DAYTON CHILDREN'S HOSPITAL

CLINICAL PRACTICE GUIDELINES

DISCLAIMER: This Clinical Practice Guideline (CPG) generally describes a recommended course of treatment for patients with the identified health needs. This CPG is not presented and should not be used as a substitute for the advice of a licensed independent practitioner, as individual patients may require different treatments from those specified, and guidelines cannot address the unique needs of each patient. Dayton Children's shall not be liable for direct, indirect, special, incidental or consequential damages related to the use of this CPG.

Dayton Children's Hospital

Newborn Intensive Care Unit
Guidelines for the Documentation of Pain/Discomfort Assessment and Intervention

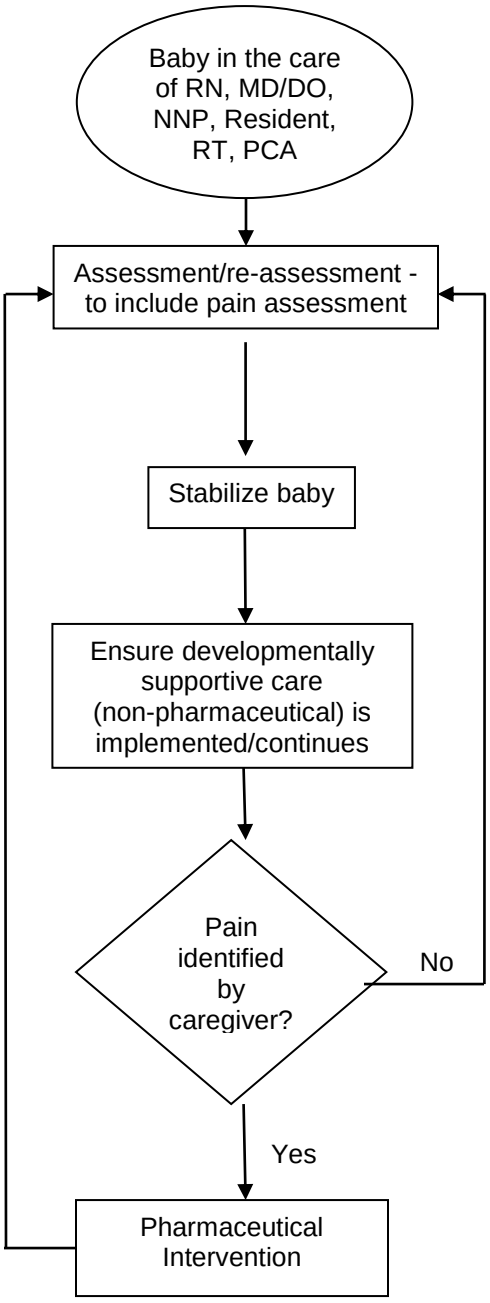
Purpose:
The NICU instituted the Pain/Discomfort Assessment Scale in October 2000 for the systematic collection of patient data that has been validated as reflective of pain in premature, term, and critically ill neonates. Grouping patient information into meaningful combinations permits the scoring of pain/discomfort, with a numeric value.

General Guidelines:

1. A registered nurse (RN) should assess each infant for pain/discomfort, by scoring the appropriate parameters on the Assessment Scale at least once on every 8 or 12 hour shift.
2. Pain indicator scores should be consistent. Examples:
   - If an infant has normal tone (0) and is sleeping (0), a relaxed face would be a 0, not a 2 (flaccid), for a score of 0 on these 3 parameters.
   - If an infant has low tone (2), no facial expression (score is probably 2, not 0), and does not cry (probably shut down - 4, not sleeping - 0), for a score of 8 on these 3 parameters.
3. Facial expression, cry/state/activity, and tone cannot be scored for infants receiving paralytic agents, those under the effects of anesthesia, and those with neurologic deficits.
4. Numeric values by themselves are less valuable than in comparison to the patient's trend or to other similar patients. Thus, an increase in score after a surgical or medical procedure (that is known to cause pain in adults) provides objective data that the infant is experiencing some degree of pain.
5. An RN reassesses patients for pain/discomfort as frequently as the patient's condition requires. For example:
   - Post surgical patients (first 72 hours) should be assessed at least every 4 hours and more often if pain scores are elevated, until pain is controlled.
   - Post procedural patients (first 24 hours) should be assessed at least every 4 hours and more often if pain scores are elevated, until pain is controlled.
   - Patients who have received pain medications (narcotics or acetaminophen) in the previous 24 hours should be assessed at least every 4 hours and more often if pain scores are elevated, until pain is controlled.
6. The pain score is documented in the electronic medical record on the NICU Hourly Documentation Flowsheet.
7. If the pain score is >2, a source of pain is identified and documented.
8. If the pain score is > 2, an intervention is provided and documented.
9. If an intervention is provided, a patient response to the intervention is documented within 30 - 60 minutes.
10. If non-pharmacologic interventions or pain medication is administered despite low pain scores, a progress note or comment providing rationale is recommended and the patient should be re-scored on the assessment scale within 30 minutes.
11. If a medication was administered, the patient is re-scored on the Assessment Scale within 30 minutes for IV medications and 60 minutes for oral medications.

NICU Pain CPG

Flowchart



Legend

Initial contact with the patient occurs:
a. At the start of a shift
b. Upon admission
c. Post-op
d. Post procedure or exam
e. Cross-covering for another caregiver

Multi-system assessment (see NICU flowsheet)
a. To include the use of a pain tool
b. Including response to interventions, including medications
c. PCAs to observe, report vital signs out of normal range, and behavior cues

Multisystem stabilization based on patient needs
- Consider that developmental care and pain management may be necessary to stabilize.

Developmentally supportive care:
a. Minimize noise, light, handling
b. Position in neutral alignment in snuggle up with boundaries and positioning device
c. No tension on attached equipment (i.e. NG, ET, Foley, CT, etc.)
d. Include family and visitors in plan of care; teaching about these listed items and goals for the baby

See pain tool, document score, and pain source (see keys)

Pharmaceutical intervention:
a. Contact appropriate physician (surgeon vs. neonatologist, attending vs. resident)
b. Obtain order for appropriate medication (see NICU protocols)
c. Administer medication appropriately

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Revised 7/01, 11/01, 3/07, 1/09, 5/11, 7/16
Reviewed 10/05, 7/14, 7/18

NICU Pain/Discomfort Assessment Scale

Date: _____

Time of assessment →																		
Facial Expression Relaxed 0 Grimace 1 Flaccid 2																		
Cry/State/Activity None/Sleeping-Alert 0 None/Fussy 1 Whimper/Fussy 2 Robust/Fussy 3 None/Shut Down 4																		
Tone Normal/Flexed 0 Increased tone 1 Flaccid 2																		
Heart rate Normal range 0 > 160 1 > 200 2 < 80 3																		
Blood Pressure ± 10% 0 + 11-20% 1 + 21% or more 2																		
Sucking Strong 0 Intermittent 1 Absent 2																		
Total Score																		
Initials																		

KEY: *** See Narrative Nurses Notes for further explanation** **If unable to score (eg. due to paralytic agents) or N/A, mark box with a dash (-).**

Category	Score	Description
Facial Expression		
Relaxed	0	Without tension
Grimace	1	Tightness of face, tight muscles, furrowed brow, chin, jaw
Flaccid	2	Without tone, mouth often hangs open
Cry/State/Activity		
No cry	0	No cry / either sleeping or looking about
None/Fussy	1	No cry / asleep or awake and restless, fussy
Whimper/Fussy	2	Weak cry / wakes at frequent intervals, fussy and irritable
Robust/Fussy	3	Strong cry / constantly awake, fussy, agitated, thrashing
None/Shut Down	4	No cry / decreased or no response to stimuli
Tone		
Normal/Flexed	0	Relaxed posture
Increased tone	1	Constant and excessive flexion / extension of the arms/legs or fingers/toes, arching
Flaccid	2	Any limpness or decrease in tone

Category	Score	Description
Heart rate		
Normal range	0	80-160 (incl. low resting HR in FT)
> 160	1	161-200
> 200	2	201 and above
< 80	3	79 and below
Blood Pressure *(Score only when BP check is needed.)*		
± 10%	0	BP within 10% of baseline prior to painful stimuli
+ 11-20%	1	BP 11-20% over baseline prior to painful stimuli
+ 21% or more	2	BP 21% or more over baseline prior to painful stim
Sucking *(Score only when awake and fussy.)*		
Strong	0	Strong and rhythmic, with pacifying effect
Intermittent	1	3-4 sucks, then stops and cries
Absent	2	Absent or disorganized due to crying

RN Signatures/Initials
