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|  | Document Scope: Hospital-wide Patient Care | |
| | Document Type: Policy, Guideline Approved on 2020-08-12 Next Review Date: 2023-08-12 | |
| | Pain Assessment | Version: 3 |

Issued by: Pain Matters Committee

1.0 Introduction

Effective pain management depends on regular assessment of the presence and severity of pain and the patient's response to pain management interventions. Regular pain assessment and documentation will facilitate treatment and communication among the health care team, patient and family. While this policy is directed towards nursing staff, it is the responsibility of all health care professionals to ensure that patients under their care are as comfortable as possible.

Pain can be assessed by any Health Care Professional (HCP) or caregiver using self-report, behavioral observation (by RN or caregivers), and physiological measures depending on the age / cognitive state of the child and/or communication capabilities.

Pain is considered to be the "fifth vital sign" and therefore should be assessed and documented along with the other vital signs. See [Vital Sign Monitoring](#)

2.0 Definitions

2.1 Pain relief goal: A pain relief goal may include, but is not limited, to a pain intensity score. Pain relief goals may include improvements in activity level, mood and sleep. Discussion with caregivers should include these variables when setting goals for preverbal or non-communicative children. Pain relief goals can change and should be evaluated regularly.

2.2 Pain management intervention: An intervention which is aimed at reducing pain and distress. This may include a combination of methods:


- Pharmacological (e.g. acetaminophen +/- nonsteroidal anti-inflammatory +/- opioid)
- Physical (e.g. application of heat/cold, physiotherapy, developmental strategies)
- Psychological (e.g. distraction techniques)
- These interventions should be evaluated within one hour for efficacy.

3.0 Policy

3.1 Every patient, at a minimum, will have a pain assessment, using a developmentally appropriate, reliable and valid measure, at the following times:







- on admission, visit to ED or ambulatory clinic
- with ordered vital signs and with moderate to severe pain/pain above the patient's stated manageable level as required
- before, during (if appropriate) and after a potentially painful intervention
- When vital signs are ordered Q1-2H (e.g. PICU) it may not be necessary to assess pain with each set of vital signs. In these cases a pain score should be documented a minimum of Q4H


3.2 All pain intensity scores will be documented in the patient's health record-electronic assessment flowsheet as per unit policy. If the patient is sleeping the word "sleeping"/"Unable to assess" is documented for the pain score for those using a self-report tool. For patients using a behavioural observation tool (e.g. FLACC-R), a score can still be documented.

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4.0 Guidelines for Assessing Pain

4.1 Pain is a subjective phenomenon and a self-report measure should be used whenever possible. Most children over the age of 3 years are capable of self-report. Behavioral observation and physiological parameters should be used to complement self-report and are an acceptable alternative when a self-report is not available. Behavioral observation and parental report are the primary methods for assessing pain in preverbal, nonverbal or cognitively impaired infants and children. Select a pain assessment tool based on the developmental age of the child and child and family preference. Recommended pain assessment tools include:

| Assessment tool | Age/Cognitive Stage |
|---|--|
| Premature Infant Pain Profile- Revised (PIPP-R) | <ul style="list-style-type: none"> preterm & fullterm neonates |
| Neonatal Infant Pain Scale (NIPS)  assessment_tool-nips.pdf | <ul style="list-style-type: none"> term to 1 year of age |
| FLACC tool  FLACC.pdf | <ul style="list-style-type: none"> 2 months - 7 years Note - FLACC is not built into EPIC. FLACC-R is preferred as it is more inclusive, score identically, and incorporates more features of pain. |
| Revised- FLACC  Revised-FLACC tool with instructions.Fdoc.pdf | <ul style="list-style-type: none"> Preferred over FLACC 2 months to 7 years, nonverbal and/or cognitively impaired up to 21 years. |
| Pain word scale (none, a little, medium, a lot)  Word Scale.pdf | <ul style="list-style-type: none"> 3 - 7 years; older children unable to use 0 -10 NRS |
| Faces Pain Scale - Revised (FPS-R)  Faces Pain Scale-Revised.pdf | <ul style="list-style-type: none"> 5 - 12 years |
| Numerical Rating Scale (NRS) 0 - 10  NRS-VAS.pdf | <ul style="list-style-type: none"> 7 years and older |

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4.2 On admissions, a pain history should be completed and may include the following components: pain intensity score (at rest and with activity), location, quality, duration, frequency, aggravating factors, alleviating factors, present pain management regime and effectiveness, previous experience with pain and coping strategies, and impact of pain (on daily routines, sleep, appetite, relationships with family and peers), and level of distress. Assess situational factors which may be affecting pain perception and response e.g. cognitive, emotional (e.g. mood), behavioural, environmental, cultural, social factors.

4.3 When possible, a patient pain relief goal will be established by the patient and family. A pain management intervention will be planned to meet the patient's goal.

4.4 A pain management intervention will occur if

- The patient pain relief goal is not achieved OR
- The pain intensity scores are unacceptable i.e.

4/10 (for NRS, Revised- FLACC and Faces scales); medium pain (Word scale); greater than or equal to 6 (PIPP-R scale); NIPS greater than or equal to 4

As pain is complex and multidimensional, caution should be taken in using cut off scores. Pain intensity scores should not be used as the only basis for deciding whether a child should be treated.

4.5 Assessment findings should be used to guide pharmacologic, physical and psychological interventions to ensure that pain is adequately managed.. See [Sickkids Formulary](#) - Analgesia Guidelines and [Application of Heat and Cold as a Pain Management Strategy](#) and [Comfort Promise](#)


4.6 Pain will be reassessed within one hour of a pain management intervention, and reassessment will continue q1h or more often until the pain relief goal is achieved.

5.0 Related Documents

- [Pain Management Clinical Practice Guideline \(CPG\)](#)
- [Care of Patients Receiving Patient Controlled Analgesia PCA and Nurse Controlled Analgesia NCA](#)
- [Care of Patients Receiving Epidural Infusions](#)
- [Care of Patients Receiving Peripheral Nerve Blocks](#)
- [Care of Patients Receiving Continuous Infusion of Opioids](#)
- [Vital Sign Monitoring](#)
- [Monitoring Requirements for Patients Receiving Opioids](#)
- [Monitoring Requirements for Patients Receiving Regional Anesthesia](#)
- [Electronic Patient Monitoring](#)

6.0 References

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Attachments:

[assessment_tool-nips.pdf](#)

[Faces Pain Scale-Revised.pdf](#)

[FLACC.pdf](#)

[NRS-VAS.pdf](#)

[PIPP-R.pptx](#)

[Revised-FLACC tool with instructions.Fdoc.pdf](#)

[Word Scale.pdf](#)