Paediatric Pain Guidelines

Quick reference guide November 2017

To be used in conjunction with full Paediatric pain guideline BTHFT November 2017.
Bradford Teaching Hospitals NHS Foundation Trust

Contents Page number

Palliative Care
Patients will often have an individual care plan for symptom control.
See links/advice on full paediatric pain guideline.

Paediatric pain profile:

For assessing pain in children with severe physical & learning impairments
www.ppprofile.org.uk

Discharge Advice
Pain advice given on discharge should be tailored to the individual child's condition/procedure undertaken. Verbal (+/- written advice if available) should be given. Contact details for the ward/appropriate community or hospital team must be given for pain escalation/concerns.

Author: Dr Sally Pollard & paediatric pain guideline team
Version 2
Review: November 2020

Acute pain management

Principles

- Assess pain in all children and young people on arrival & regularly
- Use appropriate pain assessment tool for developmental age/stage of child
  - Initially Wong-Baker faces pain rating scale
- Document score on PAWS chart (including absence of pain)
- Reassess pain score within 1 hour of intervention & regularly thereafter, with all sets of observations. Use same pain assessment tool for reassessment.
- Anticipate procedural pain: plan, intervene and assess/reassess.

Is child in pain?
Use Wong-Baker faces pain rating scale (see over)

Is pain likely to occur in this child?
(painful procedure: blood tests/ manipulation/surgery etc)

Document score on PAWS chart
Use children's pain assessment & management care plan (including absence of pain)

Anticipate pain
Plan, intervene, assess
Consider: Entonox, distraction, play therapy

Score 0: reassess pain with next routine observations or if change in clinical condition

Score 1-3: give analgesia or use non-pharmacological strategy & reassess within 1 hour

Analgesia – analgesic ladder
Preferred route oral (versus rectal or intravenous)

Mild pain (score 1):
Paracetamol +/- ibuprofen (or other NSAID)

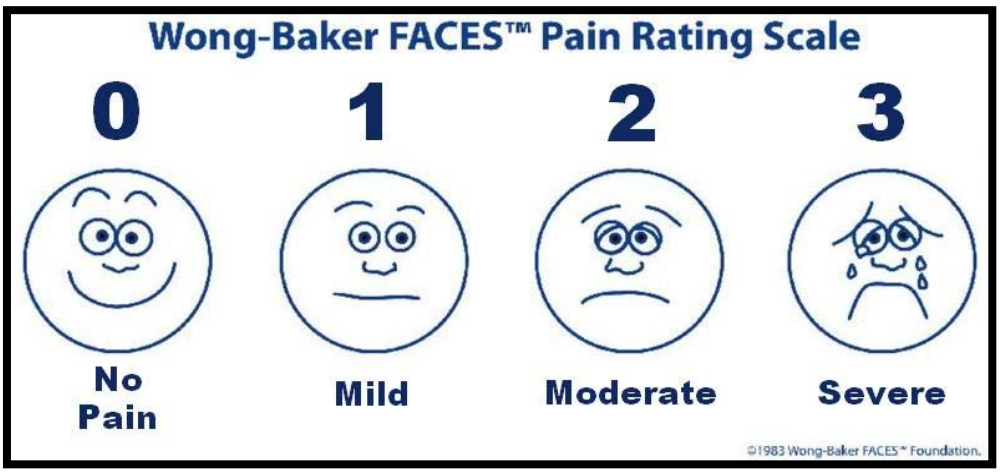
Moderate – severe pain (score 2-3):
Consider strong opioid – morphine/ diamorphine/fentanyl/oxycodone

+/- Adjuvants
Eg for neuropathic pain
Antidepressants, anticonvulsants etc

Non-pharmacological
Eg. Heat/cold/distraction/play/guided imagery

Reassessment
Within one hour of intervention
Score 0: anticipate need for regular same analgesia. Step down analgesia once regular score 0 & painful stimulus gone.
Improving pain score – continue regular analgesia, consider step up or down analgesic ladder
Persisting or worsening pain score – escalate analgesia according to analgesic ladder; give regular analgesia; seek helo from senior colleague; consider need for pain team or acute anaesthetic team

Appendix 1: Pain rating scale (adapted from College of Emergency Medicine Best practice guideline. Revised July 2013)



Behaviour	**Normal Activity** **No ↓ movement** **Happy**	**Rubbing affected area** **Decreased movement** **Neutral expression** **Able to play/talk normally**	**Protective of affected area** **↓ movement/quiet** **Complaining of pain** **Consolable crying** **Grimaces when affected part moved/touched**	**No movement or defensive of affected part** **Looking frightened** **Very quiet** **Restless/unsettled** **Complaining of lots of pain** **Inconsolable crying**
Injury (for example)	**Bump on head**	**Abrasion** **Small laceration** **Sprain ankle/knee** **Fractured fingers/clavicle** **Sore throat**	**Full thickness burns/ scalds** **Finger tip injury** **fractured forearm/ elbow/ankle**	**Superficial burns / scalds** **fractured Long bone/ dislocation** **fractured forearm/ elbow/ankle**
Illness/ condition (for example)		**Otis media** **Orbital cellulitis** **UTI** **Headache** **Sore throat**	**Respiratory** **D&V** **Colic** **Encephalitis** **Skin irritation** **Appendicitis**	**Respiratory** **D&V** **Post intubation** **Encephalitis** **Broken down skin** **Appendicitis**

Was the pain reported by: Patient, Parent or nurse?