



HEALTH HOLDING

HAFER ALBATIN HEALTH  
CLUSTER  
MATERNITY AND  
CHILDREN HOSPITAL

<b>Department:</b>	Neonatal Intensive Care Unit (NICU)		
<b>Document:</b>	Departmental Policy and Procedure		
<b>Title:</b>	Pain Assessment in Neonates		
<b>Applies To:</b>	All NICU Staff		
<b>Preparation Date:</b>	January 05, 2025	<b>Index No:</b>	NICU-DPP-026
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## 1. PURPOSE:

- 1.1 Pain in the new born will be assessed and the appropriate interventions taken.
- 1.2 Parents will be taught signs and symptoms of pain in the new born.

## 2. DEFINITIONS:

- 2.1 **Pain** is an unpleasant sensation that can range from mild, localized discomfort to agony.

## 3. POLICY:

- 3.1 The behavioural and physiological responses are used to assess pain in the new born.
- 3.2 The table below is developed at Fountain Valley Regional Hospital and Medical Centre, by F Box RN, MJ Wainwright RN and L Thompson RN. This tool should be used as a guideline for healthcare providers when assessing irritability and pain in non-verbal or pre-verbal patients.

**Table1:** Behavioural- Physiological Pain Scale for Non-Verbal or Pre-Verbal patients.

SCORE	ASSESSMENT
0	No signs of pain or irritability exhibited
+	Signs of irritability -intermittent vocalisations, soft or brief cry but able to suck or feed. -increased activity of extremities, restless, purposeless movements but trunk is relaxed -frowning, furrowed brow, eyes open -mildly increased tone of extremities
++	Signs of pain -loud cry, sustained attempts to cry -refuses to feed, eat and/or pacifier does not relieve crying -thrashing of limbs of infants -marked brow bulge in infants, grimace, eyes closed tightly -decreased activity, fatigue, social withdrawal -tense muscles, guarding, posturing -flushed face, diaphoresis -change in sleep or awake pattern

## 4. PROCEDURE:

- 4.1 Behavioural-physiological pain scale: instructions for use of assessment guideline- evaluate all newborn every 2-4 hours or more frequently as appropriate.
  - 4.1.1 Score 0: Patients are identified as those who do not exhibit one or more of the behaviours listed in the (+) or (++) boxes.

- 4.1.2 Score +: Patients demonstrate one or more of the behaviours listed in the (+) box. Use age-appropriate comforting measures. Re-evaluate.
- 4.1.3 Score ++: patients demonstrate one or more of the behaviours listed in (++) box. Consider trial of pain medication. Re-evaluate.
- 4.2 Currently there is no reliable tool that can accurately measure newborn pain. It is possible that the newborn may be experiencing pain and not demonstrate any of the behaviours identified above. Whenever the presence of pain is suspected, administration of analgesia is warranted.
- 4.3 Guidelines for nursing interventions:
  - 4.3.1 Assess the neonate if there is at least one sign in the (+) category indicating irritability, evaluate for possible causative factors such as sensory overload, position, hunger etc.
  - 4.3.2 Intervene by removing sources of pain if possible. Collaborate with Physician to provide analgesia as needed. Use comfort measures such as swaddling or containment during a procedure, use of pacifier for non-nutritive sucking, use of sucrose, tactile stimulation.
  - 4.3.3 Evaluate for increased level of comfort/ decreased stress, and document the newborn's response to interventions taken.
  - 4.3.4 Expected outcome: A decreases in (++) behaviours to a (0 or +) levels of signs indicate increased comfort.

**5. MATERIAL AND EQUIPMENT:**

N/A

**6. RESPONSIBILITIES:**

- 6.1 Physician
- 6.2 Nurse




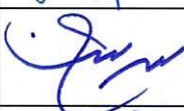



**7. APPENDICES:**

N/A

**8. REFERENCES:**

- 8.1 Ministry of Health, Policies and Procedures in Neonatology, Guidelines in Neonatal Care, page no:291-292

9. APPROVALS:

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