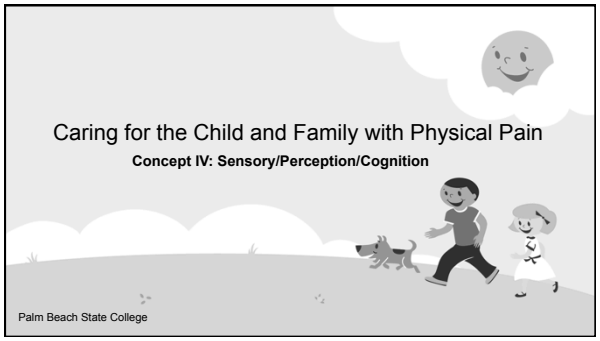
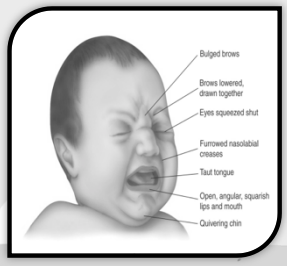


- Pain is considered the 5th Vital Sign
- Pain is a subjective finding

- Increased HR
- Increased BP
- Increased RR
- Sweating
- Flushing
- Decreased Oxygenation Saturation

Neonatal Characteristic Facial Responses to Pain



- Bulged Brow
- Eyes Squeezed Shut
- Furrowed Nasolabial Creases
- Open Lips
- Pursed Lips
- Stretched Mouth
- Taut Tongue
- Quivering Chin

- Lowering of Eyebrows
- Squaring of the jaw with tightening of the lips
- Clinched fists

Behavioral Clinical Manifestations of Pain

- Short Attention Span
- Irritability
- Facial Grimacing
- Biting Lips
- Protecting Painful Area
- Drawing up Knees
- Lethargic
- Withdrawn
- Sleep Disturbances

- General Irritability

Assessment Tools Used to Assess Pain

- Goal of Pain Assessment
  - Provide Accurate Information
    - Location of Pain
    - Intensity of Pain
    - Effects on Functioning Ability
- Appropriate Tool
  - Based on Developmental Age
  - Provide's Indirect Estimate of Pain
  - Rely Only on Observation

- Children able to communicate pain using the appropriate pain scale

Pain Assessment Tools for Neonates

Neonatal Infant Pain Scale (NIPS)

- Measures Procedural Pain
- Infants up to 6 weeks
  - Facial Expression
  - Cry Quality
  - Breathing Pattern
  - Arm & Leg Position
  - State of Arousal

Neonatal Infant Pain Scale

NIPS	0 point	1 point	2 points
Facial expression	Relaxed	Contracted	–
Cry	Absent	Mumbling	Vigorous
Breathing	Relaxed	Different than basal	–
Arms	Relaxed	Flexed/stretched	–
Legs	Relaxed	Flexed/stretched	–
Alertness	Sleeping/calm	Uncomfortable	–

Maximal score of seven points, considering pain ≥ 4.

- Cry is a higher pitch with long pauses in breathing
- Pain alters awake and sleep cycles in newborns

Pain Assessment Tools for Infants

DATE/TIME

Face
0 - No particular expression or smile
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

Legs
0 – Normal position or relaxed
1 – Uneasy, restless, tense
2 – Kicking, or legs drawn up

Activity
0 – Lying quietly, normal position, moves easily
1 – Squirming, shifting back and forth, tense
2 – Arched, rigid or jerking

Cry
0 – No cry (awake or asleep)
1 – Moans or whimpers; occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

Consolability
0 – Content, relaxed
1 – Reassured by occasional touching, hugging or being talked to, distractible
2 – Difficult to console or comfort

TOTAL SCORE

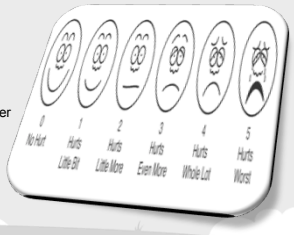
FLACC Scale

- Measures Acute Pain
- Following Surgery
- Used Until Child Can Self-Report
  - Faces
  - Legs
  - Activity
  - Cry
  - Consolability

Pain Assessment Tools for Toddlers

Wong-Baker Faces Scale

- Child understands concept
- "More or Less"
  - Lines up blocks
  - Biggest to smallest
  - Knows larger numbers and smaller numbers
    - 5 is smaller than 9
- Minimal choices on pain scale
  - None, some, a lot
- Can localize pain

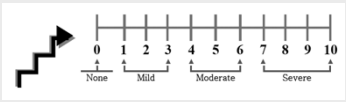


- Baker Scale: Preschool Age
- Concept of more or less
- Can localize pain location

Pain Assessment Tools for School-Age Children

The Numeric 0-10 Scale

- Based on Child's
  - Number Concepts
  - Language Skills
- By Age 8
- Can Describe Pain
  - In Detail
  - Give Location
  - Dull
  - Aching
  - Sharp
  - Burning



Comprehensive Health History

- Family Medical History
- Social History
- Past Medical History
- Immunizations
- Developmental Milestones
- Patterns of Daily Activities
  - Sleep
  - Nutrition
  - Play
  - Activities
  - Schoolwork

- IMPORANT

General Assessment

- Why is the patient experiencing pain?
- Internal factor versus external factor
  - Internal factor
    - General physical health assessment
      - Cardiovascular
      - Musculoskeletal
  - External factor
    - Exterior environment
      - Brightness of Room
    - External device
      - Cast
- Vital Signs

- Internal or External Factors
- Vital Signs

Health Assessment- Health History Questions

OLD CAT

Onset: When did the child become ill?

Location: Where is their pain located?

Duration**:** How long does the pain last?

Character: Can you tell me on a scale of 1 to 10 how bad your pain is?

Aggravating/**A**lleviating: What makes your pain better or worse?

Timing: When does your pain start and stop?

SODA

Sleep: How is the child sleeping?

Output: How many times has the child voided today? How many stools has he/she had in the past 24 hours?

Diet**:** How much fluid has the child taken in today? Has the illness affected their appetite?

Activity**:** Has their activity level changed since they have been ill?

Additional Questions: Do you have any other concerns or problems that you would like to discuss.

Common Procedures In The Clinic Setting

- Explain Procedures
  - Use Developmentally Appropriate Words
  - Educate Parents Use Informed Consent
- Intravenous Lines
- X-ray Exams

- Specimen Collection
  - Blood Sample
  - Throat Culture
- Physical Restraint
  - Elbow Restraint
  - Mummy Restraint
- Pharmacological Restraint
  - Chloral Hydrate (Aquachloral)

- Chloral Hydrate
  - alleviate anxiety
  - sedation before and after surgery
  - side effects:
    - drowsiness
    - dizziness

Nursing Diagnoses

1. Acute Pain R/T Injury or Surgery
2. Anxiety R/T Anticipation of Pain/Procedure
3. Sleep Pattern Disturbance R/T Inadequate Pain Control
4. Ineffective Breathing Pattern R/T Overmedication
5. Risk for Constipation R/T Limited Activity or R/T Medication

Medication Administration Considerations

- Allow enough time for medication to take effect
- Administer medication non-painful route
- Avoid delays in performing procedure
- Pain control
  - Major procedures
  - Minor procedures
- Anticipation
  - Causes anxiety & distress
- Document results of pain management

- Pain not treated can have a life long effect

Minor Procedures

Topical Anesthetics

- EMLA
  - 60 Minute Absorption Time
- ELA-MAX
  - 30 Minutes Absorption Time
- Intradermal Lidocaine
  - Less Than a Minute

- Numbing Cream
  - Must be applied in advance to take affect

Major Procedures & Monitoring

- **Sedation** (Medically controlled state of depressed consciousness)
  - Light to Deep
- Analgesia
  - Absence or relief of pain
- Anxiolysis
  - Antipanic
  - Antianxiety agent
- **Monitoring**
  - Patent airway
  - Respiratory effort
  - Color
  - Vital Signs
  - Level of Consciousness

Complementary Therapies

- Swaddling / Shushing
- Resting
- Side/ Stomach / Swinging
- Bathing
- Sucrose Solution/ Sucking
- Guided Imagery
- Relaxation/ Massage
- Pet Therapy, Play Therapy, Social Therapy
- Family Play
- Emotional & Spiritual Support

- Comfort Measures

QUESTION

A 9-year-old has completed a procedure and is now complaining of pain 1 hour after receiving intravenous opioid analgesia. What should the nurse do first?

1. Give more pain medication.
2. Perform a neuromuscular assessment.
3. Call the surgeon for orders.
4. Tell the child to wait another hour for the medication to work.

- Look for source of pain first then call surgeon for additional orders if pain is not alleviated after 1 hour of opioid IV Analgesia.

ANSWER

A 9-year-old has completed a procedure and is now complaining of pain 1 hour after receiving intravenous opioid analgesia. What should the nurse do first?

1. Give more pain medication.
2. **Perform a neuromuscular assessment.**
3. Call the surgeon for orders.
4. Tell the child to wait another hour for the medication to work.

The nurse looks for the source of the pain by performing a neuromuscular assessment. The nurse needs to assess the child prior to giving more pain medication. If the neuromuscular assessment is normal, the nurse might need to call the surgeon for further orders. The child should have relief from pain after one hour of receiving the intravenous medication, so waiting is not correct.

References

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Ward, Susan L. and Hisley, Shelton M. (2009). Maternal-Child Nursing Care: *Optimizing Outcomes for Mothers, Children, & Families.* Philadelphia: F.A. Davis. ISBN - 13: 978-0-8036-1486-4

Ward, Susan L. and Hisley, Shelton M. (2010). Clinical Pocket Companion for Maternal-Child Nursing Care: *Optimizing Outcomes for Mothers, Children, & Families*. Philadelphia: F.A. Davis. ISBN-13: 978-0-8036-1855-8

F.A. Davis Plus / Ward Electronic Readings Website: http://davisplus.fadavis.com/ward/bonus_unit.cfm

Table 21-3 FLACC Pain Scale

Categories	Scoring 0	1	2
Face	No particular expression or smile; disinterested	Occasional grimace or frown; withdrawn	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, shifting back and forth, tense	Arched, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or talking to; distractible	Difficult to console or comfort

Each of the five categories is scored from 0 to 2, which results in a total score

Assess pain using FLACC Pain Scale / Behavior Assessment Scale

Pain is whatever the child says it is

Faces Pain Scale is used for Preschool through School Age children