PAIN ASSESSMENT TOOL – UTILISING THE PREMATURE INFANT PAIN PROFILE (PIPP-R) TOOL

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INTRODUCTION
Pain assessment tools, such as the Premature Infant Pain Profile (PIPP-R) tool, are an important component in pain management for infants in hospitals.

1. AIM
   • To objectively assess responses to acute procedural pain in infants, utilising a validated pain assessment tool

2. PATIENT
   • Newborns

3. STAFF
   • Medical and nursing staff

4. EQUIPMENT
   • The Premature Infant Pain Profile (PIPP-R) Chart
   • Oxygen saturation and heart rate monitoring equipment

NOTES:
• A self-directed computer learning package is available in the NCC
• Post-surgical infants, infants on pain relief, painful procedures, chest drains, infants with pain symptoms should be on a PIPP-R chart and scored every hour

5. CLINICAL PRACTICE

Procedure:
1. Undertake the first two assessments with another RN who is familiar with the tool.
2. Using the Pain Score Chart (Appendix 1):
   • Score gestational age
   • Score behavioural state by observing the infant for 15 seconds, prior to cares
   • Record baseline heart rate and oxygen saturation
   • Observe the infant for 30 seconds immediately following the event
   • Look back and forth from the monitor to the baby’s face
   • Score physiologic and facial action changes seen during that time
   • Record final score, following the 30 second observation period:
     o Score ≤ 5 indicates no acute pain
     o Score >10 indicates moderate to severe pain
2. LOCAL OPERATING PROCEDURE

NEONATAL SERVICES DIVISION

Approved by Quality & Patient Care Committee
September 2018

PAIN ASSESSMENT TOOL – UTILISING THE PREMATURE INFANT PAIN PROFILE (PIPP-R) TOOL  cont’d

3. Action Plan (Appendix 1):
   • Score ≤5 – A (no action required)
   • Score 6-10 – B or C
     o Assess and provide comfort measures
     o Swaddling
     o Non-nutritive sucking
     o Oral Sucrose +/- pacifier
     o Containment
     o Breastfeeding
   • Score >10 – D
     o Assess
     o Consult with medical staff
     o Consider pharmacological treatment
     o Consider increasing medication dose, if prescribed

6. DOCUMENTATION
   • eMR
   • Daily Care Plan
   • Neonatal Observation Chart

7. RELATED POLICIES/PROCEDURES/CLINICAL PRACTICE LOP
   • Nil

8. RISK RATING
   • Low

9. NATIONAL STANDARD
   • Standard 1 Governance for Safety and quality in Health Service Organisation
   • Standard 2 Partnering with Consumers
   • Standard 4 Medication Safety
   • Standard 9 Recognising and Responding to Clinical Deterioration in Acute Health Care

10. ABBREVIATIONS AND DEFINITIONS OF TERMS

<table>
<thead>
<tr>
<th>NCC</th>
<th>Newborn Care Centre</th>
<th>RN</th>
<th>Registered Nurse</th>
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<tbody>
<tr>
<td>PIPP-R</td>
<td>Premature Infant Pain Profile – Revised</td>
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11. REFERENCES
PAIN ASSESSMENT TOOL – UTILISING THE PREMATURE INFANT PAIN PROFILE (PIPP-R) TOOL  cont’d

12. AUTHOR

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<tr>
<td>Primary</td>
<td>June 2010</td>
<td>T Lowe (RN)</td>
</tr>
<tr>
<td>Revised</td>
<td>22/3/2011</td>
<td>T Lowe (RN)</td>
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<tr>
<td></td>
<td>29/8/2018</td>
<td>KB Lindrea (CNC)</td>
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REVISION & APPROVAL HISTORY
August 2018 Revised and Approved NCC LOPs Committee
March 2011 Revised and Approved NCC Policy/Procedure Working Group
June 2010 Primary

FOR REVIEW: 2023
Appendix 1. Royal Hospital for Women NCC Pain Score Chart (adapted from PIPP-R)

<table>
<thead>
<tr>
<th>PROCESS</th>
<th>INDICATOR</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>SCORE</th>
</tr>
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<tbody>
<tr>
<td>CHART</td>
<td>Gestational Age</td>
<td>36 weeks and more</td>
<td>32 weeks to 35 weeks, 6 days</td>
<td>28 weeks to 31 weeks, 6 days</td>
<td>27 weeks and less</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Observe infant for 15 seconds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Observe baseline: Heart Rate, O₂ Saturation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Behavioural State</td>
<td>Quiet/sleep</td>
<td>Quiet/Awake</td>
<td>Active/sleep</td>
<td>Active/Awake</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eyes closed</td>
<td>Eyes open</td>
<td>Eyes closed</td>
<td>Facial movement</td>
<td>Facial movements</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No facial movement</td>
<td>No facial movement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Observe infant for 30 seconds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Heart Rate</td>
<td>Max.</td>
<td>0-4 beats/min increase</td>
<td>5-14 beats/min increase</td>
<td>15-24 beats/min increase</td>
<td>25 beats/min or more increase</td>
</tr>
<tr>
<td></td>
<td>O₂ Saturation</td>
<td>Min.</td>
<td>0-2.4% decrease</td>
<td>2.5-4.9%</td>
<td>5.0-7.4%</td>
<td>7.5% or more decrease</td>
</tr>
<tr>
<td></td>
<td>Brow Bulge</td>
<td>None</td>
<td>0-9% of time</td>
<td>Minimum 10-30% of time</td>
<td>Moderate 49-69% of time</td>
<td>Maximum 70% of time or more</td>
</tr>
<tr>
<td></td>
<td>Eye Squeeze</td>
<td>None</td>
<td>0-9% of time</td>
<td>Minimum 10-39% of time</td>
<td>Moderate 49-69% of time</td>
<td>Maximum 70% of time or more</td>
</tr>
<tr>
<td></td>
<td>Nasolabial furrow</td>
<td>None</td>
<td>0-9% of time</td>
<td>Minimum 10-39% of time</td>
<td>Moderate 49-69% of time</td>
<td>Maximum 70% of time or more</td>
</tr>
</tbody>
</table>

TOTAL SCORE

Management Initiated as per guide

**Procedural Pain Management in NCC**

<table>
<thead>
<tr>
<th>Pain Score</th>
<th>Action</th>
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<tbody>
<tr>
<td>&lt;5</td>
<td>No action required</td>
</tr>
<tr>
<td>6 - 10</td>
<td>Assess → Provide Comfort Measures</td>
</tr>
<tr>
<td>&gt;10</td>
<td>Assess → Consult with Medical staff → Consider Pharmacologic treatment → Consider increasing medication dose (if prescribed).</td>
</tr>
</tbody>
</table>

Guide to Facial Actions:

FOREHEAD: Brow bulge
BROWS: Low, drawn together
EYES: Squeezed shut
CHEEKS: Raised
NOSE: Broadened, bulging
MOUTH: Open, Squarish