Document Title:	**ACUTE PAIN ASSESSMENT AND MANAGEMENT FOR CHILDREN 3 MONTHS TO 16 YEARS**		
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Consulted With:	**Post/ Approval Committee/ Group:**	**Date:**
Agnes Watson, Joseph Hussey	Paediatric Anaesthetists	24th April 2019
Clare Fitzgerald	Pharmacist for Children	7th May 2019
Mel Chambers	Children's Services Paediatric Lead Nurse	7th May 2019
Lynne Mustard	Service Manager, Pain Management Service	20th April 2019
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Related Trust Policies (to be read in conjunction with)	Prescribing of medicines for inpatient use 08084 Prescribing medicines for outpatient use 15021 Use of Entonox for procedural pain 06000 Administering intra-nasal diamorphine to burns patients 0907206 Neonatal Analgesia for neonates 09016 Hand hygiene policyv4.1 04072 Aseptic technique and aseptic non-touch technique ANTT 08038 Pain assessment and management guidance for all wards and units 11027 Controlled drugs policy 08083 Injectable medicines policy 09060 Children and Young People Observation Policy 11046

Document Review History:			
Version No:	**Authored/Reviewer:**	**Summary of amendments/ Record documents superseded by:**	**Issue Date:**
1.0	Caroline Fox		April 2011
2.0	Jayne Somerset (JS),		March 2014
2.1 (Point 6.3 added)	Jayne Somerset (JS), Joseph Hussey (JH)		April 2016
3.0	Jayne Somerset		31 May 2016
4.0	Jayne Somerset	Full Review	4th June 2019

Index

1. Purpose

1.1 The purpose of this guideline is to improve the way in which health professionals recognise and assess pain in children. It is hoped that the guideline will also provide useful strategies for parents and for children during their experiences of health care.

2. Equality Impact Assessment

2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.
(Refer to Appendix 8)

3. Scope

3.1 This guideline is to be used by all nursing staff and medical staff caring for medical and surgical children and children with cognitive impairment from the age of 3 months to the age of 16 years.

3.2 Children and their families/carers are involved in shared decision-making about individualised pain assessment and have the opportunity to ask questions.

4. Background

4.1 Children vary greatly in their cognitive and emotional development, medical condition, response to painful interventions and to the experience of pain, as well as in their personal preferences for care.

4.2 Health professionals and parents have a responsibility to learn the language of child pain expression, to listen carefully to children's self-reports of pain and to attend to behavioural cues.

4.3 The detection of children's pain can be improved by strategies to facilitate their expression of pain in ways that are appropriate to their cognitive development, and that can be understood by the adults caring for them.

4.4 Most hospitalised children undergo procedures. These may range from venepunctures and insertions of intravenous catheters to more stressful procedures such as lumbar punctures, chest tube insertions, operations, and dressing changes.

4.5 Infants, children and adolescents can, and do, experience pain and often describe procedures and their associated anticipatory anxiety as the most distressing aspect of disease or hospitalisation

5. Assessment and Tools

5.1 Pain assessment is not an isolated element; it is an on-going and integral part of total pain management. The other elements include implementation of appropriate interventions, evaluation and reassessment.

5.2 If pain is suspected or anticipated use an appropriate assessment tool for the child's age and cognitive development.

5.3 Examples of signs that may indicate pain include changes in children's behaviour, appearance, activity level and vital signs.

5.4 Pain assessment should be carried out on all admissions as a baseline observation and recorded on the TPR (temperature, pulse and respiration) chart.

5.5 Assess, record and re-evaluate pain at regular intervals: frequency of assessment should be determined according to the individual needs of the child, and should be a minimum of twice daily, in line with Children and Young People Observation Policy; register number 11046.

5.6 Neonatal infant pain scale (NIPS) is an observer rated tool and used for pre-term and term infants. Refer to the Analgesic ladder in young infants and neonates up to 3 months (refer to Appendix 5) and refer to 09016 Analgesia for neonates on the intranet and website.

5.7 Face, Legs, Activity, Cry, and Consolability (FLACC) is an observer rated tool used for preverbal infants and children, excludes neonatal babies.
(Refer to Appendix 6)

5.8 Wong-Baker FACES pain rating scale is a self-reporting tool which can be used for verbal children more than 3 years of age.
(Refer to Appendix 7)

6. Management

6.1 For pre-term and neonates management on the Neonatal Unit will follow the guideline Analgesia for neonates; register number 09016.
(Refer to Appendix 5)

6.2 The pain step-ladders provide pharmaceutical analgesic guidance for both neonates and infants to 44wks of age and children 1 month- 16 years. The pain assessment scores reflect the stepladder analgesia required.

- Acute pain step-ladder for neonates 28 weeks – 44 weeks;
  (Refer to Appendix 5)
- Acute pain step-ladder for infants 3 months - 16years (less than 50kg).
  (Refer to Appendix 4)

- Guideline for Pain relief after Cleft Palate Surgery in Infants – information and guidance for the ward
  (Refer to Appendix 1)

6.3 **Subcutaneous Morphine**
Sub-cutaneous morphine can be used when strong rescue analgesia is required and oral morphine cannot be used or is refused by the patient. It is administered via an indwelling subcutaneous infusion cannula.
(Refer to Appendix 2)

6.4 **Alternative to Morphine**
Oxycodone immediate release (Oxynorm) can be used. This is **only** under Consultant recommendation.

Starting dose:
For patients who are aged 3 months to 1 year of age, 0.1mg / kg up to 4 hourly.
For patients who are aged over 1 year of age a dose of 0.2mg / kg maybe given up to 4 hourly.
Doses and dose intervals can be altered on consultant advice only.

6.5 Analgesia medication will be given in response to the patient's pain score and pain step-ladder.

6.6 Topical anaesthesia tetracaine may be applied for patients more than one month of age, following the pharmaceutical instructions

6.7 Entonox (50% nitrous oxide and 50% oxygen) may be used for children over 5 years requiring painful dressing changes or minor invasive procedures.

6.8 Non pharmacological methods (distraction, 'nesting') may be used in combination with analgesia.

6.9 Take home analgesia (TTAs) should be based on what is required to maintain adequate pain relief. Parents/carers and older children will be provided with verbal and written information and advice about dosage and administration of pain killers.
(Refer to Appendix 3)

7. Documentation

7.1 Acknowledging pain makes pain visible. Pain assessment should be incorporated into routine observations (as the fifth vital sign or 'TPRP' – temperature, pulse, respiration and pain). This must be recorded at least twice daily.

7.2 Raised scores will be reassessed following administration of analgesia.

7.3 All analgesia will be given as prescribed and signed for on the prescription chart.

7.4 The child's pain assessment tool, written information and advice on pain assessment and treatment should be given to parents/carers as part of their preparation for discharge for continued use at home/other care settings.

8. Staff Training

8.1 All medical and nursing staff are to ensure that their knowledge, competencies and skills are up-to-date in order to complete their portfolio for appraisal.

8.2 During induction process junior medical staff will receive instruction on current polices and guidelines.

8.3 The current edition of the British National Formulary for Children (BNF) will be available on the wards.

8.4 Where a patient's notes have demonstrated that the appropriate action has not been taken a 'risk event form' is to be completed. This will address any further training needs for staff that may require updating**.**

8.5 Expert advice to be sought from the Pain Management Service for complex or atypical pain management issues.

9. Infection Prevention

9.1 All staff should follow Trust guidelines on infection prevention ensuring that they effectively 'decontaminate their hands' before and after each procedure.

9.2 All staff should ensure that they follow Trust guidelines on infection prevention using Aseptic Non-Touch Technique (ANTT) when carrying out procedures.

10. Audit and Monitoring

10.1 Where a child's notes have demonstrated that the appropriate action has not been taken a 'risk event form' is to be completed. This will address any further training needs for staff that may require updating.

10.2 Where high risk opioids analgesia is required: i.e. (PCA Patient Controlled Anaesthesia), appropriately trained staff skill mix must be in place. All PCA patients will be seen daily by the Pain Service, and risk managed.

11. Communication

11.1 Approved guidelines are published monthly in the Trust's Focus Magazine that is sent via email to all staff.

11.2 Approved guidelines will be disseminated to appropriate staff via email after ratification of guideline by the Children & Young People Service.

12. References

British National Formulary for Children (BNFC) 2019
Available at: www.bnfc.nice.org.uk

Royal College of Nursing (2009) The recognition and assessment of acute pain in Children Available at: https://www.rcn.org.uk/professional-development/publications/pub-003542

Good practice in postoperative and procedural pain management 2nd ed. Association of Paediatric Anaesthetists of Great Britain and Ireland. Paediatric Anaesthesia 2012; 22 Suppl 1; 1-79

Willis et al, FLACC Behavioral Pain Assessment Scale: A comparison with the child's self- report. Paediatric Nursing 2003; 29 (3); 195-198

Twycross, Alison (ed). Managing pain in children: a clinical guide for nurses and healthcare professionals (2nd ed). 2013 Wiley-Blackwell 9780470670545Twycross A,

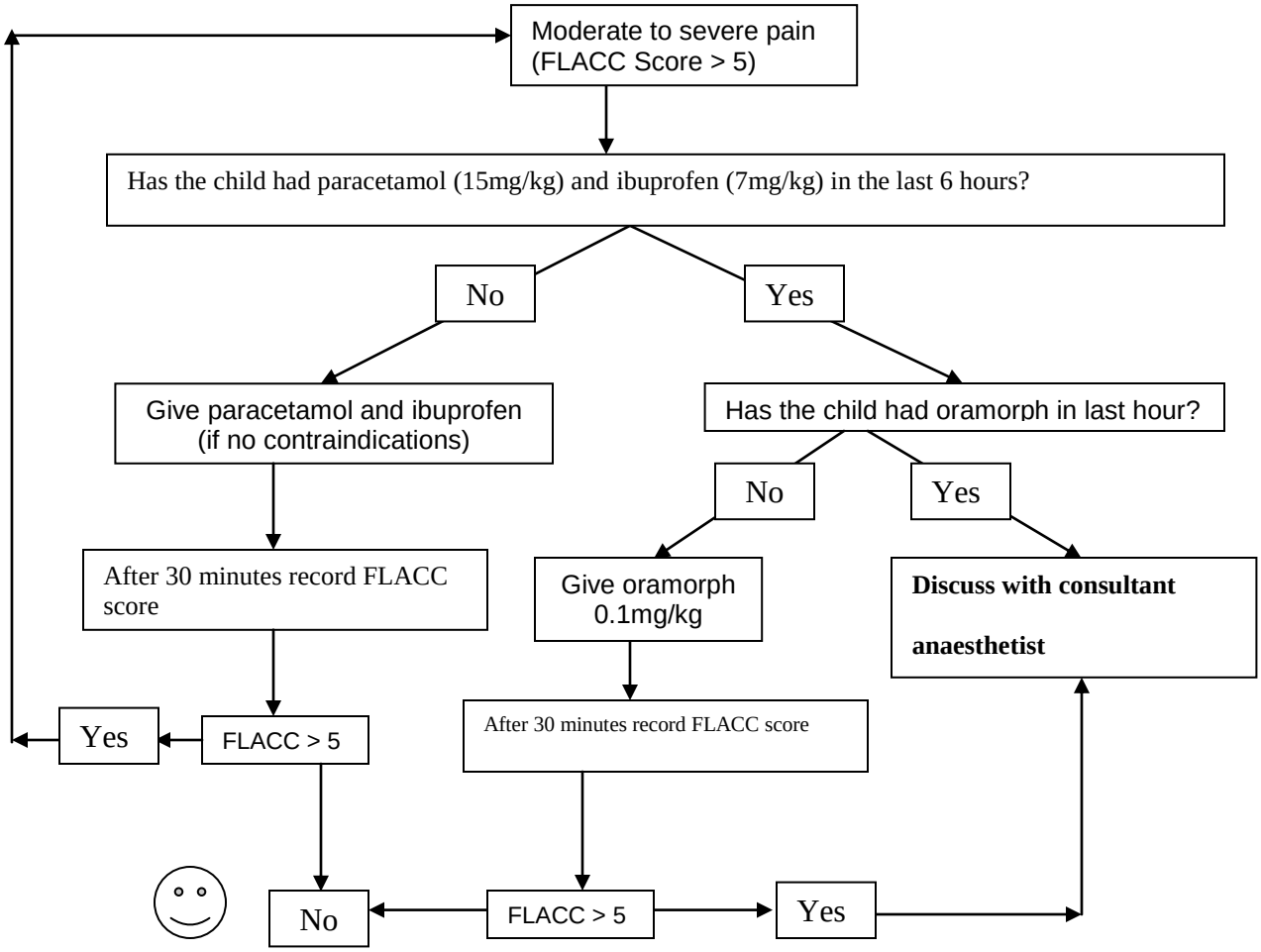
Pain Management After Day Surgery. Information sheets GOSH 2011 Available from:
www.gosh.nhs.uk/file/386/downloadwww.gosh.nhs.uk/gosh_families/information_sheets/pain

The Royal College of Emergency Medicine 'Best Practice Guideline. Management of Pain in Children' 2017 Available from:
https://www.rcem.ac.uk/docs/RCEM%20Guidance/RCEM%20Pain%20in%20Children%20-%20Best%20Practice%20Guidance%20(REV%20Jul%202017).pdf

Appendix 1 Guideline for Pain relief after Cleft Palate Surgery in Infants – Ward

Guideline for Pain relief after Cleft Palate Surgery in Infants – Ward

Record pain scores using FLACC hourly post operatively for the first 6 hours, then at 8, 12, 18, 24, 36 and 48 hours or more frequently if child has FLACC score > 5 (see below).
Simple measures such as feeding, providing comfort, ensuring that the infant is well hydrated and normothermic will reduce distress.
If FLACC > 5 follow the oral analgesia flow chart below:



FLACC pain score

	0	1	2
FACE	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
LEGS	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 cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
CONSOLABILITY	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console of comfort

Each of 5 categories is scored from 0-2 which results in a total score between 0 -10
Merkel et al 1997

Author: Agnes Watson, Consultant Anaesthetist, Feb 2014 Reviewed May 2019

Appendix 2

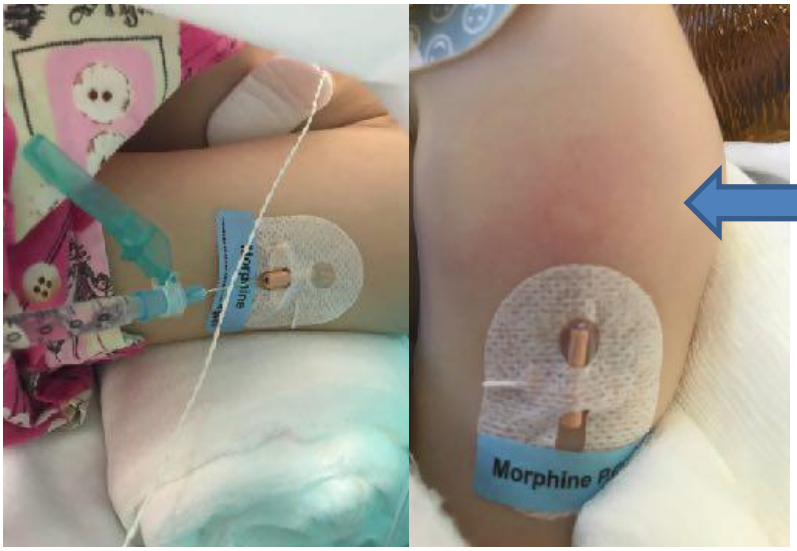
Subcutaneous Morphine – Children (3 months to 18 years)

Sub-cutaneous morphine can be used when strong rescue analgesia is required and oral morphine cannot be used or is refused by the patient. It is administered via an indwelling subcutaneous infusion cannula *(Insufusion cannula, Unomedical)*.

USE INSTEAD OF ORAL MORPHINE NOT IN ADDITION TO

Directions;
Cannula should be inserted into subcutaneous tissue and secured with dressing.
Common insertion sites include outer aspect of upper arm, just below clavicle on chest wall or in the abdomen. Cannula can remain in situ for up to 7 days. It should ONLY be used to administer Morphine. Priming volume is 0.05mls - this should be taken into account when the first dose is given. There is no need to flush the subcutaneous cannula between doses. An IV cannula should be in-situ so that Naloxone can be given in case of respiratory depression or reduction in consciousness.

USE ONLY UNDILUTED MORPHINE 10mg / 1mls



Occasional redness from local histamine release occurs frequently following injection – this should disappear after an hour

DOSAGE;
100 - 200 micrograms / kg (Max10mg) PRN. CAN BE REPEATED AFTER 4 HOURS (Every 6 hours if under 6 months of age).
Patients should be carefully observed for up to 1 hour after administration for signs of opiate toxicity - Hypoventilation, Hypoxia or reduction in conscious level.

Naloxone should be written up - 5micrograms / kg (Max 400mcg) PRN CAN BE REPEATED EVERY MINUTE. SUMMON URGENT MEDICAL ASSISTANCE IN ADDITION.

Dr J Hussey (December 2018)

Appendix 3
Children's TTA information sheet

Medicines for Children information for parents and carers

Morphine for pain

This leaflet is about the use of morphine to reduce moderate-to-severe pain. This might be pain from an injury, after an operation or due to an illness.

This leaflet has been written specifically about the use of this medicine in children. The information may differ from that provided by the manufacturer. Please read this leaflet carefully. Keep it somewhere safe so that you can read it again.

Do not give extra doses of morphine, as this can be dangerous. Do not stop giving morphine suddenly.

Name of drug

Morphine

Common brands: Oramorph®, Sevredol®, MST Continus®, Zomorph®, Morphgesic SR®, MXL®

Why is it important for my child to take this medicine?

Morphine will help to control your child's pain.

What is morphine available as?

- **Tablets:** 10 mg, 20 mg, 50 mg (these may contain lactose)
- **Sustained release capsules:** available in a range of doses from 5 to 200 mg
- **Liquid medicine:** 2 or 20 mg per mL (this contains a small amount of sugar and ethanol (alcohol)
- **Granules:** 20 mg, 30 mg, 60 mg, 100 mg or 200 mg (per sachet)
- **Suppositories:** 5 mg, 10 mg, 15 mg, 20 mg, 30 mg

When should I give morphine?

- You should give morphine regularly to keep your child's pain under control. This is every 12 hours for sustained-release morphine or every 4 hours for other forms of morphine.
- If your child has pain that comes and goes, give them a dose of morphine when they first complain of pain.
- The packaging will tell you which type of morphine you have and how often you can give it. If you are not sure, check with your doctor or pharmacist first.
- Write down the time that you give each dose, to help you remember.

How much should I give?

Your doctor will work out the amount of morphine (the dose) that is right for *your* child. The dose will be shown on the medicine label.

⚠ **It is important that you follow your doctor's instructions about how much to give.**

How should I give it?

Tablets/capsules should be swallowed with a glass of water, milk or juice. Your child should not chew the tablet.

Granules: Sprinkle or stir the granules into a small amount of soft food (e.g. yogurt) or a small drink. Your child should then swallow the food or drink straight away, without chewing. Make sure that they take it all.

Liquid medicine: Measure out the right amount using an oral syringe or medicine spoon. You can get these from your pharmacist. Do not use a kitchen teaspoon as it will not give the right amount.

Suppositories are inserted into the rectum (back passage).

- Wash your hands with soap and hot water.
- Unwrap the suppository.
- Your child should be lying on his or her side or front.
- Hold one buttock gently to one side so that you can see the back passage.
- Hold the suppository with the rounded end close to the back passage.
- Use one finger to push the suppository gently into the back passage. It needs to go in by about 2 cm.
- Your child should stay lying down for about 15 minutes so that the suppository doesn't come out.
- Wash your hands again with soap and hot water.

When should the medicine start working?

- Your child should start to feel less pain within an hour of taking the first dose of morphine.
- It will take up to 12 hours for the first dose of a sustained-release preparation to work properly. Your child will be given other pain relief for this time.
- After this, giving morphine regularly should keep your child's pain under control. If it doesn't, contact your doctor or pharmacist. Do not give extra doses of morphine.

What if my child is sick (vomits)?

Children are often sick or feel sick for the first few days of taking morphine. Your doctor may prescribe another medicine to help with this.

Tablets, capsules, granules or liquid medicine

- If your child is sick less than 30 minutes after having a dose of morphine, give them the same dose again.
- If your child is sick more than 30 minutes after taking a dose, you do not need to give another dose. Wait until the next normal dose.

Suppositories

- If your child is sick at any time, you do not need to give them another dose, as the suppository will still work.

What if I forget to give it?

- Don't worry if you forget a dose, as morphine stays in the body for a while and will continue to work.
- Give the missed dose when you remember. After that, give the next dose after the usual number of hours (12 hours for sustained-release tablets/capsules and granules; 4 hours for other forms).

What if I give too much?

⚠ It can be dangerous to give your child too much morphine.

If you think you may have given your child too much morphine, contact your doctor straight away.

If your child seems very sleepy, or if they have problems with their breathing, or stop breathing, your child may have had too much morphine. Phone for an ambulance straight away. Take the medicine container or pack with you, even if it is empty. This will be useful to the doctor.

Are there any possible side-effects?

We use medicines to make our children better, but sometimes they have other effects that we don't want (side-effects).

Side-effects you must do something about

If your child has difficulty breathing, stops breathing, or seems very sleepy, phone for an ambulance **straight away**.

Other side-effects you need to know about

- Your child is likely to feel sick or be sick (vomit) for hte first few days of taking morphine. Your doctor may prescribe another medicine to help with this.
- Most children get constipation (have difficulty doing a poo) when taking morphine. You can help by giving your child plenty to drink. Your doctor will probably suggest that your child also takes laxatives - medicines that will help them go to the toilet. It is important that your child doesn't strain on the toilet.
- Your child may get headaches, have a dry mouth or sweat, and their skin may flush (go red). They may have changes in mood. They may feel dizzy, and they may feel light-headed when they stand up.
- Your child may find it difficult to pass urine (do a wee). Contact your doctor if this happens.
- Children taking high doses of morphine may develop shaking or cramps in the large muscles of the body (myoclonus). Contact your doctor if this happens.

Can other medicines be given at the same time as morphine?

Some painkillers and cough medicines contain codeine or dihydrocodeine (you can find this information on the label). **Do not** give these to your child.

Morphine should not be taken with some common drugs that you get on prescription. It is important to tell your doctor and pharmacist that your child is taking morphine.

- You can give your child medicines that contain paracetamol or ibuprofen, unless your doctor has told you not to.
- Check with your doctor or pharmacist **before** giving any other medicines to your child. This includes herbal or complementary medicines.

Is there anything else I need to know about this medicine?

Do not stop giving morphine suddenly, as your child may get withdrawal symptoms and their pain may come back. As your child's pain improves, or if they need to stop taking morphine, your doctor will reduce the dose a bit at a time.

- You may have heard that some people become addicted to morphine or dependent on it. This is unlikely to happen when morphine is given to children in pain.
- Morphine is often given to children and adults with lifethreatening or terminal illnesses. Morphine does not shorten the person's life.
- An antidote can be given to someone who has had too much morphine. This has to be done in hospital.

General advice about medicines

- If you are not sure a medicine is working, contact your doctor. **Do not** give extra doses of morphine.
- Only give morphine to *your* child. Never give it to anyone else, even if their condition appears to be the same, as this could do harm.

If you think someone else may have taken the medicine by accident, contact your doctor straight away.

- Write down the times that you give morphine, to help you remember, and to make sure that you don't give too much.
- Make sure that you always have enough medicine. Order a new prescription at least 2 weeks before you will run out.
- Make that the medicine is not older than the 'use by' date on the packaging. Give old medicines to your pharmacist to dispose of.

Where I should keep this medicine?

- Keep the medicine in a cupboard, away from heat and direct sunlight. It does not need to be kept in the fridge.
- Make sure that children cannot see or reach it.
- Keep the medicine in the container it came in.

Who to contact for more information

Your doctor or pharmacist will be able to give you more information about morphine and other drugs or methods for pain relief.

You can also get useful information from:

NHS Direct - www.nhsdirect.nhs.uk - 0845 46 47

NHS 24 (Scotland) - www.nhs24.com - 08454 24 24 24

NHS Direct Wales / Galw Iechyd Cymru
www.nhsdirect.wales.nhs.uk - 0845 46 47

NI Direct (Northern Ireland) - www.nidirect.gov.uk

www.medicinesforchildren.org.uk

The primary source for the information in this leaflet is the British National Formulary for Children. For details on any other sources used for this leaflet, please contact us through our website, www.medicinesforchildren.org.uk

We take great care to make sure that the information in this leaflet is correct and up-to-date. However, medicines can be used in different ways for different patients. It is important that you ask the advice of your doctor or pharmacist if you are not sure about something. This leaflet is about the use of these medicines in the UK, and may not apply to other countries. The Royal College of Paediatrics and Child Health (RCPCH), the Neonatal and Paediatric Pharmacists Group (NPPG), WellChild and the contributors and editors cannot be held responsible for the accuracy of information, omissions of information, or any actions that may be taken as a consequence of reading this leaflet.

MEHT Paediatric Analgesic Ladder

Appendix 4

Children aged 3 months – 16yrs (adult guidelines for weights >50kg)

- **Go up the ladder when pain is severe / uncontrolled.**
- **Go down the ladder at appropriate patient recovering stage or if analgesic toxicity seen.**

Mild Pain
(1-3)

Oral Paracetamol
Consider loading dose
30mg/kg, then 15mg/kg 6 hourly
(Max 75mg/kg/24 hours)
Max 1g in a single dose
/ maximum 4g/24 hours
(For IV dose see BNFc)

+/or

Oral Ibuprofen
5-10mg/kg 6-8 hourly
(Max 30mg/kg/24 hours)
Max 400mg in a single dose,
max 400mg/8 hourly

Moderate Pain to Severe Pain
(4-10)

Oral Paracetamol
(as with Mild pain)

+/or

Oral Ibuprofen
(as with Mild pain)

+

Oral Morphine
***UNDER 1 YEAR OLD**
*0.1mg/kg 4 hourly PRN
OVER 1 YEARS OLD
*0.2mg/kg - 0.3mg/kg 4 hourly PRN
***Higher doses and reduced dosing intervals can be adjusted on the advice of a Consultant.**

Consider Subcutaneous Morphine using an in-dwelling cannula for children 3 months to 18 years when oral route is not tolerated. Refer to separate document.

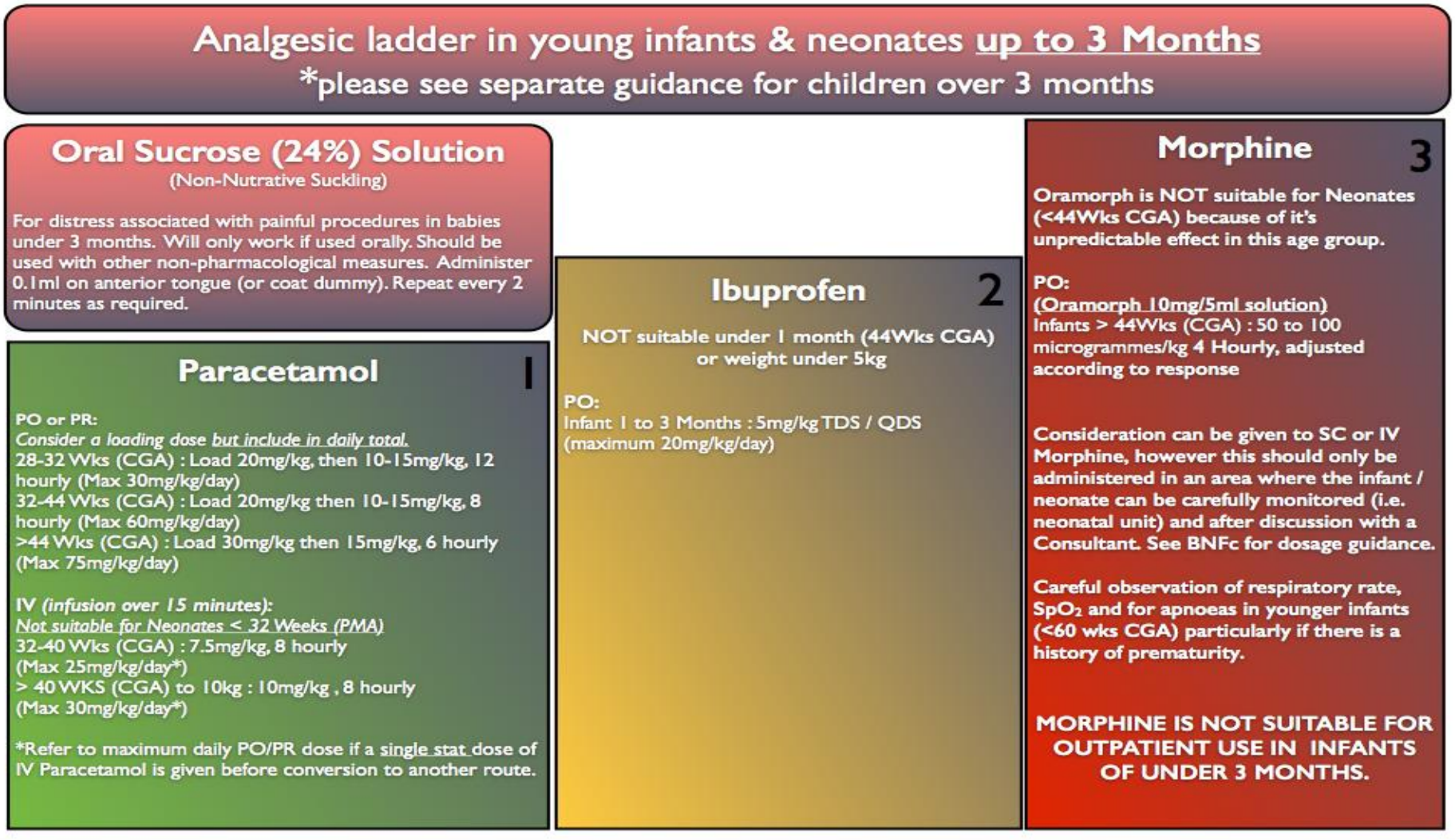
****IF CONSIDERING INTRAVENOUS MORPHINE**

1. **DISCUSS WITH A SENIOR DOCTOR PRIOR TO ADMINISTRATION**
2. **CONSULT BNFC FOR DOSAGES**
3. **CAREFUL MONITORING AND OBSERVATIONS OF THE PATIENTS' RESPIRATORY RATE, SpO_2 ARE TO BE CARRIED OUT.**
4. **ENSURE NALOXONE READILY AVAILABLE.**

****Intravenous Morphine**
50mcg/kg loading dose, increments of not more than 20mcg/kg every 5 minutes, until the pain is controlled.

CONSIDER		
For procedural pain relief	**For additional pain relief**	**Non-pharmacological methods**
Entonox (guideline 06000) **Intranasal Diamorphine (guideline 09006)**	**Central / Peripheral Nerve blocks**	**Behavioural, Distraction, Relaxation, Play**

Appendix 5 Neonatal (32 weeks to 3 months) Pain Ladder



Appendix 6
Face, Legs, Activity, Cry and Consolability (FLACC)

FLACC score for use in infants.

	0	1	2
FACE	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
LEGS	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 cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
CONSOLABILITY	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort

Appendix 7
Wong-Baker FACES Pain rating scale

No pain Quiet Asleep Neutral face Smiling	**Intermittent sleep Grimaces of discomfort**	**Restless sleep Unsettled Waking frequently Moaning**	**Awake Body held rigid Crying Agitated Screaming**

- **Wong-Baker Faces pain rating scale can be used for babies, children, and young people who have pain.**
- **Look at the faces and use the words written underneath**
- **Choose one face which describes the pain you are feeling at the moment**
- **Mum and dad will be able to help you with this**
- **It is important for you to tell us how much pain you have so that we can help to make you feel better**

Appendix 8: Preliminary Equality Analysis

This assessment relates to: Acute Pain Assessment and Management for Children 3-16 Years (10045)

A change in a service to patients		A change to an existing policy	**X**	A change to the way staff work	
A new policy		Something else (please give details)			

Questions	Answers
1. What are you proposing to change?	Full Review
2. Why are you making this change? (What will the change achieve?)	3 year review
3. Who benefits from this change and how?	Patients & Clinicians
4. **Is anyone likely to suffer any negative impact as a result of this change?** If **no**, please record reasons here and sign and date this assessment. If **yes**, please complete a full EIA.	No
5. a) Will you be undertaking any consultation as part of this change? **b) If so, with whom?**	Yes Refer to pages 1 & 2 consultation

Preliminary analysis completed by:

Name	Jayne Somerset	**Job Title**	Clinical Nurse Specialist, Pain	**Date**	April 2019