INTERIM PAIN ASSESSMENT AND MANAGEMENT – PEDIATRIC

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Information Needed:

- All patients expressing verbal or behavioral indicators of pain shall have an appropriate assessment and management of pain as indicated.
- Measurement of a patient's pain is subjective; therefore, they are the best determinant of the presence and severity of their pain.
- Determine the appropriate means to assess the pediatric patient's level of pain based upon age and developmental level and DOCUMENT. This policy includes details on three pediatric assessment tools that are recommended for use: 1) FLACC Behavioral Pain Scale (< 3 yrs), 2) Baker-Wong Faces Scale (3-7 yrs), and 3) the Visual Analog Scale (>7 years).
- Utilize the Broselow Tape to measure length and then SMC Pediatric Reference Card for determination of drug dosages, fluid volumes, defibrillation/cardioversion joules and appropriate equipment sizes.

Objective Findings:

- Initial assessment of pain shall include the following:
  - Onset
  - Provoked
  - Quality
  - Region/location
  - Scale/intensity
  - Time/duration
- Document the scale/intensity using the numeric intensity scale equivalent of 0 -10 (0=no pain - 10=worse pain ever). All three recommended pain assessment tools allow for this.
- Reassessment and documentation of a patient's pain shall be performed frequently and following any intervention that may affect pain intensity.
- The administration of pain medication for pediatric patients is contraindicated in the following situations:
  - Known or suspected head injures (GCS score less than 15)
  - If any signs or symptoms of hypoperfusion are present

Treatment:

- Routine medical care
- Determine appropriate form(s) of pain management as indicated. Initial pain management should include as appropriate any of the following interventions: repositioning, bandaging, splinting, elevation, traction, cold

packs and psychological coaching. Reassess pain intensity and document findings.

- If patient's pain is assessed as Moderate to Severe (5–10) and no contraindications are noted:
    - Determine patient's length-based weight utilizing the Broselow Tape. Based on medication availability, utilize the appropriate version of SMC Pediatric Drug Card to determine dosages.
        - For morphine administration – 2013 Pediatric Drug Card
        - For Fentanyl administration – 2018 Pediatric Drug Card
    - Pediatric Base Physician contact is required if patient's weight is less than the recommended minimums as noted on the Pediatric Drug cards. Establish IV/IO-access
    - Administer Morphine Sulfate IV/IO
        - May repeat once in 5 minutes provided patient has no signs of hypoperfusion
    - If unable to establish IV/IO, administer morphine sulfate IM.
        - May repeat once in 10 minutes provided patients has no signs of hypoperfusion
    - If morphine sulfate is unavailable, **Fentanyl** may be used following dosages found on the 2018 Pediatric Drug Card:
        - IV/IO (1 mcg/kg) slowly over 2 mins. May repeat q 5 mins to a maximum dose of 3 mcg/kg
        - IM (1 mcg/kg). May repeat once in 10 minutes. Not to exceed a maximum dose of 3 mcg/kg
        - IN (2 mcg/kg). Spray ½ dose in each nare. IN Fentanyl may NOT be repeated
    - Have naloxone readily available to reverse any respiratory depression that may occur.
    - Consider Odansetron (Zofran) ODT or IV for nausea per the Pediatric Drug Card.
    - Reassess vital signs and pain intensity after each dose of morphine sulfate or Fentanyl administration, and document using 0-10 scale.
    - If additional pain medication is indicated, contact Pediatric Base Hospital Physician

Precautions and Comments:

- Pain and anxiety are not the same and require differentiation as their treatments differ.
- An accurate and thorough assessment of pain requires that an initial assessment and on-going assessments be performed and documented. This is the community standard of care and provides clinicians with a baseline to compare subsequent evaluations of the patient's pain.
- The preferred route of analgesia is intravenous; however, if an IV cannot be established then the IO/IM route in an age-appropriate site may be used.

PEDIATRIC PAIN ASSESSMENT TOOLS

The following pain assessment tools are described in detail for prehospital personnel to assist them in the assessment of pediatric patients' pain.

FLACC Behavioral Tool

This tool is appropriate for use with children less than 3 years of age or those with cognitive impairments or any child who is unable to use the other scales. FLACC is the acronym for **F**ace, **L**egs, **A**ctivity, **C**ry and **C**onsolability. The patient is assessed in each of these categories with a score applied to behaviors evaluated. The five scores are totaled and the severity of pain is determined based on the 0-10 pain scale.

	0	1	2
FACE	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin
LEGS	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
ACTIVITY	Lying quietly, normal position, moves easily	Squirming, tense, shifting back and forth, hesitant to move, guarding	Arched, rigid or jerking, fixed position, rocking, rubbing of body part
CRY	No cry/moan (awake or asleep)	Moans or whimpers, occasional cries, sighs or complaint	Cries steadily, screams, sobs, moans, groans, frequent complaints
CONSOLABILITY	Calm, content, relaxed, needs no consoling	Reassured by hugging, talking to; distractible	Difficult to console or comfort

Baker-Wong FACES Pain Rating Scale

This tool is usually appropriate for use with children age 3 years and older.

Wong DL, Hockenberry-Eaton M, Wilson D, Winkelstein ML: Wong's Essentials of Pediatric Nursing, 6th edition, St Louis, 2001, Mosby. p 1301. Copyright, Mosby. Inc. Reprinted with permission.

Brief word instructions: Point to each face using the words to describe the pain intensity. Ask the child to choose face that best describes how he/she is feeling.
Original instructions: 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. Ask the person to choose the face that best describes how he/she is feeling.

- **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.

Visual Analog Scale

This tool is usually appropriate for use with children approximately ages 8 and older. If there is any doubt that the child clearly understands the concept of assigning a number to describe the degree of their pain, utilize the Wong-Baker FACES scale or the FLACC Behavioral tool.