Management of Pain for Babies on the Neonatal Units at UHDB - Neonatal Full Clinical Guideline - Derby and Burton

Reference no.: CH CLIN PA NN 02/Dec 20/v002

Purpose

To ensure that all babies nursed in the Neonatal Units at UHDB receive the appropriate intervention/analgesia to manage their pain where necessary. Babies on the neonatal units are often subject to medical procedures which can cause discomfort and acute pain. Exposure to pain and stress in the neonatal period has been linked to adverse neurodevelopmental outcomes and adverse responses to future pain. Nursing assessment must consider subtle cues which can indicate pain and stress, and respond appropriately with comfort measures and/or analgesia where required.

Aim & Scope

To provide clear guidelines for all staff working on the Neonatal Units, regarding the need for Intervention/analgesia in babies.

Implementing the Guidelines

The pain charts will be started on admission to the area for all babies.

All babies requiring pain assessment will have it recorded alongside the nursing observations of vital signs. This will usually be when giving cares or moving unless otherwise stated or the baby's pain management dictates that pain assessment is carried out more frequently, i: e before, during and after painful procedures. Babies should have a pain assessment documented at the time of admission.

The Assessment of Pain and subsequent response is subject to regular audit by the pain link nurses and this information is shared with the multidisciplinary team.

The Assessment of Pain:

Stand where the baby can be clearly seen and observe for 30 seconds

Gently touch the baby's lower limbs to determine muscle tone/tension

Consider physiological conditions that might influence the score

Consider medications prescribed that might alter behaviour or physiological responses

Consider other environmental issues which could affect baby's responses

Identify the frequency of pain assessment required

Complete pain score appropriate to Derby/Burton sites at appropriate time

Correctly score pain score and complete appropriate documentation on observation chart

Implements appropriate nursing comfort measures and/or administer pain relief in accordance with baby's stress cues.

Reassesses pain score following intervention

Comfort measures:

Wherever possible, parents should be encouraged to participate in positive touch and care to gain an awareness of specific cues and to ensure consistency.

- Repositioning: Supporting limbs/trunk, ensuring feet can brace against nest or hands, taking care with wires and equipment.
- Wrapping/Containment
- Kangaroo care
- Minimal handling
- Decreasing environment stressors e.g. reducing noise by closing incubator doors softly, reducing alarm volume where appropriate, shading baby from light
- Tactile soothing
- Talking to baby
- Nappy change
- Non-nutritive sucking
- Breastfeeding
- Soothing voice
- Mouth care using EBM
- Sucrose

Sucrose – Please see Sucrose monograph available on net-I or BNFc for dosing and contraindications.

Should be considered for babies undergoing painful/uncomfortable procedures such as:

Venous, Arterial or Capillary Blood Sampling

Adhesive tape removal

Immunisations

Nasogastric tube insertion

(List is not exhaustive)

<u>Using the Neonatal Pain Assessment Tool Scoring System (PAT) (Derby Site only)</u>

The PAT incorporates 10 categories:

1) Posture/Tone
2) Sleep Pattern
3) Expression
4) Colour
5) Cry
6) Respirations
7) Heart Rate
8) Saturations
9) Blood pressure
10) Nurse Perception

A Score of 1-5 indicate the need for a nursing comfort measure. Parents should also be educated on comfort measures.

A Score of >5 indicates the need for nursing measure and/or analgesia and medical review of analgesia.

If Analgesia is required, this should be prescribed and administered according to guidance in the BNFc or through using Paracetamol and Sucrose monographs available on net-i.

- **If PAT score is high please record baby's response to nursing comfort measure and/or analgesia at a later assessment – approximately 30 minutes later.**

PAT Scoring System

Score	0	1	2
Posture/Tone	Relaxed	Extended Digits wide spread, Trunk rigid Limbs drawn out	Flexed and/or Tense Fists clenched Trunk Guarding Limbs drawn to midline
Sleep Pattern	Relaxed/Settled		Agitated/Withdrawn Wakes with a startle: Restless Easily woken: squirming No clear sleep/Wake pattern
Expression	Relaxed	Frown Shallow furrows Eyes tightly closed	Grimace Deep furrows Eyes tightly closed
Colour	Pink, Well perfused		Pale/Dusky/Flushed
Cry	No		Yes When disturbed: whining Does not settle after handling Loud: Whimpering
Respirations	Within normal limits	Tachypnoea	Apnoea At rest or with handling
Heart Rate	Within normal limits	Tachycardia	Fluctuating Spontaneous or at rest
Oxygen Saturations	Normal		Desaturations with or without handling
Blood Pressure	Normal		Hypo/Hypertensive
Nurses Perceptions	No pain is perceived by me		I think the baby is in pain

Burton Hospitals NHS Foundation Trust

Neonatal Unit

PAIN ASSESSMENT TOOL

Name
Date of Birth
Hospital Number

SCORE

0-4 Nursing comfort measures
5-8 nursing comfort measures, constantly review
Score above 5, increase comfort measures, consider/ review analgesia

Assess within 1 hour of admission

Prior to and after a procedure
Prior to cares or if signs of distress/discomfort
One hour after pain management intervention

Sedated babies – observe for changes in vital signs as sedation will mask behavioural signs

				Date	Time	Score	Procedure	Measures taken
Cry	• No cry • Whimper • Vigorous	0 1 2						
Body movements	• Relaxed • Restless • Exaggerated	0 1 2						
Facial movements	• Normal • Frown with slight furrow • Grimace with deep furrow /Eyes tightly shut. chin quiver	0 1 2						
Consolability	• Content/ relaxed • Settles with comfort measures • Difficult to console / comfort	0 1 2						

COMFORT MEASURES: R – repositioning; S- swaddling; C – comfort/containment holding; E – decreasing environmental stimulation; V-soothing voice; P -non-nutritive sucking (pacifier); K – kangaroo care; PTB – breast feed; EBM – Expressed breast milk; Su - Sucrose

References (including any links to NICE Guidance etc.)

RCH Neonatal Pain Assessment Tool Scoring System
Copyright: *Neonatal Unit, Royal Children's Hospital, Flemington Road, Parkville, Victoria, Australia 3052.*

Hodginkson k, Bear M, Thorn J, Van Blaricum Sue (1994) Measuring pain in neonates: evaluating an instrument and developing a common language. The Australian Journal of Advanced Nursing Vol 12, No1 September-November

Documentation Controls

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