Pain Assessment in Paediatric Oncology Patient

Jeanny Cheung
Nurse Specialist, PWH
9 July 2016
What is Pain?

- Pain is an unpleasant sensory and emotional experience with actual or potential tissue damage, or described in terms of such damage.

- It is always subjective and interpreted by the individual.
“Pain in children is often inadequately assessed and undertreated.”
The American Academy of Pediatrics & the American Pain Society 2001

- Uncontrolled or chronic pain in children can leave them victimized, depressed, isolated & lonely
- It can also affect their ability to cope with cancer
- Parents may experience guilt, anger & depression (WHO, 1998)
- Nurses & other healthcare providers must realize children feel pain just as adults & their pain must be treated appropriately

<table>
<thead>
<tr>
<th>症状</th>
<th>化療前</th>
<th>化療後</th>
<th>化療後4個月</th>
</tr>
</thead>
<tbody>
<tr>
<td>精力不足</td>
<td>75.8%</td>
<td>70.5%</td>
<td>57.4%</td>
</tr>
<tr>
<td>脱髮</td>
<td>69.2%</td>
<td>65.6%</td>
<td>62.3%</td>
</tr>
<tr>
<td>疼痛</td>
<td><strong>62.1%</strong></td>
<td>68.9%</td>
<td>52.5%</td>
</tr>
<tr>
<td>感到昏昏欲睡</td>
<td>49.2%</td>
<td>57.4%</td>
<td>36.7%</td>
</tr>
<tr>
<td>恶心</td>
<td>47.0%</td>
<td>80.3%</td>
<td>50.0%</td>
</tr>
</tbody>
</table>
Types of pain need for assessment

**Neuropathic**

- Caused by nerve damage
- Peripheral, autonomic & central nervous system
- Described in terms of numbness, burning, electrical and/or tingling sensations, sharp, shooting pain
- Associated with:
  - chemotherapy: VCR
  - Radiotherapy
  - Surgery: limb-salvage, amputation
Types of pain need for assessment

Nociceptive
- cause by pass or ongoing tissue injury
- in the form of mechanical, thermal or chemical
  • Somatic: response to inflammation & damage to the soft tissue, muscle, skin, & bone aching, piercing, more localized
  • Visceral: referred to another body site dull, squeezing, more diffuse
  • Associated with tissue damage: mucositis,

Friedrichsdorf and King, (2007)
Source of pain for our patient

- **Procedures**: blood taking, BMA, LP, biopsy
Source of pain for our patient

• **Treatment:**
- chemo: mucoisitis, abdominal pain, perianal pain
- inflammation, infection
- drug extravasation
Source of pain for our patient

• **Disease:**
  - brain tumour → headache
  - bone pain → ALL, Osteosarcoma, metastasis
  - organmegaly, tumour enlargement

• Psychological

• Other: AVN
Goal of Pain Assessment

Provide accurate information

• Location
• Intensity of pain
• Its effects on patient’s functioning

Facilitates

• Identify cause of pain
• diagnosis & disease monitoring
• **maximum pain relief with minimal side effects**
• alleviate needless suffering
QUEST

- **Question** the patient
- **Use** pain rating scales
- **Evaluate** behavior & physiologic change
- **Secure** parents’ involvement
- **Take** cause of pain into account
- **Take** action & evaluate results

Baker & Wong, (1987)
ABCs of Pain Assessment

• **Assess**: Always evaluate a child with cancer for potential pain. Paediatric patient with different ages may respond in different way when they have pain.

• Infants & toddlers can show their pain only by how they look and act.

• Teenage & adolescent may deny their pain for fear of more painful treatment.
**ABCs of Pain Assessment**

- **Body**: Physical examination should include a comprehensive check of all body areas for potential pain sites.
- **Patient’s reactions**: grimacing, rigidity, contracture may indicate pain.
- **Context**: Consider the impact of family, health-care, and environment factors on the child’s pain.
ABCs of Pain Assessment

• **Document:** Record the severity of a patient’s pain on a regular basis

• **Use of pain scale:** Simple & appropriate for developmental level, ± cultural context

• **Evaluate:** Assess the effectiveness of pain interventions regularly and modify the treatment plan as necessary, until the child’s pain is alleviated or minimized.
Assess location of pain

- Given help to find the location of the pain for young patient
- Older children are able to speak
- Child may ask to paint the location by indicate in a picture

head / chest / abdomen / oral mucosa / anal area
left arm / right arm / left leg / right leg
Onset & Characteristic of pain

Distending 胀痛
Squeezing 压痛
Sore 酸痛
Pricking 针刺痛
Dull 隐痛 /钝痛
Burning 烧灼痛
Stinging 麻刺痛
Numbing 麻痹的
Cramping 痉挛性的

• acute 急性的
• gradual 渐进性的
• intermittent 间断性的
• occasional 偶尔的
• constant 持续性的
• chronic 慢性的
• chemo related 化学相关的
• disease related 疾病相关的
Other areas for assessment

• Associated symptoms
• Triggers, alleviating factors
• Impacted functioning
eating, sleep, physical activity
COGNITIVE
- Inaccurate understanding (treatment, disease, prognosis)
- Little active control (choices or pain-reducing strategies)
- Uncertainty re. effective therapies (drug and non-drug)
- Negative expectations (obtaining pain relief, prognosis)
- Aversive relevance (disease and treatments)

BEHAVIORAL
- Family or staff responses that increase children’s distress or lessen their control
- Inconsistent use of pain control therapies
- Little use of child initiated pain-control methods
- Withdrawal from normal activities (school, sports, social)
- Altered parental responses to child ren. typical parenting relationships

EMOTIONAL
- High anticipatory anxiety (procedures)
- Frustration regarding disruption to life
- Fear, anxiety, sadness, depression (re. prognosis and impact on life)
- Anger
- Fear of being sick
- Underlying anxiety or depression (co-morbid condition)

Neuromodulatory Mechanisms

Nociceptive or Neuropathic Stimulation

Child
Age, Cognitive level, Gender, Prior pain experience, Temperament, Coping abilities, Family learning, Culture

Pain and Distress

Fig. 1. Situational factors mediating children’s pain (McGrath & Crawford, 2010)
Variety of tools for pain assessment

- Poker chips
- Face rating scale
- Visual analog scale
- Word graphic rating scale
- Face scale
3 key aspect

• Self Measurement (numeric or pictorial scales, verbal description)
• Behavioral Assessment (facial expression, withdrawal from pain, guarding, agitation)
• Physiological Assessment (vital signs, diaphoresis)
Systematic review of observational (behavioral) measures of pain for children and adolescents aged 3 to 18 years

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Abstract

Observational (behavioral) scales of pain for children aged 3 to 18 years were systematically reviewed to identify those recommended as outcome measures in clinical trials. This review was commissioned by the Pediatric Initiative on Methods, Measurement, and Pain Assessment in Clinical Trials (www.imm pact.org). In an extensive literature search, 20 observational pain scales were identified for review including behavior checklists, behavior rating scales, and global rating scales. These scales varied in their reliance on time sampling and inclusion of physiological items, facial and postural items, as well as their inclusion of multiple dimensions of assessment (e.g., pain and distress). Each measure was evaluated based on its reported psychometric properties and clinical utility. Scales were judged to be indicated for use in specific acute pain contexts rather than for general use. Two scales were recommended for assessing pain intensity associated with medical procedures and other brief painful events. Two scales were recommended for post-operative pain assessment, one for use in hospital and the other at home. Another scale was recommended for use in critical care. Finally, two scales were recommended for assessing pain-related distress or fear. No observational measures were recommended for assessing chronic or recurrent pain because the overt behavioral signs of chronic pain tend to habituate or dissipate as time passes, making them difficult to observe reliably. In conclusion, no single observational measure is broadly recommended for pain assessment across all contexts. Directions for further research and scale development are offered.
### Expression of pain in children

<table>
<thead>
<tr>
<th>Developmental group</th>
<th>Expressions of Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants 1-12months</td>
<td>- Exhibit body rigidity or thrashing may include arching</td>
</tr>
<tr>
<td></td>
<td>- Exhibit facial expression of pain (brows lowered and drawn together, eyes tightly closed, mouth open and squares)</td>
</tr>
<tr>
<td></td>
<td>- Cry intensely/loudly</td>
</tr>
<tr>
<td></td>
<td>- Be inconsolable</td>
</tr>
<tr>
<td></td>
<td>- Draw knees to chest</td>
</tr>
<tr>
<td></td>
<td>- Exhibit hypersensitivity or irritability</td>
</tr>
<tr>
<td></td>
<td>- Have poor oral intake</td>
</tr>
<tr>
<td></td>
<td>- Be unable to sleep</td>
</tr>
</tbody>
</table>

Hockenberry-Eaton et al. (1999)
### Expression of pain in children

<table>
<thead>
<tr>
<th>Developmental group</th>
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</table>
| Toddlers 13m-3yrs   | - Be verbally aggressive, cry intensely  
|                     | - Exhibit regressive behaviour or withdraw  
|                     | - Exhibit physical resistance by pushing painful stimulus away after it is applied  
|                     | - Guard painful area of body  
|                     | - Be unable to sleep  |

Hockenberry-Eaton et al. (1999)
# Expression of pain in children

<table>
<thead>
<tr>
<th>Developmental group</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Preschoolers/</td>
<td>- verbalize intensity of pain</td>
</tr>
<tr>
<td>Young children 4-6yrs</td>
<td>- see pain as punishment</td>
</tr>
<tr>
<td></td>
<td>- Exhibit thrashing of arms &amp; legs</td>
</tr>
<tr>
<td></td>
<td>- Attempt to push stimulus away before it is applied</td>
</tr>
<tr>
<td></td>
<td>- be uncooperative</td>
</tr>
<tr>
<td></td>
<td>- Need physical restrain</td>
</tr>
<tr>
<td></td>
<td>- Cling to parent, nurse, or significant other</td>
</tr>
<tr>
<td></td>
<td>- Request emotional support (e.g. hugs, kisses)</td>
</tr>
<tr>
<td></td>
<td>- Understand that there can be secondary gains associated with pain</td>
</tr>
<tr>
<td></td>
<td>- be unable to sleep</td>
</tr>
</tbody>
</table>

Hockenberry-Eaton et al. (1999)
## Expression of pain in children

<table>
<thead>
<tr>
<th>Developmental Group</th>
<th>Expressions of Pain</th>
</tr>
</thead>
</table>
| School-Age children 7-12yrs | - Verbalize pain  
- Use an objective measurement of pain  
- Be influenced by cultural belief  
- Experience nightmares related to pain  
- Exhibit stalling behaviours (e.g. Wait a minute or I’m not ready)  
- Have muscular rigidity such as clenched first, white knuckles, gritted teeth, contracted limbs, body stiffness, closed eyes, or wrinkled forehead  
- Include all behaviours of preschoolers/young children  
- Be unable to sleep |

Hockenberry-Eaton et al. (1999)
# Expression of pain in children

<table>
<thead>
<tr>
<th>Developmental group</th>
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</tr>
</thead>
</table>
| Adolescents 13-19yrs| -Localize and verbalize pain  
                        -Deny pain in presence of peers  
                        -Have changes in sleep patterns or appetite  
                        -Be influenced by cultural beliefs  
                        -Exhibit muscle tension and body control  
                        -Display regressive behaviour in presence of family  
                        -Be unable to sleep |

Hockenberry-Eaton et al. (1999)
Evidence-based Assessment of Pediatric Pain

Lindsey L. Cohen,¹ PhD, Kathleen Lemanek,² PhD, Ronald L. Blount,³ PhD, Lynnda M. Dahlquist,⁴ PhD, Crystal S. Lim,¹ MA, Tonya M. Palermo,⁵ PhD, Kristine D. McKenna,⁴ MS and Karen E. Weiss,⁴ MS

¹Georgia State University, ²College of Medicine, Ohio State University, ³University of Georgia, ⁴University of Maryland Baltimore County, and ⁵Oregon Health and Science University

Objective  To conduct an evidence-based review of pediatric pain measures. Methods  Seventeen measures were examined, spanning pain intensity self-report, questionnaires and diaries, and behavioral observations. Measures were classified as “Well-established,” “Approaching well-established,” or “Promising” according to established criteria. Information was highlighted to help professionals evaluate the instruments for particular purposes (e.g., research, clinical work). Results  Eleven measures met criteria for “Well-established,” six “Approaching well-established,” and zero were classified as “Promising.” Conclusions  There are a number of strong measures for assessing children’s pain, which allows professionals options to meet their particular needs. Future directions in pain assessment are identified, such as highlighting culture and the impact of pain on functioning. This review examines the research and characteristics of some of the commonly used pain tools in hopes that the reader will be able to use this evidence-based approach and the information in future selection of assessment devices for pediatric pain.
Review of pain assessment tools

Royal College of Nursing (2009) reviewed 89 papers, examine 41 separate tools. 11 self-report tools & 20 observer-rated tools were included in the Clinical practice guideline: Recognition & assessment of acute pain in children, September 2009.
# Review on pain assessment tools

<table>
<thead>
<tr>
<th>Tool name</th>
<th>Features</th>
<th>Suitable for setting:</th>
<th>Suitable for (age [years]):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alder Hey Triage Pain Scale (AHTPS)</td>
<td><img src="image.png" alt="Eye" /> <img src="image.png" alt="Book" /></td>
<td>During triage in A&amp;E</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️</td>
</tr>
<tr>
<td>Cardiac Analgesic Assessment Tool (CAAT)</td>
<td><img src="image.png" alt="Eye" /> <img src="image.png" alt="Book" /></td>
<td>Routine care in paediatric intensive care unit after surgery</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️</td>
</tr>
<tr>
<td>Chedoke-Mcmaster Paediatric Pain Management Sheet</td>
<td><img src="image.png" alt="Eye" /> <img src="image.png" alt="Head" /> <img src="image.png" alt="Book" /></td>
<td>Post-operative pain</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️</td>
</tr>
<tr>
<td>Colour Analogue Scale</td>
<td><img src="image.png" alt="Head" /> <img src="image.png" alt="Book" /></td>
<td>Post-operative pain and acute pain in the emergency department</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️</td>
</tr>
<tr>
<td>Children's Hospital of Eastern Ontario Pain Scale (CHEOPS)</td>
<td><img src="image.png" alt="Eye" /> <img src="image.png" alt="Book" /></td>
<td>Post-operative and peri-procedural pain</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️</td>
</tr>
<tr>
<td>COMFORT</td>
<td><img src="image.png" alt="Eye" /> <img src="image.png" alt="Book" /> <img src="image.png" alt="Graph" /></td>
<td>Post-operative and peri-procedural pain</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️</td>
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<tr>
<td>Derbyshire Children's Hospital Pain Tool (DCHPT)</td>
<td><img src="image.png" alt="Eye" /> <img src="image.png" alt="Book" /></td>
<td>Post-operative pain</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️</td>
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<tr>
<td>FACES scale (Wong-Baker)</td>
<td><img src="image.png" alt="Eye" /> <img src="image.png" alt="Book" /></td>
<td>Peri-procedural pain</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️</td>
</tr>
</tbody>
</table>
### Children’s Hospital of Eastern Ontario Pain Scale (CHEOPS)

#### FLACC

#### Wong-Baker Faces Pain Rating Scale

<table>
<thead>
<tr>
<th>Tool name</th>
<th>Features</th>
<th>Suitable for setting:</th>
<th>Suitable for (age [years]):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faces Pain Scale (FPS; by Bieri)*</td>
<td></td>
<td>Post-operative pain</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️</td>
</tr>
<tr>
<td>Face, Legs, Arms, Cry, Consolability (FLACC)</td>
<td></td>
<td>Post-operative and peri-procedural pain</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️</td>
</tr>
<tr>
<td>Nursing Assessment of Pain Intensity (NAPI; a modification of CHEOPS)</td>
<td></td>
<td>Post-operative pain</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️</td>
</tr>
<tr>
<td>OUCHER*</td>
<td></td>
<td>Post-operative pain (outpatient and ambulatory)</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️</td>
</tr>
<tr>
<td>Poker Chip Tool</td>
<td></td>
<td>Post-operative and peri-procedural pain</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️</td>
</tr>
<tr>
<td>Post-operative Pain Score (POPS)</td>
<td></td>
<td>Post-operative pain</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️</td>
</tr>
<tr>
<td>Pain Rating Scale</td>
<td></td>
<td>Post-operative pain</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️</td>
</tr>
<tr>
<td>Sheffield Children’s Hospital Facial Expression Scale</td>
<td></td>
<td>Post-operative pain</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️</td>
</tr>
<tr>
<td>Toddler Preschool Post-operative Pain Scale (TPPSS)</td>
<td></td>
<td>Post-operative pain</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️</td>
</tr>
<tr>
<td>University of Wisconsin Pain Scale</td>
<td></td>
<td>Peri-procedural pain</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️</td>
</tr>
<tr>
<td>Visual Analogue Scale (self rated)</td>
<td></td>
<td>Post-operative pain</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️</td>
</tr>
<tr>
<td>Visual Analogue Scale (observer rated)</td>
<td></td>
<td>Post-operative pain</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️</td>
</tr>
<tr>
<td>Verbal Rating Scale</td>
<td></td>
<td>Post-operative pain</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️</td>
</tr>
<tr>
<td>Word Descriptor Scale</td>
<td></td>
<td>Peri-procedural pain</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️</td>
</tr>
<tr>
<td>Word Graphic Rating Scale</td>
<td></td>
<td>Post-operative pain</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️ ✔️</td>
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</table>

**Key**
- ✍️ Self-report tool
- 📝 Observer rated tool
- 📏 Training necessary
- 🔊 Tool includes physiological measures (e.g. blood pressure, heart rate)
- ✔️ Indicates groups for which the tool is suitable
- ❌ Indicates groups for which the tool has not been validated

Royal College of Nursing (2009)
Numerical Pain Scale (NRS)

- Ask the patient (usually > age 12 years) to rate their pain from 0 to 10
- Requires the understanding that increasing ordinal numbers mean pain at a higher intensity
Wong-Baker 面部表情疼痛量表

Wong-Baker FACES® Pain Rating Scale

无痛 | 微痛 | 较痛 | 更痛 | 非常痛 | 剧痛
---|---|---|---|---|---
No Hurt | Hurts Little Bit | Hurts Little More | Hurts Even More | Hurts Whole Lot | Hurts Worst

www.wongbakerFACES.org

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### FLACC Scale: Merkel, (1997)

<table>
<thead>
<tr>
<th>Categories</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face</td>
<td>No particular expression or smile</td>
<td>Occasional grimace or frown, withdrawn, disinterested</td>
<td>Frequent to constant quivering chin, clenched jaw</td>
</tr>
<tr>
<td>Legs</td>
<td>Normal position or relaxed</td>
<td>Uneasy, restless, tense</td>
<td>Kicking or legs drawn up</td>
</tr>
<tr>
<td>Activity</td>
<td>Lying quietly, normal position, moves easily</td>
<td>Squirming, shifting back and forth, tense</td>
<td>Arched, rigid or jerking</td>
</tr>
<tr>
<td>Cry</td>
<td>No cry (awake or asleep)</td>
<td>Moans or whimper, occasional complaint</td>
<td>Crying steadily, screams or sobs, frequent complaints</td>
</tr>
<tr>
<td>Consolability</td>
<td>Content, relaxed</td>
<td>Reassured by occasional touching, hugging or being talked to distractible</td>
<td>Difficult to console or comfort</td>
</tr>
</tbody>
</table>

Each of the five categories (F)Face; (L)Legs; (A)Activity; (C)Cry; (C)Consolability is scored from 0-2, resulting in a total score range of 0 to 10.
# Neonatal Infant Pain Scale

<table>
<thead>
<tr>
<th>NIPS</th>
<th>0 point</th>
<th>1 point</th>
<th>2 points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facial expression</td>
<td>Relaxed</td>
<td>Contracted</td>
<td></td>
</tr>
<tr>
<td>Cry</td>
<td>Absent</td>
<td>Mumbling</td>
<td>Vigorous</td>
</tr>
<tr>
<td>Breathing</td>
<td>Relaxed</td>
<td>Different than basal</td>
<td></td>
</tr>
<tr>
<td>Arms</td>
<td>Relaxed</td>
<td>Flexed/stretched</td>
<td></td>
</tr>
<tr>
<td>Legs</td>
<td>Relaxed</td>
<td>Flexed/stretched</td>
<td></td>
</tr>
<tr>
<td>Alertness</td>
<td>Sleeping/calm</td>
<td>Uncomfortable</td>
<td></td>
</tr>
</tbody>
</table>

Maximal score of seven points, considering pain ≥ 4.
Physiological indicators

- Whenever self-report is not possible and motor function is not normal, use physiological criteria:
  - Altered observations (HR, RR, BP, SaO2), posture/tone, sleep pattern, skin colour/sweating
  - Not good indicators to use as single marker
  - May vary enormously, affect by fear, anger, anxiety, sepsis, hypovolaemia...
Time to assess

• Evidence of best time to assess pain is limited
• Based on expert opinion
• Recommend at least 4-6 hour (RCN, 2002; Van Dijk et al., 2004; Anand, 2001; AHCPR, 1992)
• Increase in pain severity
• Lack of response to pain management or worsening of a child’s clinical condition
Pain assessment cycle

1hr for oral analgesic
30min for parenteral analgesic
Patient asleep, record & reassess later

Pain Goal

(RCN, 2009)
Time to assess in our current setting

- At the time of admission
- At regular intervals after initiation of treatment
- At each new report of pain
- After pharmacologic or non-pharmacologic intervention, at an appropriate interval
- 15-30mins after parental therapy, 1 hr after oral administration of analgesic
Approach to pain

- Listen to the patient
- Believe the patient
- Acknowledging pain makes pain visible.
- Assessment according to age & developmental level
- Teach to use pain scale
- Use same scale each time
- Use multiple informants
Approach to Pain

- Pain assessment should be incorporated into routine observations as the fifth vital sign
- Pain assessment is not an isolated element
- It is an ongoing & integral part of total pain management
- Other elements include implementation of appropriate interventions, evaluation and reassessment
Reference


