# Management of Acute Pain in Children

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## 1. Pain Assessment

Allow the child and their family to express any fears, concerns or anxieties relating to the pain or previous pain experiences

Ask about the pain:

| | |
|---|---|
| **Impact** | On daily living e.g. play or school |
| **Location** | Where is the pain? |
| **Intensity** | How bad is it? |
| **Type of pain** | e.g. sharp, stabbing, aching, burning |
| **Duration** | How long has it been going on? |
| **Exacerbation** | Is it constant or intermittent? What makes it worse? |
| **Interventions** | What treatment has already been given? Has it helped? |

- As a minimum, pain should be assessed with each full set of observations.
  Children in severe pain should be assessed more frequently (see **action & re-assessment** section)

- Use assessment to:
  - Determine the need for non-pharmacological and/or pharmacological interventions
  - Observe for deterioration in a child's condition. Consider surgical patients – could there be complications, do they need a surgical review?
  - Consider whether the pain is consistent with the child's working diagnosis (and think about alternative diagnosis)

## PAIN ASSESSMENT TOOLS

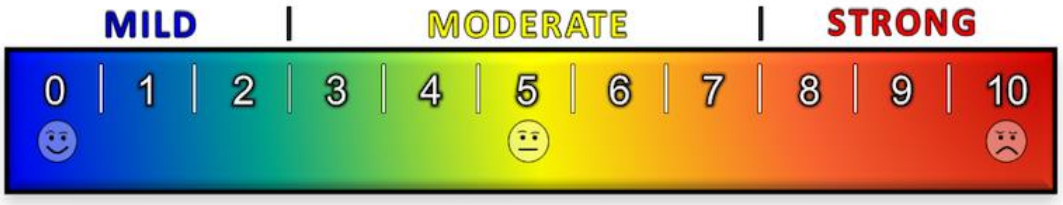
### 1. FLACC – suggested for ages 2 months – 7 years (score /10)

***Each indicator category is scored from 0-2, giving a total score of 0 to 10***

| Indicator | Score 0 | Score 1 | Score 2 |
|---|---|---|---|
| **F**ace | No particular expression or smile | Occasional grimace or frown, withdrawn, disinterested | Frequent to constant quivering chin, clenched jaw |
| **L**egs | Normal position or relaxed | Uneasy, restless, tense | Kicking, or legs drawn up |
| **A**ctivity | Lying quietly, normal position, moves quietly | Squirming, shifting back and forth, tense | Arched, rigid or jerking |
| **C**ry | No cry (awake or asleep) | Moans or whimpers, occasional complaint | Crying steadily, screams or sobs, frequent complaints |
| **C**onsolability | Content, relaxed | Reassured by occasional touching, hugging or being talked to, distractible | Difficult to console or comfort |

### 2. Faces (Wong and Baker) – suggested ages 8 years and over (score /5)


### 3. Visual Analogue Scale (VAS) – suggested ages 8 years and over (score /10)




### 4. Non-communicating Children

For non-communicating children please see Appendix 1 for the Non-Communicating Children's Pain Checklist – Revised (NCCPC-R)

## 2. Re-assessment & Action

Re-assessment must be timely and appropriate to the severity of the pain (see next page)

**NO – MILD PAIN** (FLACC score = 0 -3 / Faces score = 0- 1 / VAS score = 0-3)

- Re-assess pain as requested / at least with routine observations
- Give prescribed analgesia within 30 minutes of assessment
- Consider non-pharmacological intervention: e.g. play therapy, distraction, hot/cold pack
- Consider step-down needed from regular analgesia
- Analgesia should be available on the "as required" section of the drug chart

**MODERATE - SEVERE PAIN** (FLACC score = 4-10 / Faces score = 2-5 / VAS score = 4-10 )

- Give prescribed analgesia as soon as possible or at least within 20 minutes of assessment
- Consider non-pharmacological intervention: e.g. play therapy, distraction, hot/cold pack
- May need opioid analgesia
- If IV Morphine is required titrate to resolve pain and discuss an escalation plan. The decision for morphine boluses is only made by a senior team member and use is restricted to CED / theatres.
- If PCA/NCA is started, assess every 30 minutes for at least the first 2 hours to ensure adequate pain relief is ongoing
- Re-assess frequently and contact relevant medical/surgical team for review and escalation

## 3. Non-pharmacological Interventions

| Psychological | Physical/Sensory | Environmental |
|---|---|---|
| Parental presence | Alleviating pressure from pain site | Awareness of adverse effects of light, noise, music, alarms etc. |
| Reassurance, information and explanation to child and parents | Check position | Encourage normal sleep cycle and rest periods |
| Quiet, calm, child-orientated environment | Mattresses and pillows – can they be changes or adjusted? | |
| Allow choices | Physiotherapy | |
| Distraction techniques e.g. TV/DVD, schooling, play specialist, music | Hot/cold packs<br>Massage | |
| Cognitive behaviour therapy | TENS | |
| Guided imagery | Breastfeeding | |
| Relaxation techniques | Non-nutritive sucking (dummy/pacifier) | |
| | Sucrose | |

## 4. Pharmacological interventions

When prescribing:

- Anticipate pain at admission and ensure every child has analgesia prescribed in the "as required" section of the drug chart
- Children with regular analgesia prescribed should have an "as required" option
- Children should return to the wards following surgery with analgesia prescribed
- Escalation of prescribing may need to be rapid in some children (e.g. sickle cell crisis)

- Some children will have individualised pain management protocols based on previous experience – **use these**. The patient should have a copy, and there should be a copy in the medical notes.
- Assess the effectiveness of treatment and manage accordingly
- **DO** prescribe according to the patient's weight
- **DO NOT** prescribe according to the patient's age
- **DO** prescribe the dose in mg (milligrams)
- **DO NOT** prescribe the dose in mL (millilitres)
- **IF THE PATIENT IS OBESE: DISCUSS WITH PHARMACY TEAM / READ LINK BELOW**
  **https://www.sps.nhs.uk/articles/how-should-medicines-be-dosed-in-children-who-are-obese/**
- **Use the analgesic drug formulary (below) for dosing of analgesia within the RACH.**
  - Consider the use of local analgesia (e.g. benzydamine (Difflam®) spray) at any stage

| **Stepwise approach to pain management**<br>Omit drugs which are contraindicated – see below | | | | Oral Morphine Regular | IV Morphine (PCA/NCA) | Epidural / local anaesthetic infusions |
|---|---|---|---|---|---|---|
| | | | Oral Morphine PRN | | | |
| | | NSAID Regular | NSAID Regular | NSAID Regular | NSAID Regular | NSAID Regular |
| | Paracetamol PRN/Regular | Paracetamol Regular | Paracetamol Regular | Paracetamol Regular | Paracetamol Regular | Paracetamol Regular |

**Start pain relief at an appropriate step to the patient's level of pain** (e.g. post-operative patients may require PCA/NCA + regular oral analgesia as a minimum)

**Cautions and Contraindications:**

| Paracetamol | NSAIDs | Opioids |
|---|---|---|
| Consider reduced doses in hepatic impairment (discuss with a pharmacist) | True Allergy **Contraindicated** | Avoid use / reduce doses / increase interval in renal impairment – discuss all use in this situation with consultant. |
| | Upper GI bleed **Contraindicated** | Can cause respiratory depression |
| | Renal disease **Contraindicated** | May cause nausea and vomiting |
| | Thrombocytopenia or other bleeding disorder | Caution in chronic headache – risk of medication overuse headache |
| | Asthma (check if NSAIDs have previously been tolerated) | |
| | Age restrictions (PR diclofenac from 6 months only) | |

**Simple Analgesics** (Paracetamol & NSAIDs)

- When escalating analgesia, these **must** be given regularly and at maximum doses
- Do not avoid NSAIDs if nil by mouth or if patient has a poor appetite.
  Consider the duration of use and whether providing gastric protection is indicated. In the absence of additional risk factors, gastric protection is not routinely required.
- **Omit** NSAIDs if contraindicated (see above): it may be necessary to replace with oral opioids.
- Paracetamol can be given orally, rectally or intravenously.
- Do not prescribe Paracetamol as 'PO / IV' – **doses can be different**. If switching from one route to the other, re-prescribe, stating the new route.
- **Post-operative paracetamol dose not used at RACH routinely.** Discuss individual cases with Pharmacist
- **No paracetamol dose should be greater than 1 g every 4–6 hours (max QDS)**

**Opioids**

- Morphine is the opioid medicine of choice at RACH. **CODEINE is NOT used** at RACH as it is a pro-drug and there is a wide variation in how a person metabolises it. Worldwide there have been deaths in children due to codeine use.
- Naloxone and anti-emetics **must** be prescribed "as required" alongside ongoing opioid prescriptions, irrespective of the route
- For initial analgesia of traumatic injuries or severe pain, intranasal fentanyl may be given in CED (see below).
- For longer term opioid use (> 2 days), laxatives should be prescribed
- Oral Morphine liquid is the first line choice. Immediate release Morphine tablets can be used if the liquid is not tolerated, or tablets are preferred. Modified Release Morphine preparations are not recommended for acute pain.
- Dihydrocodeine may be used as an oral alternative in older children.
- Boluses of IV Morphine may be given to establish pain relief, which may then be followed by regular oral doses, or a PCA/NCA depending on the clinical situation, **however the use of morphine boluses is restricted to CED / theatres only, and the decision for use must be made and supervised by a senior team member. Only the 50mg/50mL preparation should be used for morphine boluses.**

**Opioids (cont.)**

- Patients who need two or more doses of IV morphine to relieve pain may need PCA/NCA (see guidance at the end of the document).
- When IV Morphine boluses are given in CED or theatres, the child should have appropriate monitoring to ensure that respiratory depression is recognised.

**Avoid use / reduce doses / increase interval in renal impairment – discuss all use in this situation with consultant.**

**Intranasal fentanyl**

Typically used in the CED for fast acting analgesia for the relief of moderate to severe pain.

- **Indication for use**
  - Initial analgesia for traumatic injuries e.g. fractures, burns/scalds, fingertip injuries
  - Procedures: suturing, painful dressing changes.
- **Contraindicated in:**
  - Children <10kg / known allergy / children with a head injury or decreased GCS / epistaxis / airway / respiratory problem
- **Dose used 1.5 micrograms/kg (maximum 75 micrograms per** microgram/kg intravenous dose.
- **Fentanyl solution of 50 micrograms/ml should be used.** Use a 1ml syringe attached to a mucosal atomizer.

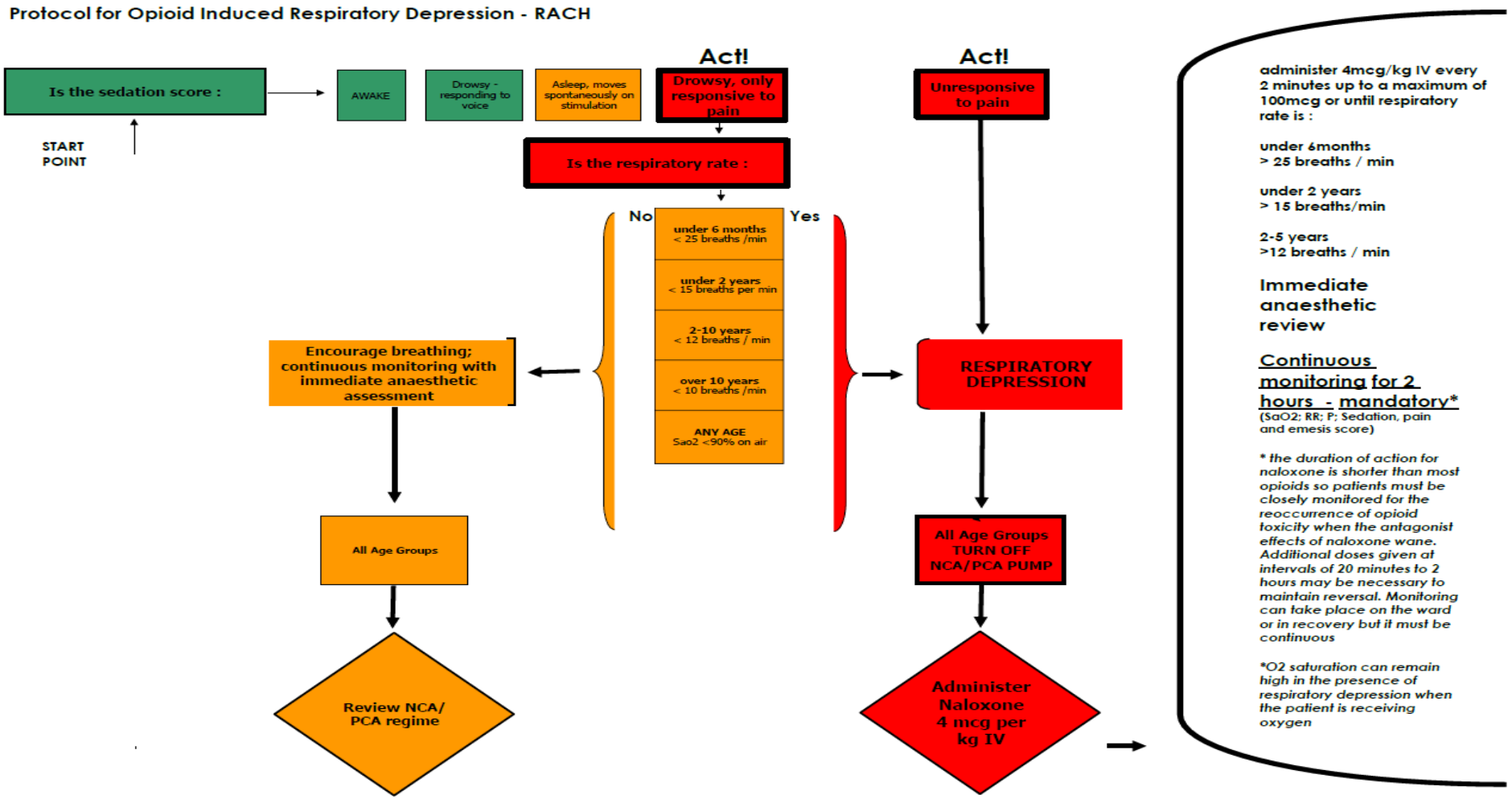
**Absorption** can be as fast as the intravenous route with therapeutic serum levels obtained within 2 mins, therefore the same side effects can occur.

Optimum effects last for 30 minutes but pain relief is often experienced for much longer.

## 5. Opioid Antagonists: Respiratory suppression / Overdose

Over dosage with opioids see BNFc

Respiratory suppression



## 6. Analgesic Drug Formulary

**Part 1: Children >1 month old (corrected gestational age)**

| Simple Analgesics | | | | | | |
|---|---|---|---|---|---|---|
| Drug | Route | Weight/Age | Dose | Frequency | Formulations | Notes |
| Paracetamol | Oral | >1 month | 15mg/kg Max 1g | 4-6 hourly Max QDS | Suspension: 120mg/5mL 240mg/5mL Tablets: 500mg | Rectal uptake is slower and more variable than other routes<br><br>Oral drug is rapidly absorbed from the small bowel with almost 100% bioavailability, and has a similar onset time to IV preparation. |
| | Rectal | >1 month | 15mg/kg Max 1g | | Suppositories: 60mg 125mg 250mg 500mg | |
| | IV infusion over 15 minutes | <10kg | 7.5mg/kg | | IV infusion: 1g /100mL 500mg/ 50mL 100mg/10mL<br><br>Doses under 100mg should use the 100mg in 10mL ampoules to reduce risk of error | |
| | | 10-50kg | 15mg/kg | | | |
| | | ≥50kg | 1g | | | |
| Ibuprofen | Oral | >1 month | 10mg/kg **or** | 8 hourly **or** | Suspension: 100mg/5mL Tablets: 200mg 400mg | These are maximum doses. For pain and inflammation in rheumatic disease including juvenile idiopathic arthritis doses, see BNFc |
| | | | 7.5mg/kg | 6 hourly | | |
| Naproxen | Oral | >1 month | 5mg/kg Max 500mg | 12 hourly | Tablets: 250mg 500mg | Note only available in tablet form |
| Diclofenac | Rectal | >6 months 8-11kg | 12.5mg | 12 hourly Max 4 days | Suppositories: 12.5mg 25mg 50mg | Oral diclofenac is non-formulary |
| | | >6 months 12kg+ | 1mg/kg Max 50mg | 8 hourly Max 4 days | | |

| Opioid Analgesics | | | | | | |
|---|---|---|---|---|---|---|
| Drug | Route | Weight/Age | Dose | Frequency | Formulations | Notes |
| Morphine Sulphate | Oral | 1-3 months | 50-100 micrograms/kg | 4 hourly | Solution: 10mg/5mL Tablets: 10mg 20mg | All doses are for initiation of treatment and should be adjusted according to response.<br><br>**The use of morphine boluses for pain is restricted to CED / theatres only, and decision for use must be made and supervised by a senior team member**<br><br>Ensure Naloxone and anti-emetic is prescribed for every child. |
| | | 3-6 months | 100-150 micrograms/kg | | | |
| | | 6-12 months | 200 micrograms/kg | | | |
| | | 1-12 years | 200-300 micrograms/kg | | | |
| | | 12 years + | 5 – 10 mg | | | |
| | IV injection over 5 minutes | 1-6 months | 100 micrograms/kg | 6 hourly | Injection: 50mg/50ml **only** | |
| | | 6 months-12 years | 100 micrograms/kg | 4 hourly | | |
| | | 12-17 years | 5mg | 4 hourly | | |
| | SC injection | 1-6 months | 100-200 micrograms/kg | 6-hourly | Injection: 10mg/mL 30mg/mL | |
| | | 6 months-2 years | 100-200 micrograms/ kg | 4-hourly | | |
| | | 2-12 years | 200 micrograms/kg | 4-hourly | | |
| | | 12-18 years | 2.5-5mg | 4-hourly | | |
| Fentanyl | IN intranasal | Children > 10 kg | 1.5 micrograms/kg (max dose 75 micrograms) | Can give second dose after 30 minutes | Injection: 50 micrograms/ml | |
| Dihydrocodeine | Oral | 1-4 years | 500 micrograms/kg | 4-6 hourly Max QDS | Tablets: 30mg | |
| | | 4-12 years | 0.5-1mg/kg | | | |
| | | 12-17 years | 30mg | | | |

| Naloxone | | | | | |
|---|---|---|---|---|---|
| Drug | Route | Weight/Age | Dose | Frequency | Formulations |
| Naloxone | IV | All ages | **Respiratory depression**<br>4-10 micrograms/kg<br><br>*If no respiratory improvement:*<br>100 micrograms/kg (max 2mg) may be used | Repeat at intervals of 1 minute up to a maximum of 2mg total | Injection:<br>400 micrograms/mL |
| | | | **Severe Pruritus**<br><br>0.5 micrograms/kg | Repeat at 10 minute intervals up to a maximum of 4 doses | |

**Part 2: Children <1 month old (corrected gestational age)**

| Drug | Route | Weight/Age | Dose | Frequency | Formulations |
|---|---|---|---|---|---|
| Paracetamol | Oral | 28-32 weeks CGA | 10-15mg/kg<br>Max 30mg/kg/day | 8 – 12 hourly | Suspension:<br>120mg/5mL |
| | | >32 weeks CGA | 10-15mg/kg<br>Max 60mg/kg/day | 6 – 8 hourly | |
| | Rectal | 28-32 weeks CGA | 10-15mg/kg<br>Max 30mg/kg/day | 12 hourly | Suppositories:<br>60mg<br>125mg |
| | | >32 weeks CGA | 15-20mg/kg<br>Max 60mg/kg/day | 8 hourly | |
| | IV infusion over 15 minutes | <32 weeks CGA | 7.5mg/kg | 12 hourly | IV infusion:<br>500mg/ 50mL<br>100mg/10mL |
| | | >32 weeks CGA | | 8 hourly | |
| Morphine Sulphate | Oral | All neonates | *Initially:*<br>50-100 micrograms/kg | *Initially:*<br>4 hourly | Solution:<br>10mg/5mL<br>100 micrograms/mL |
| | For IV Morphine in Neonates refer to Neonatal guidelines.<br>In this age group, this will usually be given in NICU. | | | | |

## 7. Patient Controlled Analgesia (PCA) & Nurse Controlled Analgesia (NCA)

**The decision to use a PCA/NCA should be made by a Consultant and discussed with the Pain Team / third on Anaesthetist, and a strategy for analgesia must be documented in the clinical notes.**

**See separate PCA / NCA policy for indications and preparation of the child and family.**

- NB. Regular simple analgesia **must** be continued
- Record Baseline observations *including* a pain score before commencing a PCA/NCA

**PCA/NCA prescriptions**

- IV bolus doses of morphine are given prior to starting PCA/NCA to achieve complete pain control, but only in CED or theatres, and only on senior team member's decision and supervision.
- If pain returns after PCA/NCA is commenced, review the patient, history, pump usage and prescription and check this against the pump
  - Pain control should be regained with prescribed morphine "top-up" doses.
  - These may be given via the pump with "clinician override" once prescribed on the medication chart.
  - Choose a dose according to pain severity – repeated doses of the existing PCA/NCA bolus dose for milder pain, or up to 50 micrograms/kg for severe pain
  - Repeat up to four times at 5 minute intervals with monitoring (as described above)
- The PCA/NCA dose should then be doubled OR the background infusion titrated upwards as appropriate depending on the history of pump usage. This should always be done after discussion with the Consultant
- **If pain is still not controlled** a consultant to consultant discussion should take place with the on call paediatric anaesthetic consultant, and an escalation plan made.

***Morphine PCA/NCA prescriptions***

| | **Children < 50kg** | | **Children ≥ 50kg** | |
|---|---|---|---|---|
| | **NCA** | **PCA** | **NCA** | **PCA** |
| **Morphine Sulfate** | 1mg/kg in 50mL sodium chloride 0.9% *(1mL = 20 micrograms/kg)* | | 50mg in 50mL sodium chloride 0.9% *(1mL = 1mg)* | |
| **Loading Dose** | 2.5 – 5mL *(50 – 100 micrograms/kg)* | | 1 – 5mL *(1 – 5mg)* | |
| **Bolus Doses** | 0.5 – 1mL *(10 – 20 micrograms/kg)* | | 0.5 – 1mL *(0.5 – 1mg)* | 0.5 – 2mL *(0.5 – 2mg)* |
| **Max dose in 4 hours** | | | | |
| **Lockout** | 20 minutes | 5 – 10 minutes | 20 minutes | 5 – 10 minutes |
| **Background Infusion** | 0, 0.2, 0.5 or 1 mL/hr | 0 or 0.2 mL/hr | 0, 0.2, 0.5 or 1 mL/hr | 0 or 0.2 mL/hr |

***Fentanyl PCA/NCA prescriptions***

| | Children < 50kg | | Children ≥ 50kg | |
|---|---|---|---|---|
| | **NCA** | **PCA** | **NCA** | **PCA** |
| **Fentanyl** | 25 micrograms/kg in 50mL sodium chloride 0.9% *(1mL = 0.5 micrograms/kg)* | | 1250 micrograms in 50mL sodium chloride 0.9% *(1mL = 25 micrograms)* | |
| **Loading Dose** | 0.5 – 2mL *(0.25 – 1 microgram/kg)* | | 0.5 – 2mL *(12.5 – 50 micrograms)* | |
| **Bolus Doses** | **5 – 50kg:** 0.5 – 1mL *(10 – 20 micrograms/kg)* | 0.5 – 2mL *(0.25 – 1 microgram/kg)* | 0.5 – 1mL *(12.5 – 25 micrograms)* | |
| | **< 5kg:** 0.2 – 0.5mL *(0.1 – 0.25 micrograms/kg)* | | | |
| **Max dose in 4 hours** | 20mL *(10 micrograms/kg)* | | 20mL *(500 micrograms)* | |
| **Lockout** | 20 – 30 minutes | 5 – 10 minutes | 20 – 30 minutes | 5 – 10 minutes |
| **Background Infusion** | **5 – 50kg:** 0.2 – 1mL/hr | 0 – 0.2 mL/hr | 0.2 – 1 mL/hr | 0.2 – 2 mL/hr |
| | **< 5kg:** 0.2 – 0.5mL/hr | | | |

## 8. Discharge Considerations

The NHS belongs to everybody and we must ensure that its resources are used in the best possible way for all patients. Paracetamol and ibuprofen are approximately four times more expensive when it is prescribed on the NHS compared to when it is purchased in pharmacies or supermarkets. This policy reflects the Position Statement on the Prescribing of Paracetamol and Ibuprofen in Brighton and Hove CCG.

It is normal for patients being discharged from RACH **NOT** to be supplied with paracetamol or ibuprofen on their TTO's.

- We recognise that over the counter (OTC) dosing guidance is different from prescribed doses.
    - In situations where it is felt that the higher doses are essential to patient care these doses should be prescribed on a TTO in mg and in ml for the dose. It is essential and in line with hospital policy that these TTO's are screened by a pharmacist before the patient is discharged. However there will be no supply of medication. Oral syringes will be provided if needed for dose administration.

- Supplies **will** be made for patients who have had:
    - Tonsillectomy see **Tonsillectomy & Adenoidectomy Discharge Pro-forma** (Microguide > Paediatric and Neonatology > Paediatrics > A-Z > D > Daycare / Level 7 guidelines)
    - Emergency surgery and are being discharged the same day

- Other situations which must be discussed with pharmacy and agreed before the TTO is dispensed.
- Under 3 months a supply MUST be made if needed.

Other analgesia, not available OTC may be prescribed on discharge if needed by the patient. This could include rectal diclofenac, or any opioid analgesic prescribed.

Morphine sulphate 10mg/5ml oral solution is treated as a Controlled drug (CD) within the trust. The total quantity to supply, in words and figures, is required on the TTO.

**References**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4. Brighton and Sussex University hospitals NHS Trust. Children's Opioid Infusion Record, Morphine.
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## Appendix 1 – Non-communicating Children's Pain Checklist

The NCCPC-R was designed to be used for children, aged 3 to 18 years, who are unable to speak because of cognitive (mental/intellectual) impairments or disabilities. It can be used whether or not a child has physical impairments or disabilities. The NCCPC-R was designed to be used without training by parents and caregivers (carers). It can also be used by other adults who are not familiar with a specific child (do not know them well).

**How often has this child shown these behaviours in the last 2 hours?**

**0 = NOT AT ALL 1 = JUST A LITTLE 2 = FAIRLY OFTEN 3 = VERY OFTEN NA = NOT APPLICAPBLE**

**i. Vocal**

| | | | | | |
|---|---|---|---|---|---|
| 1. Moaning, whining, whimpering (fairly soft) | 0 | 1 | 2 | 3 | NA |
| 2. Crying (moderately loud) | 0 | 1 | 2 | 3 | NA |
| 3. Screaming/yelling (very loud) | 0 | 1 | 2 | 3 | NA |
| 4. A specific sound or word for pain (e.g. a word, cry or type of laugh) | 0 | 1 | 2 | 3 | NA |

**ii. Social**

| | | | | | |
|---|---|---|---|---|---|
| 5. Not co-operating, cranky, irritable, unhappy | 0 | 1 | 2 | 3 | NA |
| 6. Less interaction with others, withdrawn | 0 | 1 | 2 | 3 | NA |
| 7. Seeking comfort or physical closeness | 0 | 1 | 2 | 3 | NA |
| 8. Being difficult to distract, not able to satisfy or pacify | 0 | 1 | 2 | 3 | NA |

**iii. Facial**

| | | | | | |
|---|---|---|---|---|---|
| 9. A furrowed brow | 0 | 1 | 2 | 3 | NA |
| 10. A change in eyes, including: squinching, opened wide, frowning | 0 | 1 | 2 | 3 | NA |
| 11. Turning down of mouth, not smiling | 0 | 1 | 2 | 3 | NA |
| 12. Lips puckering up, tight, pouting or quivering | 0 | 1 | 2 | 3 | NA |
| 13. Clenching or grinding teeth, chewing or thrusting tongue out | 0 | 1 | 2 | 3 | NA |

**iv. Activity**

| | | | | | |
|---|---|---|---|---|---|
| 14. Not moving, less active, quiet | 0 | 1 | 2 | 3 | NA |
| 15. Jumping around, agitated, fidgety | 0 | 1 | 2 | 3 | NA |

**v. Body and Limbs**

| | | | | | |
|---|---|---|---|---|---|
| 16. Floppy | 0 | 1 | 2 | 3 | NA |
| 17. Stiff, spastic, tense, rigid | 0 | 1 | 2 | 3 | NA |
| 18. Gesturing to or touching part of body that hurts | 0 | 1 | 2 | 3 | NA |
| 19. Protecting, favouring or guarding part of body that hurts | 0 | 1 | 2 | 3 | NA |
| 20. Flinching or moving the body part away, being sensitive to touch | 0 | 1 | 2 | 3 | NA |
| 21. Moving the body in a specific way to show pain e.g. head back, arms down, curls up etc. | 0 | 1 | 2 | 3 | NA |

**vi. Physiological**

| | | | | | |
|---|---|---|---|---|---|
| 22. Shivering | 0 | 1 | 2 | 3 | NA |
| 23. Change in colour, pallor | 0 | 1 | 2 | 3 | NA |
| 24. Sweating, perspiring | 0 | 1 | 2 | 3 | NA |
| 25. Tears | 0 | 1 | 2 | 3 | NA |
| 26. Sharp intake of breath, gasping | 0 | 1 | 2 | 3 | NA |
| 27. Breath holding | 0 | 1 | 2 | 3 | NA |

**vii. Eating/Sleeping**

| | | | | | |
|---|---|---|---|---|---|
| 28. Eating less, not interested in food | 0 | 1 | 2 | 3 | NA |
| 29. Increase in sleep | 0 | 1 | 2 | 3 | NA |
| 30. Decrease in sleep | 0 | 1 | 2 | 3 | NA |

**Score summary:**

| Category | i | ii | iii | iv | v | vi | vii | Total |
|---|---|---|---|---|---|---|---|---|
| Score | | | | | | | | |

**A total score of 7 or more indicates a child has pain**