Chapter 07: Pain Assessment and Management in Children

MULTIPLE CHOICE

1. A 2-year-old child has been returned to the nursing unit after an inguinal hernia repair. Which pain assessment tool should the nurse use to assess this child for the presence of pain?
   a. FACES pain rating tool
   b. Numeric scale
   c. Oucher scale
   d. FLACC tool

   ANS: D
   A behavioral pain tool should be used when the child is preverbal or doesn’t have the language skills to express pain. The FLACC (face, legs, activity, cry, consolability) tool should be used with a 2-year-old child. The FACES, numeric, and Oucher scales are all self-report pain rating tools. Self-report measures are not sufficiently valid for children younger than 3 years of age because many are not able to accurately self-report their pain.

   PTS: 1  DIF: Cognitive Level: Apply  REF: 145 | 150
   MSC: Area of Client Needs: Physiologic Integrity

2. The nurse is caring for a 6-year-old girl who had surgery 12 hours ago. The child tells the nurse that she does not have pain, but a few minutes later she tells her parents that she does. Which should the nurse consider when interpreting this?
   a. Truthful reporting of pain should occur by this age.
   b. Inconsistency in pain reporting suggests that pain is not present.
   c. Children use pain experiences to manipulate their parents.
   d. Children may be experiencing pain even though they deny it to the nurse.

   ANS: D
   Children may deny pain to the nurse because they fear receiving an injectable analgesic or because they believe they deserve to suffer as a punishment for a misdeed. They may refuse to admit pain to a stranger but readily tell a parent. Truthfully reporting pain and inconsistency in pain reporting suggesting that pain is not present are common fallacies about children and pain. Pain is whatever the experiencing person says it is, whenever the person says it exists. Pain would not be questioned in an adult 12 hours after surgery.

   PTS: 1  DIF: Cognitive Level: Analyze  REF: 145
   MSC: Area of Client Needs: Physiologic Integrity

3. A nurse is gathering a history on a school-age child admitted for a migraine headache. The child states, “I have been getting a migraine every 2 or 3 months for the last year.” The nurse documents this as which type of pain?
a. Acute  
b. Chronic  
c. Recurrent  
d. Subacute  

ANS: C  
Pain that is episodic and reoccurs is defined as recurrent pain. The time frame within which episodes of pain recur is at least 3 months. Recurrent pain in children includes migraine headache, episodic sickle cell pain, recurrent abdominal pain (RAP), and recurrent limb pain. Acute pain is pain that lasts for less than 3 months. Chronic pain is pain that lasts, on a daily basis, for more than 3 months. Subacute is not a term for documenting type of pain.

PTS: 1  DIF: Cognitive Level: Understand  REF: 151  
TOP: Integrated Process: Communication and Documentation  
MSC: Area of Client Needs: Physiologic Integrity  

4. Physiologic measurements in children’s pain assessment are:  
a. the best indicator of pain in children of all ages.  
b. essential to determine whether a child is telling the truth about pain.  
c. of most value when children also report having pain.  
d. of limited value as sole indicator of pain.  

ANS: D  
Physiologic manifestations of pain may vary considerably, not providing a consistent measure of pain. Heart rate may increase or decrease. The same signs that may suggest fear, anxiety, or anger also indicate pain. In chronic pain, the body adapts, and these signs decrease or stabilize. Physiologic measurements are of limited value and must be viewed in the context of a pain-rating scale, behavioral assessment, and parental report. When the child states that pain exists, it does. That is the truth.

PTS: 1  DIF: Cognitive Level: Understand  REF: 145  
MSC: Area of Client Needs: Physiologic Integrity  

5. Nonpharmacologic strategies for pain management:  
a. may reduce pain perception.  
b. make pharmacologic strategies unnecessary.  
c. usually take too long to implement.  
d. trick children into believing they do not have pain.  

ANS: A  
Nonpharmacologic techniques provide coping strategies that may help reduce pain perception, make the pain more tolerable, decrease anxiety, and enhance the effectiveness of analgesics. Nonpharmacologic techniques should be learned before the pain occurs. With severe pain, it is best to use both pharmacologic and nonpharmacologic measures for pain control. The nonpharmacologic strategy should be matched with the child’s pain severity and taught to the child before the onset of the painful experience. Some of the techniques may facilitate the child’s experience with mild pain, but the child will still know the discomfort was present.

PTS: 1  DIF: Cognitive Level: Understand  REF: 159  
MSC: Area of Client Needs: Physiologic Integrity
6. Which drug is usually the best choice for patient-controlled analgesia (PCA) for a child in the immediate postoperative period?
   a. Codeine  
   b. Morphine  
   c. Methadone  
   d. Meperidine  

   ANS: B
   The most commonly prescribed medications for PCA are morphine, hydromorphone, and fentanyl. Parenteral use of codeine is not recommended. Methadone is not available in parenteral form in the United States. Meperidine is not used for continuous and extended pain relief.

PTS: 1  DIF: Cognitive Level: Remember  REF: 162 | 164
MSC: Area of Client Needs: Physiologic Integrity

7. A lumbar puncture is needed on a school-age child. The most appropriate action to provide analgesia during this procedure is to apply _____ before the procedure.
   a. TAC (tetracaine-adrenaline-cocaine) 15 minutes  
   b. transdermal fentanyl (Duragesic) patch immediately  
   c. EMLA (eutectic mixture of local anesthetics) 1 hour  
   d. EMLA (eutectic mixture of local anesthetics) 30 minutes  

   ANS: C
   EMLA is an effective analgesic agent when applied to the skin 60 minutes before a procedure. It eliminates or reduces the pain from most procedures involving skin puncture. TAC provides skin anesthesia about 15 minutes after application to nonintact skin. The gel can be placed on the wound for suturing. Transdermal fentanyl patches are useful for continuous pain control, not rapid pain control. For maximal effectiveness, EMLA must be applied approximately 60 minutes in advance.

PTS: 1  DIF: Cognitive Level: Apply  REF: 167-168
MSC: Area of Client Needs: Physiologic Integrity

8. The nurse is caring for a child receiving intravenous (IV) morphine for severe postoperative pain. The nurse observes a slower respiratory rate, and the child cannot be aroused. The most appropriate management of this child is for the nurse to:
   a. administer naloxone (Narcan).  
   b. discontinue IV infusion.  
   c. discontinue morphine until child is fully awake.  
   d. stimulate child by calling name, shaking gently, and asking to breathe deeply.  

   ANS: A
   The management of opioid-induced respiratory depression includes lowering the rate of infusion and stimulating the child. If the respiratory rate is depressed and the child cannot be aroused, then IV naloxone should be administered. The child will be in pain because of the reversal of the morphine. The morphine should be discontinued, but naloxone is indicated if the child is unresponsive. The child is unresponsive, therefore naloxone is indicated.
9. The nurse is completing a pain assessment on a 4-year-old child. Which of the depicted pain scale tools should the nurse use with a child this age?

a. [FACE scale]

b. [Numeric pain scale]

c. [Word graphic scale]

d. [Visual analogue scale]

ANS: A

The pain scale appropriate for a 4-year-old child is the FACES pain scale. Numeric pain scales can be used on children as young as age 5 as long as they can count and have some concept of numbers and their values in relation to other numbers. Word graphic scales and visual analogue scales are used preferably for school-age children.

MULTIPLE RESPONSE

1. A nurse recognizes which physiologic responses as a manifestation of pain in a neonate? (Select all that apply.)
   a. Decreased respirations
   b. Diaphoresis
   c. Decreased SaO_2
   d. Decreased blood pressure
   e. Increased heart rate

   ANS: B, C, E

   The physiologic responses that indicate pain in neonates are increased heart rate, increased blood pressure, rapid, shallow respirations, decreased arterial oxygen saturation (SaO_2), pallor or flushing, diaphoresis, and palmar sweating.

2. A nurse is monitoring a patient for side effects associated with opioid analgesics. Which side effects should the nurse expect to monitor for? (Select all that apply.)
3. Which dietary recommendations should a nurse make to an adolescent patient to manage constipation related to opioid analgesic administration? (Select all that apply.)
   a. Bran cereal
   b. Decrease fluid intake
   c. Prune juice
   d. Cheese
   e. Vegetables

   ANS: A, D, E
   To manage the side effect of constipation caused by opioids, fluids should be increased, and bran cereal and vegetables are recommended to increase fiber. Prune juice can act as a nonpharmacologic laxative. Fluids should be increased, not decreased, and cheese can cause constipation so it should not be recommended.

4. Surgery has informed a nurse that the patient returning to the floor after spinal surgery has an opioid epidural catheter for pain management. The nurse should prepare to monitor the patient for which side effects of an opioid epidural catheter? (Select all that apply.)
   a. Urinary frequency
   b. Nausea
   c. Itching
   d. Respiratory depression

   ANS: B, C, D
   Respiratory depression, nausea, itching, and urinary retention are dose-related side effects from an epidural opioid. Urinary retention, not urinary frequency, would be seen.
1. A dose of oxycodone (OxyContin) 2 mg/kg has been ordered for a child weighing 33 lb. How many milligrams of OxyContin should the nurse administer? (Record your answer as a whole number.)

ANS: 30
The child’s weight is divided by 2.2 to get the weight in kilograms. Kilograms in weight are then multiplied by the prescribed 2 mg. 33 lb/2.2 = 15 kg. 15 kg \times 2 \text{ mg} = 30 \text{ mg}.

PTS: 1 DIF: Cognitive Level: Apply REF: 164

ESSAY

1. A patient on an intravenous opioid analgesic has become apneic. The nurse should implement which interventions? Place the interventions in order from the highest priority (first intervention) to the lowest priority (last intervention). Provide your answer using lowercase letters separated by commas (e.g., a, b, c, d).
   a. Place the patient on continuous pulse oximetry to assess $\text{SaO}_2$. 

b. Administer the prescribed naloxone (Narcan) dose by slow IV push.
c. Ensure oxygen is available.
d. Prepare to calm the child as analgesia is reversed.

ANS:
b, a, c, d

The Narcan prescribed dose should be given, first by slow IV push every 2 minutes until effect is obtained. The second intervention should be assessment of the patient’s SaO₂ status. Oxygen should be made available and administered if the SaO₂ status indicates hypoxemia. Last, the child should be calmed as the analgesia is reversed.

PTS: 1
DIF: Cognitive Level: Apply
MSC: Area of Client Needs: Physiologic Integrity

REF: 172