Medical Education Systems, Inc.

Pain Management: Children

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Pain Management: Children

Learning Objectives

Upon successful completion of this course, you will be able to:
- Identify and discuss the key elements of a pain management plan
- List some of the questions that need to be asked of patients regarding "pain"
- Identify the important elements of the "children's pain bill of rights"
- List and discuss the "do's" and "don'ts" of patient pain management

Introduction

Pain assessment and management should be conducted differently from population to population. An infant may express pain or discomfort differently from a geriatric person, who in turn, may have a totally different response to pain from a person who has difficulty communicating. Although these populations may have different experiences, diseases such as cancer, HIV, or sickle cell know no boundaries. With these terrible diseases comes the associated and sometimes unique pain.

Pain is very common problem that has brought suffering in one form or another, to most of us throughout our lives. In fact, pain is the most common reason we seek medical attention. Health care professionals in all settings encounter pain. Unfortunately it is often under treated in spite of the availability of effective drugs and other therapies.

Too frequently it is discovered that pain management has a low priority in a system focused on treating disease. Failure to routinely assess and document pain, and the fact that no one is accountable when pain is poorly managed, further leads to inadequate pain management.

All patients at admission are asked the following screening or general questions about the presence of pain: Do you have pain now? Have you had pain in the last several months? If the patient responds "yes" to either question, additional assessment data are obtained:

- Pain intensity (use a pain intensity rating scale appropriate for the patient population; pain intensity is obtained for pain at present, at worst, and at best or least; if at all possible, the pain rating scale is consistently used in the organization and between disciplines)
- Location (ask the patient to mark on a diagram or point to the site of pain)
- Quality, patterns of radiation, if any, character (elicit and record the patient's own words whenever possible)
- Onset, duration, variations and patterns
- Alleviating and aggravating factors

- Present pain management regimen and effectiveness
- Pain management history (including a medication history, presence of common barriers to reporting pain and using analgesics, past interventions and response, manner of expressing pain)
- Effects of pain (impact on daily life, function, sleep, appetite, relationships with others, emotions, concentration, etc.)

Pain: The Fifth Vital Sign

"Unrelieved pain is a persisting and unnecessary shortcoming in American healthcare, affecting millions of patients annually" (C. Richard Chapman, 2000). Poorly controlled pain increases lengths of stay, increases morbidity, increases ER and clinic visits, has negative physiological and psychological consequences and decreases patient satisfaction. Only 1 in 4 patients receives adequate pain relief. More than 50 million patients are partially or fully disabled related to chronic pain. Only 30% of cancer patients with pain get adequate relief.

How did this happen? What are the barriers to pain treatment? Barriers include our own beliefs and experiences about pain, lack of emphasis on the patients self report of pain, lack of standards for systematic pain assessment, and knowledge deficit regarding drug and non-drug treatments. Fear of addiction, drug tolerance and physical dependence on drugs is a concern by both health care providers and patients.

The Joint Commission of Healthcare Accreditation (JCAHO) introduced pain management standards that began being scored effective January 2001. All healthcare organizations are held accountable to these standards. The pain standards are:

- Patient Rights-Patients have the right to appropriate assessment and management of pain. This includes the initial assessment of pain, education of all relevant providers in pain assessment and management, education of patients and families regarding their role in the managing pain, and communicating to patients and families that pain management is an important part of care.

- Assessment-Pain is assessed in all patients-All patients are assessed upon admission for the presence of pain to include location, duration, intensity, pain management history and the effect of pain of daily life. The assessment and measure of pain is recorded in a way that facilitates regular reassessment and follow-up.

- Patient Education-Patients are taught that pain management is an important part of their treatment.

- Continuum of Care-Provision of continuing care including symptom management

Health care organizations should form a team to develop an approach to pain management. The team will be assessing current practice, developing guidelines and protocols and providing staff education. Their basic philosophy is, pain is the “Fifth Vital Sign” and is to be assessed in all patients with each set of vital signs. As cited earlier in the article, effective pain management decreases morbidity, lengths of stay, enables the patient to ambulate and tolerate treatments and procedures, and increases patient satisfaction. Remember, the only person who can measure pain is the patient. Pain is what the patient says it is.

PAIN MANAGEMENT RECOMMENDATIONS

- ADMINISTER ANALGESICS ORALLY WHENEVER POSSIBLE.
- THERE IS NO ANALGESIC CEILING WITH PURE OPIOIDS.
- INCREASE DOSE UNTIL PAIN RELIEF IS ACHIEVED.
- DO NOT USE PLACEBOS TO DETERMINE IF PAIN IS "REAL".
- ASSESS PAIN, PAIN RELIEF AND SIDE EFFECTS FREQUENTLY AND ADJUST DOSAGE.
- CHANGE TO ANOTHER DRUG IF SIDE EFFECTS ARE UNMANAGEABLE.
- BELIEVE THE PATIENT'S REPORT OF PAIN

CHILDREN’S PAIN BILL OF RIGHTS

Parents have a right to:

- Act on behalf of their child.
- Have their child’s pain prevented or controlled adequately.
- Discuss their child’s pain history and pain behavior.
- Tell what special name for hurt the child uses (such as “boo-boo, “owie,” or other).
- Do what comforts their child when he or she is in pain.
- Know what kind of pain can be expected and for how long.
- Know how pain will be controlled before, during, and after any procedure.

- Know the risks, benefits, and side effects of pain medications.
- Sign a statement of informed consent about a pain plan.
- Be with their child before, during, and after a medical procedure.
- Be with their child up to and immediately after surgery.
- Have a commitment from doctors and nurses to assess their child's pain on a regular basis.
- Know who is accountable for their child's pain relief.
- Have doctors and nurses' use topical and /or local anesthetics before any injections, needle sticks, or invasive procedures.
- Have postoperative pain managed aggressively.
- Request painless methods of administering medications (oral or intravenous line, instead of injection).
- Avoid rectal administration in children over two years of age whenever **possible.**
- Have doctors and nurses listen to their assessment of how much pain their child is experiencing.
- Remind those who care for their child that pain management is an important part of any diagnostic, medical, or surgical procedure.
- Request a second opinion if they feel the child's pain is being poorly managed or if doctors and nurses do not share their concerns about preventing and controlling their child's pain.
- Act as an aggressive advocate for their child.

REMINDERS

- Parents can never assume that their child's pain will be taken care of automatically. They should always ask about pain control.
- Do not assume that if a child has received medication for pain, the pain has been adequately and appropriately treated. Assessment should continue.

PATIENT'S PAIN BILL OF RIGHTS

Patients have a right to:

- Have their pain prevented or controlled adequately.
- Have their pain and pain medication history taken.
- Ask how much pain to expert and how long it might last.
- Have their pain questions answered freely.
- Develop a pain plan with their doctor.
- Know what medication, treatment, or anesthesia will be given.
- Know the risks, benefits, and side effects of treatment.
- Know what alternative pain treatments may be available.
- Sign a statement of informed consent before any treatment.
- Be believed when they say you have pain.
- Have their pain assessed on an individual basis.
- Have their pain assessed using the 0=no pain, 10=worst pain scale.
- Ask for changes in treatments if their pain persists.
- Receive compassionate and sympathetic care.
- Receive pain medication on a timely basis.
- Refuse treatment without prejudice from their doctor.
- Seek a second opinion or request a pain care specialist.
- See their records upon request.
- Include their family in decision-making.
- Remind those who care for them that pain management is part of their diagnostic, medical or surgical care.

NEWBORN PAIN SCALE

SCORE	LEVEL	DEFINITION	**SUGGESTED INTERVENTION**

0	No Apparent Pain	• No crying - resting - calm • Relaxed body posture - sleeping • No deviation in VS or O2	**None**
1	Uncomfortable	• Intermittent: whimper - restlessness - tense muscles - comfort/calms self • Able to sleep. Occasional up, down O2 & VS <10% of baseline	Comfort Measures
2	Mild Pain	• Whimpering cry - moaning - restless - irritable - tense muscles - difficult to console - able to sleep • VS; HR, BP up<20% of baseline • Frequent O2 up, down <20% of baseline	Comfort Measures Consider Analgesics
3	Moderate Pain	• Sobbing - loud cry - grimace - continuous irritability - tense rigid body - intermittent sleep • up, down O2 > 20% of time • up VS - HR &/or BP> 10% of time	Comfort Measures Analgesics
4	Severe Extreme Pain	• High pitch cry - grimace/grunt - thrashing - tremulous - buckling vent - constantly awake - inconsolable • up O2 > 30% of time, up CO2 • up VS - HR &/or BP > 20% of time	Analgesics Comfort Measures

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PAIN: THE 5TH VITAL SIGN
PRINCIPLES OF PAIN MANAGEMENT

DO'S	DON'TS
DO **RESPOND TO REPORTS OF PAIN IN A TIMELY AND EFFECTIVE MANNER**	DON'T **DELAY IN RESPONDING TO PATIENT'S REPORTS OF PAIN**
DO **USE SUBCUTANEOUS (SQ) OR INTRAVENOUS ROUTE (IV) WHEN ADMINISTERING PAIN MEDS PARENTERALLY**	DON'T **USE THE INTRAMUSCULAR ROUTE (IM) WHEN ADMINISTERING PARENTERAL ANALGESICS - IT IS MORE PAINFUL AND ABSORPTION IS ERRATIC**
DO **CONSIDER USING MORPHINE WHEN CHOOSING AN OPIOID ANALGESIC**	AVOID **MEPERIDINE (DEMEROL), ESPECIALLY IN ELDERLY AND RENALLY COMPROMISED PATIENTS, DUE TO ITS NEUROTOXIC METABOLITE AND SHORTER DURATION OF ACTION**
DO **USE AROUND-THE-CLOCK (ATC)**	DON'T **USE ANALGESIC ADJUVANTS**

DOSING OF ANALGESICS IN THE MANAGEMENT OF ACUTE POST-OP PAIN AND CHRONIC PAIN	SUCH AS HYDROXYZINE (VISTARIL) AND PROMETHAZINE (PHENERGAN)
DO **INCLUDE DOSE WITHHOLDING PARAMETERS WHEN ORDERING OPIOIDS AROUND-THE-CLOCK (e.g. HOLD FOR RESPIRATION RATE <14 OR SEDATION).** DO **USE PRN DOSING FOR INTERMITTENT PAIN, e.g. DRESSING CHANGES, P.T.**	DON'T **ORDER PRN ANALGESICS FOR CONSTANT PAIN** DON'T **ORDER ANALGESICS 1-2 TABS Q 3-4 HOURS PRN** **BE SPECIFIC, e.g., TAKE 1 TABLET EVERY 4 HOURS.**
DO **BE AWARE OF THE ACETAMINOPHEN CONTENT OF COMBINATION ORAL PRODUCTS SUCH AS PERCOCET.** **WATCH OUT FOR POTENTIAL LIVER TOXICITY WITH CUMULATIVE DAILY DOSE OF >4GM OF ACETAMINOPHEN**	DON'T **WAIT FOR CONSTIPATION TO OCCUR BEFORE STARTING PATIENTS ON BOWEL MANAGEMENT THERAPY - START A LAXATIVE/STOOL SOFTENER EARLY IN THERAPY FOR PATIENTS ON AROUND-THE-CLOCK OPIOIDS**

Recommended Pain Assessment Tools
Age / Development Specific

	FLACC	Faces	VAS (0-5)	No Scale No Score
> 7 years			X	
Intubated but can communicate		X	X	
> 3 years		X		
< 3 years, Pre-verbal	X			
Non-verbal, Develop delayed	X			
Unarousable, Difficult to arouse, Medically Paralyzed				X

FLACC: NonVerbal Pain Scale

	0	1	2
Face	**No particular expression or smile**	**Occasional grimace or frown, withdrawn, disinterested**	**Frequent to constant quivering chin, clenched jaw**
Legs	**Normal position or**	**Uneasy, restless, tense**	**Kicking, or legs drawn**

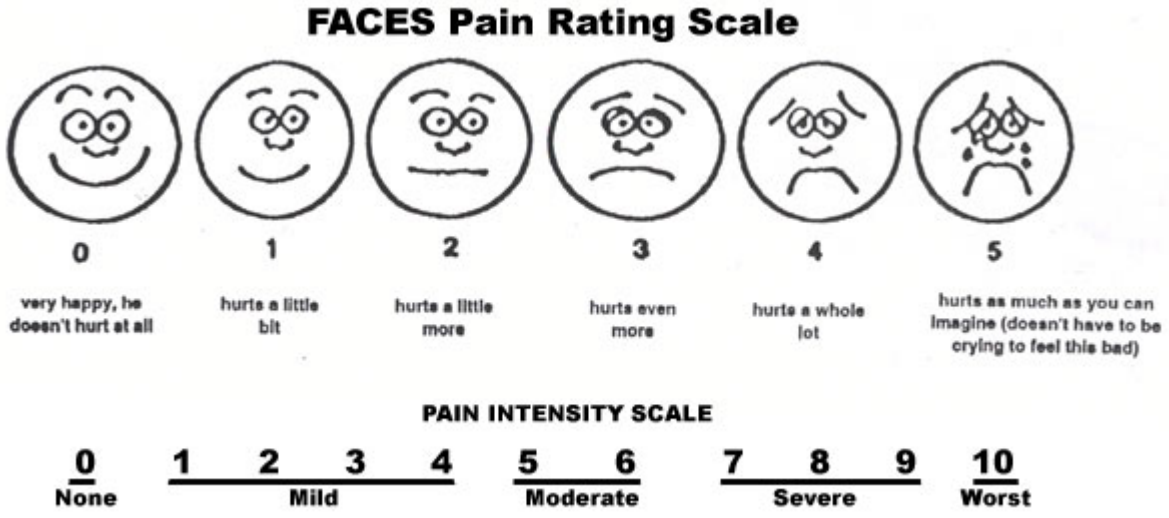
	relaxed		**up**
Activity	**Lying quietly, normal position, moves easily**	**Squirming, shifting back and forth, tense**	**Arched, rigid or jerking**
Cry	**No cry (awake or asleep)**	**Moans or whimpers, occasional complaint**	**Crying steadily, screams or sobs, frequent complaints**
Consolability	**Content, relaxed**	**Reassured by occasional touching, hugging or being talked to, distractible**	**Difficult to console or comfort**

*Score each category from 0-2, add together to total between 0 and 10.

- Appropriate for patients less than 3 years of age, preverbal patients
- Do Not use for patients greater than 3 years who can signal a pain score or point to a Face on the FACE scale
- DO NOT use for patients receiving paralytics

Faces Pain Rating Scale

- Recommended for ages 3 and older
- Explain each face to the patient using recommended terminology
- Ask the patient to choose the face that best describes how they are feeling
- DO NOT use for patients receiving paralytics



Verbal Analog Scale

0	no pain
1	a little pain
2	a little more pain
3	a whole lot of pain
4	even more than that
5	worst possible pain

- Recommended for most patients over 7 years of age
- The child must understand greater than and less than
- Ask the patient a simple single-digit subtraction problem: (5 - 2 = ??)
- Instruct the child as to what each number means

SUMMARY OF PRINCIPLES OF MEDICATION ADMINISTRATION

- In this course you learned that the key to effective pain management is to prevent pain before it occurs whenever possible.

  The route by which analgesic medication is administered depends on the
  - surgical procedure or medical intervention performed,
  - patient's underlying condition(s),
  - patient's ability to take oral / enteral medication(s),
  - practicality or availability of a particular route, e.g.., venous access,
  - need for achievement of rapid pain control,
  - dosage forms available, and the
  - cost of available medication dosage forms

- In general, analgesics should be administered on an around-the-clock (ATC) basis with additional as needed doses available for breakthrough pain.

- Scheduled analgesic administration allows for delivery of a constant amount of drug to analgesic receptor sites. This avoids the "peak and valley" effect and achieves maximal pain control with minimum adverse effects.

- If an increase in pain is expected, a dose of analgesic medication may be given in anticipation to prevent or minimize increased pain. For example, administration of a dose of opioid prior to a patient's planned physical therapy session may allow the patient to participate more comfortably in the therapy exercises.

- In addition to scheduled opioid doses, supplemental doses of a short-acting opioid should be available on an as needed (prn) basis for breakthrough or incidental pain.

- To manage severe pain, morphine is the opioid of choice.

- Addition of a non-opioid analgesic to morphine or other opioid may enhance pain management.

- Moderate pain may be managed with a less potent opioid alone or in combination with a NSAID or acetaminophen.

- Mild pain may be well managed with simply a NSAID or acetaminophen.

Examination

Select the *best* answer to each of the following items. Mark your responses on the Answer Form.

1. Pain assessment and management should be conducted _____ from population to population.

a. uniformly
b. consistently
c. equally
d. differently

2. More than _____ million patients are partially or fully disabled related to chronic pain.

a. 5
b. 20
c. 50
d. 110

3. Fear of_____, drug tolerance and physical dependence on drugs is a concern by both health care providers and patients

a. high costs
b. addiction
c. errors
d. miscalculation

4. Patients have the right to appropriate assessment and management of pain. This includes:

a. initial assessment of pain
b. education of all relevant providers in pain assessment and management
c. education of patients and families regarding their role in the managing pain
d. All of the above

5. The only person who can measure pain is the _____.

a. doctor
b. attending nurse
c. person trained specifically in pain management
Xd. patient

6. Which of the following statements related to pain management recommendations is false:

a. Administer analgesics orally whenever possible.
b. Administer analgesics orally whenever possible.
c. Increase dose until pain relief is achieved.
d. All of the above are true.

7. Under the "children's pain bill of rights," which of the following statements is false:

a. Parents have a right to act on behalf of their child.
b. Parents have a right to have their child's pain prevented or controlled adequately.
c. Parents have a right to know the risks, benefits, and side effects of pain medications.
d. All of the above statements are true.

8. Only _____% of cancer patients with pain get adequate relief.

a. 10
b. 30
c. 40
d. 50

9. The route by which analgesic medication is administered depends on the:

a. the surgical procedure or medical intervention performed
b. the patient's underlying condition(s)
c. the patient's ability to take oral / enteral medication(s),
d. All of the above

10. In general, analgesics should be administered on a(n) _____basis.

a. hourly
b. tri-hourly
c. nightly
d. around-the-clock (ATC)

11. Too frequently it is discovered that pain management has a low priority in a system focused on treating disease.

a. True
b. False

12. Do not assume that if a child has received medication for pain, the pain has been adequately and appropriately treated. Assessment should continue.

a. True
b. False

13. Parents can never assume that their child's pain will be taken care of automatically. They should always ask about pain control.

a. True
b. False

14. Parents should remind those who care for their child that pain management is an important part of any diagnostic, medical, or surgical procedure.

a. True
b. False

15. Parents should make a point to know who is accountable for their child's pain relief.

a. True
b. False

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