Growing Up With Us...©
A Newsletter For Those Who Care For Children

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BEHAVIORAL OBJECTIVES
AFTER READING THIS NEWSLETTER THE LEARNER WILL BE ABLE TO:

1. Distinguish age-appropriate pediatric pain assessment, including collection of subjective and/or objective data.
2. Describe common reactions to pain at different developmental periods in childhood.

Whatever is physically painful to adults should be considered painful to children, unless proven otherwise. And, because of children’s changing developmental levels, procedures which are not considered painful to adults, such as examination of the mouth or ears, may be painful to children. Fear of pain is prevalent among ill or hurt children of all ages.

KEY PEDIATRIC PAIN MISCONCEPTIONS

- Infants do not feel pain.
- Children tolerate pain better than adults.
- Children cannot tell you when or where they hurt.
- Children always tell the truth about pain.
- Children become accustomed to pain and painful procedures.

It is a basic right of patients of all ages to experience no pain while in our care. Yet, research shows that ongoing pain assessments, and therefore management, are performed on less than one-third of pediatric patients. Numerous misconceptions exist related to pain and children, which often result in lack of pain assessment and under-treatment of pain. Pain assessment and management are critical components in the care of children. First and foremost, on-going pain assessment and management is essential to prevent unnecessary suffering.

This newsletter will discuss pediatric pain assessment as the first step toward pain management. Age-appropriate pain assessments, including collection of subjective and/or objective data, will be reviewed. Children’s reactions to pain at different developmental periods will also be discussed.

PAIN ASSESSMENT

Regardless of the age of the child, it is the role of the healthcare professional to initiate pain assessments.

Systematic pain assessments, including subjective and objective data, should be performed and documented at admission and at least once a shift. They should be performed and documented more frequently, depending on the child’s clinical condition, after pain medication is given, and if pain is anticipated, such as post-operatively or when caring for a burned child.

Before assessing a child’s pain, it is important to determine the word used at home to describe pain. Using language familiar to the child in the medical setting is always essential to communication. Young children may use such terms as “owie”, “boo-boo”, “hurt”, “ouchie” or just about anything else. It is not until the school-age period that children can describe their pain in any detail.

Pediatric pain assessment, like children’s understanding and reactions to pain, follows developmental trends. The developmental level of children affects their ability and desire to communicate pain, as well as their behavioral response to it.

SUBJECTIVE DATA:

Pain is a subjective experience and, therefore, the child’s self-report of pain is considered the standard for pain assessment. By definition, “pain is whatever the patient says it is, existing whenever the patient says it does.” But, verbal responses to pain are often not possible with children. Self-report of pain is obviously not possible in pre-verbal children, including infants and young toddlers. It is also challenging in children, regardless of age, who are developmentally delayed or too upset to communicate. And, for several developmental reasons, older children may not verbalize their pain, as well, or even admit to it when asked directly. Children do not always tell the truth about their pain. For example, older children may deny pain to a stranger, such as an unfamiliar healthcare provider.

Preschoolers typically view pain, as well as hospitalization and treatments, as punishment for some real or imagined misdeed. Believing pain is a consequence they deserve, they may not report being in pain. Likewise, school-age children may deny pain for fear of receiving a “shot”. It is at this point, that all too commonly, further pain assessment is not done, resulting in unmanaged pain and suffering.

It is the role of the healthcare professional caring for children to observe for physical and behavioral signs that the child is experiencing pain.

Although the child is the only person who knows if he or she is in pain, if the child is unable or unwilling to communicate pain, parents are often the second best source of information.
Parents are typically experienced at noticing subtle changes in their child which could indicate pain, such as clinging to a parent, changes in sleep, mood or eating patterns. Also, children will typically readily admit pain to a parent. This should not be interpreted as attention-seeking behavior, but rather as a report of pain.

OBJECTIVE DATA:
Regardless of the age of the child, physical responses and general observations typically become evident with pain. Physical signs may include flushing of the skin, sweating, an increase in blood pressure, pulse and respirations and/or a decrease in oxygen saturation. Generalized observations may include problems sleeping or eating, as well as restless, irritable or withdrawn behavior. Depending on the type and location of pain, children may also display behaviors that indicate localized body pain, such as pulling of the ear for ear pain or rubbing the abdomen for stomach pain.

Behavioral responses to pain follow a developmental trend and are key to pain assessment of children of all ages. Observing the child is the primary means of assessing pain in pre-verbal children and serves as supportive data of an older child’s report of pain. It’s important to remember, a child’s report of pain is more important than his or her behavior. For example, unlike adults and older children, toddlers typically become more active and restless when experiencing pain. More age-specific pain assessment is needed, while withholding judgment.

AGE-SPECIFIC PAIN RESPONSES & REACTIONS

Infants
Children under 6 months of age typically cannot localize pain, but they do sense generalized pain. Although young infants have no memory of painful procedures, their pain is still real. Facial expressions, such as lowered eyebrows, tightly closed eyes and open mouth, are key indicators of pain in young infants. They may also express pain by squirming or flailing about, and of course, crying.

Older infants have a more deliberate reaction to pain, reacting with physical resistance and crying loudly. They are also able to begin localizing pain, such as withdrawing their leg after an injection. They may refuse to lie still and typically try to push any painful stimuli, such as an injection syringe, away after it is applied.

Toddlers
One to three year olds have a poorly defined concept of their body boundaries, wondering, “Where do I stop and where does the world begin?” As a result, intrusive procedures, those which enter the body, such as examination of the ear or mouth, are quite distressing. This age-group is as likely to react to such painless procedures as intensely as they would to physically painful ones.

Toddlers commonly react with intense emotion and physical resistance to any actual or perceived painful experience.

They typically push a painful stimulus away before it is applied. Behaviors indicating pain in this age-group include facial grimacing, clenching of the teeth/lips, opening of the eyes wide, and rocking. Aggressiveness, such as biting, kicking, hitting or running away, is also common. Toddlers are also quite vocal in their expression of pain, typically screaming “Ow!” and requesting a painful procedure to “STOP!” Tell the child when the procedure is really over, not almost, and the tears will typically cease.

Preschoolers
Three to six year olds have a vivid imagination, as well as a poorly developed concept of their body. Therefore, fears of pain typically escalate to one of bodily mutilation. For example, when a preschooler has a cast removed, there is the fear that his or her arm will be cut off. The child needs to be reassured this will not happen, as the procedure is completed quickly. Additionally, when preschoolers fall and scrape their knee, it is common for them to not react to the injury or pain until they look down and see blood. Then, they typically react by screaming uncontrollably. Having a band-aid® to put immediately on an opening in their skin, such as when an IV is removed, is helpful. Preschoolers typically believe their “guts” will leak out through the “hole” in their skin and the band-aid will keep that from happening.

Aggression is also a common response to pain for preschoolers, such as kicking, hitting and verbal pleas, “Get out!”, or “I hate you!” Additionally, they may plead, “Please, please don’t do that.”

School-Agers
Children, six to twelve years old, have a better understanding of their bodies and can usually explain exactly where their pain is. Descriptive words to explain the type of their pain, such as “stinging”, “aching”, are also commonly used. School-agers also develop more passive ways to cope with pain, such as clenching their teeth, making fists or pounding a pillow. However, it is not unusual for some school-agers to revert to earlier reactions to pain. School-agers usually apply stallng behaviors to postpone painful procedures, such as “Wait a minute!” Limits need to be placed on such behaviors. Also, socialization can influence how school-agers, especially boys, deal with pain. Expectations, such as “Just grin and bear it” or “Big boys don’t cry” may directly influence behavioral responses. Healthcare providers should reassure children, of all ages and genders, that it’s okay to cry if they feel pain.

On-going pediatric pain assessment not only meets regulatory standards, but is a critical first step in planning pain management strategies. Pain assessment tools, as well as age-appropriate pain management measures, will be discussed in an upcoming newsletter.
POPULATION/AGE-SPECIFIC EDUCATION POST TEST

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Caring For Children

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Competency: Demonstrates Age-Specific Competency by correctly answering 9 out of 10 questions related to Pediatric Pain.

PEDIATRIC PAIN

1. Steven is scheduled for a dressing change. He pleads, “Please wait until my lunch comes. I want to eat first.” After lunch, he claims, “No wait, I’m too full.” This behavior is typical of which age-group?

   a. Toddlers
   b. Preschoolers
   c. School-agers
   d. All of the above

2. A 2 year old cries uncontrollably while getting his blood drawn. What would be most important to say to the child just as soon as the procedure is over?

   a. “It’s over. We’re done.”
   b. “Do you want me to stay with you?”
   c. “Did that hurt?”
   d. “Let me go find your Mom.”

3. Of the following, who is best able to determine a child’s pain? The:

   a. healthcare provider.
   b. child’s parents.
   c. child’s siblings.
   d. child.

4. Infants do not feel pain as intensely as older children.

   a. True
   b. False

5. Children who are repeatedly hospitalized become accustomed to pain.

   a. True
   b. False
6. Jenny, 4 years old, is crying quietly. She has a broken arm. She fell off a top bunk bed at home when she and her younger brother were wrestling. When you inquire if she is in pain, Jenny responds, “No, it’s okay.” The healthcare provider knows preschoolers typically:
   a. are unable to localize and verbalize their pain.
   b. believe their pain is punishment for a misdeed.
   c. have highly developed ways of coping with pain.
   d. tolerate pain better than adults.

7. Jenny also has a very minor laceration on her leg. The healthcare provider appropriately:
   a. praises her for being a “big girl”.
   b. assesses her circulatory status.
   c. gets a band-aid® to put on it.
   d. tells her, “It’ll be okay”.

8. During removal of a cast a 5 year old screams, “Don’t cut my arm off!” This is likely because the preschooler fears:
   a. intrusive procedures.
   b. bodily mutilation.
   c. being immobilized.
   d. altered body image.

9. Pain assessment should be initiated by the healthcare provider on all ill or hurt children.
   a. True
   b. False

10. Sam, 15 months old, is in his crib with his eyes open. He is immediately post-op. The healthcare provider should:
    a. chart that Sam "denies pain".
    b. assess further for physical and behavioral signs of pain.
    c. determine how Sam interacts with his parents.
    d. assess Sam's mobility.