HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Pediatrics		
Document:	Multidisciplinary Policy and Procedure		
Title:	Pain Assessment and Management in Pediatric Patient		
Applies To:	All Pediatric Staff		
Preparation Date:	January 12, 2025	**Index No:**	PED-MPP-003
Approval Date:	January 26, 2025	**Version :**	2
Effective Date:	February 26, 2025	**Replacement No.:**	PICU-MPP-025 (1)
Review Date:	February 26, 2028	**No. of Pages:**	5

1. PURPOSE:

1.1 The purpose of this policy is to establish a standardized process for the appropriate assessment and management of pain in all pediatric patients.

2. DEFINITIONS:

2.1 **Pain** – refers to an unpleasant sensory or emotional experience associated with actual or potential tissue damage or described in terms of such damage.

2.2 **Acute Pain** – is one of the most common adverse stimuli experienced by children, occurring as a result of injury, illness and medical procedures.

2.3 **Chronic Pain** – malignant or non-malignant pain that exist beyond its expected time frame for healing or where healing may not have occurred. It is persistent pain that is not amenable to routine pain control methods. Note: Patients with chronic pain may have episodes of acute pain related to treatment, procedure, disease progression or reoccurrence.

2.4 **Pain Assessment** – is an important part of pain management. To adequately assess a child's response to treatment, it is necessary to have ongoing assessment of the child's pain. Pain is a subjective experience, individual self – reporting is the perfect method for assessing pain.

2.4.1 Children who cannot communicate pain information due to age or developmental status, observational and behavioral assessment fools are acceptable alternatives.

2.5 **High Risk Pain Population** – may include infants and children.

2.6 **Pain Management** – the use of pharmacological and non-pharmacological interventions to control the patient's identified pain. Pain management extends beyond pain relief, encompassing the patient quality of life and ability to work productively, to enjoy recreation.

3. POLICY:

3.1 Patients have a right to assessment of pain and to appropriate intervention when pain is present or anticipated.

3.2 This policy applies to all ventilated and non – ventilated patient treated patients in Ministry of Health.

3.3 All healthcare providers are responsible and accountable for ensuring effective pain management.

4. PROCEDURE:

4.1 Pain Assessment:

4.1.1 Pain severity and pain relief shall be assessed and reassessed at regular intervals, and this information shall be used in deciding the appropriate intervention, which may include pharmacological and non – pharmacological techniques.

4.1.2 Only approved pain assessment scales shall be utilized.

4.1.2.1 The Verbal Numeric Rating Scale (VNRS) uses either a vertical or a horizontal pre – measured line (10mm) to estimate pain.

4.1.2.2 The ends of the lines represent the two extremes of pain (0"No Pain" to 10"Worse Pain").

4.1.2.3 It may include a numerical representation along the line.
4.1.2.4 The child makes a mask on the line to indicate his/her level of pain.
4.1.2.5 The pain score is calculated by measuring the distance from the left end point of the scale to the child's mask.

4.1.3 Numeric Rating Scale (NRS) – used in older children who understand abstract and concept.
4.1.3.1 It does not include any lines, but is administered as a script asking the child to rate his/her pain from 0 to 10.
4.1.3.2 With "0" being no pain and "10" being the worst pain.

4.1.4 In younger children, developmental capabilities may hinder the use of purely numeric scales and therefore pictorial based pain scale such as the Wong Baker Faces Pain Scale is used.

4.1.5 FLACC pain score from 1 month to 7 years old

4.1.6 Behavioural Pain scale – to assess pain in ventilated, unconscious and/or sedated patients

4.1.7 Neonatal pain scale(CRIES) – from 0 to 1 month

4.1.8 Pain assessment is documented thru careware system,

4.2 Pain Management

4.2.1 Non – pharmacological Pain Management.
4.2.1.1 Use of massage.
4.2.1.2 Heat and/or cold compresses.
4.2.1.3 Applying pressure or vibration.
4.2.1.4 Repositioning.
4.2.1.5 Psychological comfort measures include use of imagery, distraction and relaxation techniques.

4.2.2 Pharmacological Management:
4.2.1.1 Use of non – opioids agents such as Acetaminophen and NSAID's.
4.2.1.2 Non opioids are frequently combined with an opioid to provide balanced multimodal analgesia to treat moderate to severe pain.
4.2.1.3 Opioids work primarily in the central nervous system through the MU receptors. It includes Morphine, Codeine, etc.

5. MATERIAL AND EQUIPMENT:

N/A

6. RESPONSIBILITIES:

6.1 Physician
6.2 Nurses

7. APPENDICES:

7.1 Verbal Numeric Rating Scale (VNRS)
7.2 Wong Baker Pain Scale
7.3 FLACC Scale
7.4 Behavioural pain scale
7.5 Neonatal pain scale (Cries)

8. REFERENCES:

8.1 Ceclie Wong, Elaine Lav, Lori Palozzi, Pain Assessment tools and Pain Management in Children. http://www.ncbi.n;m.nih.gov
8.2 American Academyof Pediatrics, Committee on Psychological Aspect of Child and Family Health, 2001.

9. APPROVALS:

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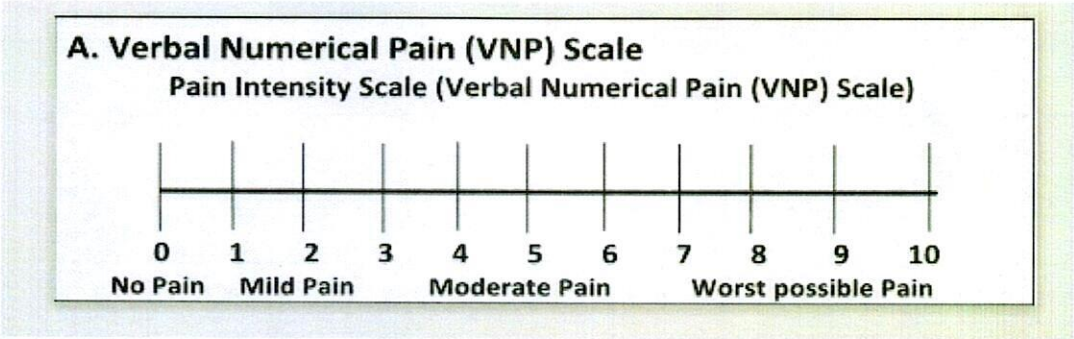
Appendices 7.1 Verbal Numeric Rating Scale (VNRS)



Appendix 7.2 Wong Baker Pain Scale

WONG BAKER PAIN SCACE

(7 years old and above)

CATEGORY	DESCRIPTION	PAIN SCORE
a) ntensity	No pain	0
	Milc pain, Annoying	1-2
	Nagging pain, Uncomfortable	3-4
	Miserable	5-6
	Intense, Dreadful, Horrible	7-8
	Worst pain, Possible	9-10
b) Location	Where does it hurt?	
c) Onset	When did the pain start?	
d) Duration	How long have you had this pain?	
e) Quality	Constant , On and Off	
	Dull or Sharp	
	Burning or Pressure	
	Radiating	

Appendices 7.3 FLACC SCALE

Categories	Scoring		
	0	1	2
Face	No Particular expression smile	Occasional grimace or frown, withdrawn, Disinterested	Frequent to constant quivering chin, clenched jaw
Leg	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 crying (awake or sleep)	Moans or whimpers, occasional complaint	Crying Steadily, screams or sobs frequent complaints
Consulability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distracted	Difficult to console or comfort

Instructions:

Each of the five categories(F) Face; (L Legs; (A)Activity; (C) Consulability Is scored form 0-2, which result in a total score between 0 and 10.

Appendices 7.4 Behavioural Pain Scale

BEHAVIORAL PAIN SCALE

(To assess pain in ventilated, unconscious and /or sedated patients, please write appropriate answer and sum up)

CATEGORY	DESCRIPTION	SCORE
FACIAL EXPRESSION	RELAXED	1
	PARTIALLY TIGHTENED (eg. brow lowering)	2
	Fully tightened (eg. eyelid closing)	3
	Grimacing	4
UPPER LIMBS	No movement	1
	Partially bent	2
	Fully bent with finger flexion	3
	Permanently retracted	4
COMPLIANCE WITH VENTILATION	Tolerating movement	1
	Coughing with movement	2
	Fighting with ventilator	3
	Unable to control ventilation	4

Scoring: 0-3 No pain 4-6 Mild pain
7-9 Moderate pain 10-12 Severe pain

Appendices 7.5 Neonatal Pain Scale (Cries)

NEONATAL PAIN SCALE

CRIES

(0-1 month)

	0	1	2
Crying	No	High Pitched	Inconsolable
Requires O2 For saturation Greater than 95 %	No	Less than 30 %	Greater than 30 %
Increased Vital Sign	HR, Bp within 10 % of Pre-op Values	11 % to 20 % Pre-op Values	Greater than 21 % of Pre-op Values
Expression	No	Grimace	Grimace / Grunt
Sleeplessness	No	Wakes at Frequent Intervals	Constantly Awake

Instructions:

Each indicator is rated on a 3 point scale (0 , 1, 2) that result is a total score from 0 to 10