Queensland Paediatric Emergency Care

Skill Sheets

Acute Pain Assessment in Children

The majority of children who present to Emergency Departments experience pain as a component of their presenting complaint. The reporting of pain is subjective and can be difficult to assess in the absence of self-reporting. Nurses play a pivotal role in pain assessment, management and monitoring. Reliable, validated and easy to use pain assessment frameworks and tools have been developed so clinicians can accurately assess paediatric pain. This skill sheet will focus on assessing paediatric pain using the QUESTT framework.

Q	Question the child
U	Use pain rating scales provided in this skill sheet
E	Evaluate behaviour and physiological changes
S	Secure carers involvement
T	Take cause of pain into account
T	Take action and evaluate response

Q

Question the child

The age and developmental stage of the child influences their understanding of what the word pain means. You can substitute the word for more developmentally appropriate terms such as 'hurt' or 'ouch'. Ask the child questions to give you an understanding of the previous degree of pain the child has experienced, how they are likely to behave and whether they are likely to tell you about it.

When asking a child where they have pain or where it hurts you might:

- Ask them to point to where it hurts.
- Ask them to point on a teddy bear or doll of thier choice where it hurts.
- Colour the area of hurt on a drawing of the human figure.
- Ask their caregiver on their behalf. Some children only feel safe and confident reporting pain to their caregivers.

U

Use a paediatric pain rating scale

Validated paediatric pain assessment tools, such as the FLACC behavioural pain assessment scale and FACES pain scale, assist nurses by enabling them to ensure their assessment is effective, consistent and objective. Discuss the paediatric pain assessment tools used within your emergency department with your nurse educator.

As children mature and develop, they are less likely to display or express their pain and distress through behaviours. Children and young people should be given the opportunity to use a self-assessment tool. Once a child can effectively use a self-assessment tool, observational tools like FLACC and rFLACC should then only be used when the child is UNABLE communicate.

Self-assessment tools:

- Numeric
- Verbal numbers rating
- Faces Pain Scale - Revised
- Simple verbal descriptor eg. small, medium, big

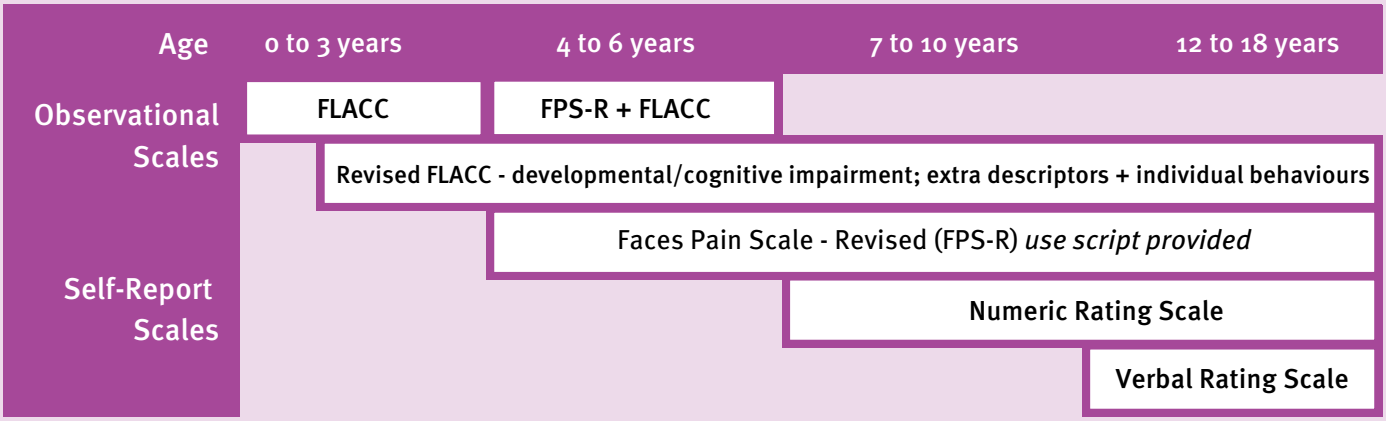
Observational Scale:

- FLACC
- rFLACC

Pain should be assessed at both rest and movement. Clinical decision regarding best management for pain is not based soley on pain intensity scores, rather a combination of all information gathered.

The impact of pain on function and recovery can be quantified using the **Functional Activity Score (FAS):**
A = no limitation, B = mild/moderate limitation, C = severe limitation

Age-based guide to pain scales:



Adapted from original source: Clinical Observations - Considerations in Children, Queensland Children's Hospital and Health Service (2023)

Observational Pain Tools

FLACC and Revised FLACC (rFLACC)

The table below is a combined FLACC and rFLACC tool. This tool is used for children who are pre-verbal or unable to self-report pain (eg. developmental or neurological impairment).

The child should be observed for one minute. A score is given out of a total of 10, with 10 indicating the highest level of pain or discomfort.

Categories	Score 0	Score 1	Score 2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested; **appears sad or worried**	Frequent to constant frown, clenched jaw, quivering chin; **distressed looking face; expression of fright or panic.** Individualised behaviour.
Legs	Normal position or relaxed; usual tone and motion to limbs	Uneasy, restless, tense; **occasional tremors**	Kicking, or legs drawn up; **marked increase in spasticity, constant tremors or jerking. Individualised behaviour.**
Activitiy	Lying quietly, normal position, moves easily, regular rhythmic respiration	Squirming, shifting back and forth, tense; **mildly agitated (head back and forth, aggression); shallow breathing, splinting**	Arched, rigid, or jerking; **severe agitation, head banging; shivering (not rigors); breath holding, gasping or sharp intake of breaths, severe splinting. Individualised behaviour.**
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or **sobs, frequent complaints, repeated outbursts, constant grunting. Individualised behaviour.**
Consolabililty	Content, relaxed	Reassured by occasional touching, huggung, or being talked to, distractable	Difficult to console or comfort, **pushing away caregiver, resisting care or comfort measures. Individualised behaviour.**

Adapted from original source: Clinical Observations - Considerations in Children, Queensland Children's Hospital and Health Service (2023)

Self-Report Pain Tools

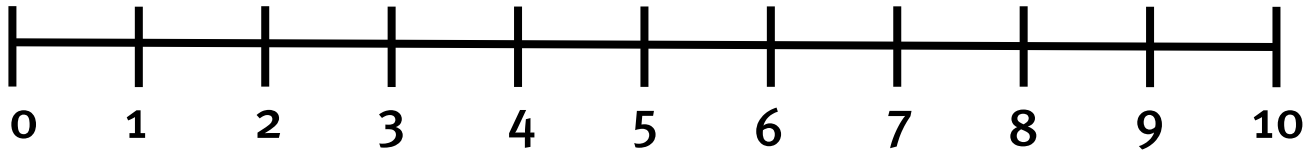
Faces Pain Scale Revised (FPS-R)

To access the pain scale refer to the International Association for the Study of Pain website: https://www.iasp-pain.org/resources/faces-pain-scale-revised

This includes specific instructions on the use of the pain scale.

Numeric Rating Scale (NRS)

The NRS is best used as a visual tool from around 7 to 12 years of age, after which it can be used as a Verbal Rating Scale (VRS).



Verbal Descriptor Scale

Some children will find it easier to rate thier pain using verbal descriptors. Younger children may find it helpful to describe their pains in terms such as small, medium or big. For older children, more descriptors can be added. Examples include: none, mild, moderate, severe, excrutiating or unbearable.

E

Evaluate behaviour and physiological changes:

Changes in behaviour are valuable indicators when assessing pain in children, especially non-verbal children. However, children's behaviours vary greatly, and assessment must not be based solely on behaviour as this can lead to inadequate pain management.

Children may fear what will happen if they admit to having pain, for example, they may get a needle or medicine, so they may deny having any pain. At times children may be too unwell or withdrawn to communicate pain through their behaviour or they may diminish or exaggerate their pain behaviours depending on the context of the environment pain is experienced in.

Behaviour indicators that may present when a child is in pain include:

- restless / irritable / aggressive
- lethargic / unusual quietness
- unusual posture / reluctance to move
- sleep patterns disturbed
- whimpering, crying, sobbing, screaming
- increased clinging
- note facial expressions

Physiological changes can be evident with acute pain, however, are not isolated to pain and may have other cause. Physiological indicators that may present when a child is in pain include:

- tachycardia
- tachypnoea
- hypertension
- flushing of the skin
- diaphoresis
- dilation of pupils
- decreased oxygen saturations

ALERT

Ensure that any abnormal physiological indicators are assessed further for other causes.

S

Secure caregivers involvement:

Caregivers know their child best! This includes knowing how their child responds to pain, particularly in the case of developmentally delayed or nonverbal children. They will also be able to provide an insight into the child's previous experiences with pain.

T

Take the cause of pain into account:

It is important that the cause of a child's pain is investigated. A good rule to follow in a paediatric pain assessment is to remember whatever is painful to an adult is also painful to an infant or child.

T

Take action and evaluate results:

Take action appropriate to the pain score. This may include pharmaceutical and non-pharmaceutical interventions as suggested below. Please note these tables are a guide only and not exhaustive.

For further detailed information on escalating analgesic options please refer to your hospitals local pain management procedure or the CHQ Procedure: Acute Pain Management (QH only). Please ensure you evaluate the effectiveness of any intervention utilised. This should be done by a follow up pain assessment and clearly documented in the patient chart.

Pain Assessment	Mild	Moderate	Severe
Suggested Action	Offer paracetamol and/or ibuprofen Implement non-pharmacological interventions	In addition to "mild" pain management: Offer oxycodone and/or fentanyl (as per HHS standing order/medical review)	In addition to "mild" and "moderate" pain management: Seek medical review. The child may require intravenous opioids.

Non-pharmacological options:

- hot and cold packs
- elevation and splinting of injured limbs
- repositioning
- breathing and relaxation techniques
- distraction eg. videos, photos, bubbles, music, colouring-in

CHQ Paediatric Procedural Pain Management Videos

Videos

Introduction	Prevention	Communication
A vital time: 0 to 24 months	The most influential years: 2 to 5 years	
Primary School age: team work makes the dream work	Teenagers: a time of great independence	

References:

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