Pain Assessment and Management


Policy Group: Neurological

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Purpose
Neonatal patients are subjected to a variety of noxious stimuli in the course of their stay. Staff require an understanding of pain management in the Neonatal Nursery.

Policy Statement
Neonatal patients undergoing intensive care are subjected to a variety of unpleasant and painful experiences resulting from many diagnostic, surgical, and therapeutic procedures. Evidence suggests that neonates have an increased sensitivity to pain as compared with older age groups. Because they are unable to give a verbal report of their pain experience, surrogate indicators must be used to establish the presence of pain. These surrogate indicators are not able to differentiate between pain and distress and so it may not be possible to differentiate between them. Good pain management is essential to the patient’s well-being and pain prevention is better than treatment. Parents/caregivers should play a key role in this process.

SOURCES OF PAIN
- Painful procedures commonly done in the Neonatal Nursery include the following: arterial puncture, heel lancing, lumbar puncture, Retinopathy of Prematurity examination, suprapubic bladder tap, venipuncture, bladder catheterization, central line insertion/removal, chest tube insertion/removal, dressing change, gavage tube insertion, intramuscular injection, peripheral intravenous access, mechanical ventilation, postural drainage, removal of adhesive tape, suture removal, tracheal intubation/extubation, tracheal suctioning, and body cooling. In addition, other sources of pain may include areas of inflammation, localized infection, skin burns, and skin abrasions.

- Parents/caregivers and health care professionals must talk openly and honestly about acute and chronic pain associated with medical diseases, as well as about pain associated with operative, diagnostic, and therapeutic procedures. Discussion should also occur about distressed behavior exhibited by sick and well babies.

ASSESSMENT OF PAIN
- Health care professionals can diagnose neonatal pain only by recognizing the neonate’s associated behavioral and physiological responses. Pain may not be evident in the behavior of preterm infants because of their immature responses. Therefore, the presence of pain should be presumed in all situations usually considered to cause pain in adults and children, even in the absence of behavioral or physiologic signs.

- Pain histories in the form of a pain score should be taken before the occurrence of painful experiences in order to facilitate post-procedural assessment of pain.
Assessment of an infant’s pain should be implemented in the presence of pain and in all health care situations where it is reasonably expected that pain will occur to evaluate the pain response and the efficacy of behavioral, environmental, and pharmacological agents employed.

Parents/caregivers should be taught to observe how their infant expresses pain through physiologic and behavioral cues. It should be recognized that pain and distress can result in the same physiologic and behavioral cues.

Assessment of neonate’s pain with the N-PASS and the neonate’s response to intervention should be accurate and timely. N-PASS scoring is required:

- Prior to administration of a medication for pain to confirm the assessment of pain in the neonate.
- For baby’s receiving continuous infusions of analgesics or sedatives to monitor their level of pain and/or sedation.
- Pain/sedation assessment should be done one hour after administering analgesics and/or sedatives to assess response to the medication.
- Ongoing assessment of infant’s sedation/pain should be done every 4 hours for baby’s receiving continuous infusions of analgesics or sedatives. (Refer to the N-PASS under the Neonatal Pain Assessment policy).

Pre-procedure teaching concerning pain and the assessment and treatment of such pain should occur routinely with parents/caregivers if at all possible.

MANAGEMENT OF PAIN

- Pain is managed most effectively by preventing, limiting, or avoiding noxious stimuli and providing analgesia.

- Prophylactic analgesia has an important role with respect to intravenous injections and painful procedures. Analgesics should be given in anticipation of known painful circumstances. Topical or local agents are used when appropriate. This includes the use of Maxilene ® 4 (Lidocaine Cream 4%) for any procedure where the skin is punctured, the procedure can wait for 30 minutes, the neonate’s gestational age was 37 weeks or the neonate is greater than 2 weeks old.

- The approach to pain/sedation management should be multi-modal and involve both pharmacologic and non-pharmacologic strategies as these have often an additive and sometimes synergistic effect on the reduction of pain. Behavioral methods, including skin-to-skin, breast feeding, sucrose, non nutritive sucking, swaddling, containment, or facilitated tucking are vitally important during minor to moderate stressful procedures to help minimize the infant’s pain and distress while maximizing the infant’s own regulatory and coping abilities. These non-pharmacologic comfort measures can be used with pharmacologic therapy to provide additive or synergistic benefits. Sucrose should be administered whenever possible to patients immediately before eye examination, immunizations, and attempts at intravenous access and whenever there is reasonable expectation of pain.

- Intramuscular route injection of analgesics is considered a last resort. Minimize use of heel lancing for blood collection. Use only mechanical spring-loaded lance when necessary.
- It is imperative that those who order and administer analgesics and sedatives ensure the drug type and dose is correct, that it is administered in a timely fashion, and its efficacy is assessed and modified as necessary.
- When there is uncertainty whether behavior indicates pain and if there is reason to suspect pain, an analgesic trial should be done since it can be diagnostic as well as therapeutic.
- Administration of acetaminophen via the oral or rectal route should be routinely employed where pain is anticipated for procedures such as immunization administration, injections and other painful diagnostic and therapeutic procedures. Acetaminophen may be given before immunizations and injections and in addition to other analgesia following surgery.
- Parents/caregivers should be taught techniques that are comforting to their infant so that they are able to help provide non-pharmacologic comfort during minor painful procedures.
- It may not be practical or desirable to eliminate all post-operative and procedural pain. Pain reduction to acceptable levels is a realistic goal in the majority of circumstances.

**DOCUMENTATION**
- Regular bedside documentation (as indicated in assessment) of the assessment of pain and of the interventions employed on the N-PASS flow sheet using the N-PASS scale is essential for good pain management.
- Environmental factors that appear to reduce or exacerbate the infant's pain should be documented.
- Behavioral and environmental strategies that are used alone or in conjunction with pharmacologic therapy should be documented.
- The level of parents’ involvement with and knowledge of their infant's pain cues and current pain management should be recorded.

**Applicability**  
All Covenant Health neonatal staff and physicians.

**Related Documents**  
Adapted with permission from Stollery Children’s Policy and Procedure Manual:  
Pain Management Policy, October 2010

**RELATED POLICIES AND PROCEDURES**  
Maxilene ® 4 Cream  
Sucrose Administration
References


Revisions

Pain Management, July 2004
October, 2015
Signing

Original Signed
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