Advisory 26-02 Pediatric Pain Assessment and Management Education

To: All Agencies and Personnel

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Background and Rationale

Pain assessment and management are core components of high-quality prehospital care. However, both national literature and local data demonstrate that pediatric patients – particularly younger and non-verbal children – are significantly under-assessed and undertreated for pain in the prehospital setting. This gap is not due to lack of clinical intent, but rather reflects challenges unique to pediatric care, including developmental variability, uncertainty around appropriate pain assessment tools, and discomfort with medication routes and dosing in children.

Within MLREMS, regional data review has identified opportunities to improve consistency in pediatric pain assessment, documentation, and severity-based management. Younger children are less likely to have a documented pain score, and when treated, less likely to be treated by the evidence-based route. These patterns represent a system-level opportunity for improvement.

To address these gaps, MLREMS has developed a standardized, evidence-based pediatric pain education package focused on:

- Developmentally appropriate pain assessment
- Severity-based pain management

This education aligns with national best practices and the National Model EMS Clinical Guidelines and supports safe, effective, and equitable pain care for pediatric patients across the region.

Education Overview

The Pediatric Pain Assessment and Management education consists of **two linked modules**:

1. Pediatric Pain Assessment: https://youtu.be/Jvno9cYJons
2. Pediatric Pain Management: https://youtu.be/LpvNFsox3AE

Completion of both modules is strongly recommended, as pain assessment directly informs appropriate pain management.

The education may be completed asynchronously and is intended for both ALS and BLS clinicians, consistent with regional protocols and scope of practice.

Clinical Guidelines and Field Resources

The MLREMS Pediatric Pain Management Guideline is available at: https://www.mlrems.org/training/

This guideline is also available within Handtevy as a point-of-care reference, under “Resources”.

A pediatric pain scale tool may be printed and laminated for placement in the ambulance. It is available at: https://www.mlrems.org/training/

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MLREMS Pediatric Pain Management Guideline

Assessment, Treatment, and Interventions

The choice of medication class, route of administration, dosing, and frequency are *based on pain severity*.

Numerical Rating Pain Scale	Severity
0	None
1-3	Mild
4 - 6	Moderate
7-10	Severe

1. Determine patient's pain score assessment using a pain scale appropriate for their age and/or ability to self-report*:

Age or Patient Factor	Type of Scale	Appropriate Scale
≤ 7 years old and those with cognitive impairment or inability to self-report	Observational	Faces, Legs, Arms, Cry, Consolability (FLACC)
3–10 years old:	Self-report scale	Wong Baker Faces
Greater than 10 years old:	Self-report scale	Numeric Rating Scale (NRS)

2. All patients with pain should receive non-pharmacologic pain management interventions, including but not limited to:
   a. Verbal reassurance and calming communication to reduce fear and anxiety
   b. Use of distraction techniques (e.g., toys, videos)
   c. Placement in a position of comfort
   d. Application of ice pack(s) for pain due to trauma
   e. Application of splint or immobilization device for pain due to trauma
   f. Application of heat pack(s) for pain due to medical cause
   g. Provide warm blankets or environmental comfort adjustments

3. If the patient has minor or moderate pain, or if using as an adjunct for severe pain, administer oral non-opioid analgesia (e.g., acetaminophen, ibuprofen) when equipped, able, and they can safely tolerate oral medications.

4. For severe pain, intranasal fentanyl is the preferred initial opioid analgesic and route of administration. ALS assistance for pain management should be requested if available for patients with severe pain.

5. Reassess pain after intervention and redose opioid after ten (10) minutes if needed in severe pain. Consider intravenous access if initial intranasal and oral agents are insufficient to manage pain.

Key considerations:

- Medications should be dosed using the Handtevy® application and cross-checked with another provider.
- Use of non-invasive capnography is an earlier predictor of hypoventilation than pulse oximetry if opioid medications are administered and should be considered for all children receiving opiates.
- Consider administration of oral antiemetics to treat nausea and/or prevent nausea associated with opioid administration.
- Onset of action is dependent on the pharmacokinetics of the drug class as well as route of administration; oral analgesics are effective for pain control but have a slower onset of action, so plan accordingly.

Key Documentation Elements

- Acquire and document patient's allergies prior to administration of medication.
- Obtain and document a complete set of vital signs (pulse, blood pressure, respiratory rate, pulse oximetry and neurologic status assessment) within five minutes before medication and approximately five minutes after medication administration, particularly when administering opiates.
- Obtain and document the initial patient pain scale assessment, after each analgesic medication administration, and upon arrival at destination.
- Documentation of medication administration with correct dose

PEDIATRIC PAIN ASSESSMENT

Ages 6 mo- 7 years or non-verbal:

FLACC Pain Scale

CATEGORIES	SCORES 0	SCORES 1	SCORES 2	Score
Face	*No particular expression or smile; disinterested*	*Occasional grimace or frown, withdrawn*	*Frequent to constant frown,clenched jaw*	
Legs	*No 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 crying (awake or asleep)*	*Moans or whimpers Occasional complaint*	*Crying steadily, screams or sobs, freq complaints*	
Consolability	*Content, relaxed*	*Reassured by occasional touching, hugging, talking*	*Difficult to console or comfort*	
Total possible FLACC score between 0 and 10			**TOTAL**	

Ages 3 - 8 years:

Wong-Baker FACES® Pain Rating Scale

0

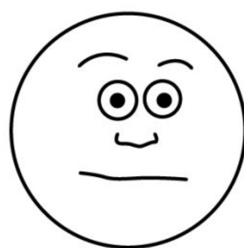
No Hurt

"Your body feels totally okay"

2

Hurts Little Bit

"It hurts a tiny bit, but you can still play or talk."



4

Hurts Little More

"You have to think about it because it keeps bothering you."

6

Hurts Even More

"You might feel like you need to stop what you're doing."

8

Hurts Whole Lot

"It feels like you really want help right away."

10

Hurts Worst

"This is the biggest hurt you can imagine."