friends about patient.

1. Did patient ever mention/demonstrate pain?
2. Have patient's actions/activities/ mood changed?
3. What do you think causes the pain?

- Grimacing, frowning, blinking, tightly closed or widely open eyes
- Moaning, crying, groaning, calling out, screaming
- Hitting, biting, rigid posture; increase in head movements, rocking, tugging legs; guarding part of the body, change in walking, restless



If patient unable to describe pain location; have them use the figures to help clarify.

Attachment 3 Comfort Behavioral Scale

COMFORT Behavioral Scale
Validated for critically ill pediatric patients
Observe for 2 minutes.

ALERTNESS
1 - Deeply asleep
2 - Lightly asleep
3 - Drowsy
4 - Fully awake and alert
5 - Hyper alert

CALMNESS
1 - Calm
2 - Slightly anxious
3 - Anxious
4 - Very anxious
5 – Panicky

RESPIRATORY DISTRESS (score only in mechanically ventilated children)
1 - No coughing and no spontaneous respiration
2 - Spontaneous respiration with little or no response to ventilation
3 - Occasional cough or resistance to ventilation
4 - Actively breathes against ventilator or coughs regularly
5 - Fights ventilator; coughing or choking

CRYING (if not intubated)
1 - Quiet breathing, no crying
2 - Sobbing or gasping
3 - Moaning
4 - Crying
5 – Screaming

PHYSICAL MOVEMENT
1 - No movement
2 - Occasional, slight movement

3 - Frequent, slight movements
4 - Vigorous movement
5 - Vigorous movements including torso and head

MUSCLE TONE (after stimulation)
1 - Muscles totally relaxed; no muscle tone
2 - Reduced muscle tone
3 - Normal muscle tone
4 - Increased muscle tone and flexion of fingers and toes
5 - Extreme muscle rigidity and flexion of fingers and toes

FACIAL TENSION
1 - Facial muscles totally relaxed
2 - Facial muscle tone normal; no facial muscle tension evident
3 - Tension evident in some facial muscles
4 - Tension evident throughout facial muscles
5 - Facial muscles contorted and grimacing

TOTAL SCORE 6-30

Attachment 4

NPASS Scale
Validated for patients less than 3 months, 0 to 100 days of age, and 23 weeks gestation and above.

NPASS: NEONATAL PAIN AGITATION AND SEDATION SCALE (Revised 3/28/2008)

Assessment Criteria:	Sedation		Normal	Pain/Agitation	
	-2	-1	0/0	1	2
Crying/ Irritability	No cry with painful stimuli	Moans or cries minimally with painful stimuli	No sedation/ No pain signs	Irritable or crying at intervals Consolable	High-pitched or silent-continuous cry Inconsolable
Behavior/ State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	No sedation/ No pain signs	Restless, squirming Awakens frequently	Arching, kicking Constantly awake or arouses minimally/ no movement (not sedated)

Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	No sedation/ No pain signs	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex ↓muscle tone	No sedation/ No pain signs	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/RR/BP SaO_2	No variability with stimuli Hypoventilation or apnea	<10% variability from baseline with stimuli	No sedation/ No pain signs	VS ↑ 10-20% from baseline SaO_2↓ to 76-85% with stimulation - quick↑	VS ↑>20% from baseline SaO_2↓ to <75% with stimulation – slow ↑ Out of sync with vent

Premature Pain

a)	+ 3 if <23 0/7 weeks GA
b)	+ 2 if 2 30/7-31 6/7 weeks GA
c)	+ 1 if 32-35 6/7 weeks GA

a)	+ 3 if <28 weeks CGA
b)	+ 2 if 28-31 6/7 weeks CGA
c)	+ 1 if 32-35 6/7 weeks CGA