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

<table>
<thead>
<tr>
<th>Categories</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Face</td>
<td>No particular expression or smile</td>
</tr>
<tr>
<td>Legs</td>
<td>Normal position or relaxed</td>
</tr>
<tr>
<td>Activity</td>
<td>Lying quietly, normal position, moves easily</td>
</tr>
<tr>
<td>Cry</td>
<td>No cry (awake or asleep)</td>
</tr>
<tr>
<td>Consolability</td>
<td>Content, relaxed</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Assessment Criteria</th>
<th>Normal</th>
<th>Pain / Agitation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Crying Irritability</strong></td>
<td>Appropriate crying&lt;br&gt;Not irritable</td>
<td>Irritable or crying at intervals&lt;br&gt;Consolable</td>
</tr>
<tr>
<td><strong>Behavior State</strong></td>
<td>Appropriate for gestational age</td>
<td>Restless, squirming&lt;br&gt;Awakens frequently</td>
</tr>
<tr>
<td><strong>Facial Expression</strong></td>
<td>Appropriate Relaxed</td>
<td>Any pain expression intermittent</td>
</tr>
<tr>
<td><strong>Extremities Tone</strong></td>
<td>Relaxed hands and feet&lt;br&gt;Normal tone</td>
<td>Intermittent clenched toes, fists and/or finger splay&lt;br&gt;Body is not tense</td>
</tr>
<tr>
<td><strong>Vital Signs HR, BP, RR, O₂ Sats</strong></td>
<td>Within baseline or normal for gestational age</td>
<td>↑ 10-20% from baseline&lt;br&gt;( \text{SaO}_2 ) ↓ to 76-85% with stimulation - quick ↑</td>
</tr>
</tbody>
</table>

**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

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.*


NUMERIC SCALE FOR PAIN ASSESSMENT

<table>
<thead>
<tr>
<th>No pain</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Worst pain</th>
</tr>
</thead>
</table>

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-Pharmacologic/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
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
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 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