Ashford and St. Peter's Hospitals
NHS Foundation Trust

Management of Acute Pain in Children

Best Practice Guidelines For Paediatric Inpatients

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Status:

Approval date:	June 2025
Ratified by:	GSACT Clinical Governance GSACT Divisional Board Paediatric Governance Group Drugs and Therapeutic Committee
Review date:	June 2028

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History

Issue	Date Issued	Brief Summary of Change	Author
1	November 2022	New guidelines	Richard Hawkins
2	March 2025	Updated pain team staff members	Richard Hawkins

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Policy Author	Richard Hawkins
Department/Directorate	GSACT/Paediatric Services
Date of issue	June 2025
Review due	June 2028
Ratified by	GSACT/Children's Services Clinical Governance
Audience	All clinical staff caring for children with acute pain

Executive summary

All paediatric patients in the Trust experiencing acute pain post-operatively or as a result of illness must receive safe, effective and appropriate analgesia to enable them to return to normal activity as soon as possible

This guidance is relevant to: Inpatient Pain Service, Registered Nurses, Anaesthetists, Independent Prescribers, Pharmacy, Operating Department Practitioners, Doctors and Allied Health Professionals.

This guideline should not be used for the management of persistent (chronic) pain or palliative care pain unless adopted by those areas.

Other guidelines to be referred to:

Management of PONV in children

Intranasal Analgesia (Fentanyl and Diamorphine) for children and young people in the Paediatric Emergency Department

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Glossary of Terms

ASPH	Ashford & St Peter's Hospitals
IV	Intravenous
NCA	Nurse controlled analgesia
NGT	Nasogastric tube
NSAIDs	Non-steroidal anti-inflammatory drugs
PCA	Patient controlled analgesia
PEG	Percutaneous Endoscopic Gastrostomy
PEJ	Percutaneous Endoscopic Jejunostomy
PONV	Post operative nausea & vomiting
PO	Per oral
PR	Per rectum
PRN	Pro re nata (as required)
QDS	Quater die sumendum (four times a day)
TDS	Ter die sumendum (three times a day)
TENS	Transcutaneous electrical nerve stimulation
WHO	World Health Organisation

INTRODUCTION

This guideline is aimed at healthcare professionals treating children and young people (from herein referred to as child or children) with acute pain between the ages of 0-18 years, admitted to ASPH.

The Inpatient Pain Service

The Inpatient Pain Service is coordinated by a dedicated Clinical Nurse Specialist between 0800-1600 hours, Monday to Friday. The service provides management and guidance for all acute pain issues. Ward rounds occur on weekday mornings.
Acute pain management issues occurring out of hours (between 1800hrs - 0800hrs Monday to Friday and during weekends) must be referred to the on-call Anaesthetic registrar (bleep 5007). The on-call Paediatric team and the paediatric nurse in charge should also be informed.

Key contact numbers:

- Clinical Nurse Specialists (CNS): (M Thompson, T Irvine-Smith, S Silk) Bleep 5042 (0800-1600hrs Mon – Fri)
- Inpatient Pain Team Consultant Anaesthetists: R Hawkins, M Sinnott
- Pharmacist: Bleep 8282
- On-call Anaesthetic Registrar: Bleep 5007 (24/7 cover)
- Paediatric Registrar: Bleep 5315

PAIN ASSESSMENT & OBSERVATION

Pain assessment must be tailored to each individual child, according to age and level of cognitive development.
Where possible, accurate pain assessment is based on a child's self-report, together with clinical observation of behavioural and physiological signs.
Always re-assess pain regularly, including after analgesic administration, to ensure optimum efficacy of analgesia and observe regularly for any potential side effects.

****Pain assessment tools may assist the child in describing and communicating pain****
See Appendix for assessment tools

- ✓ For neonates - specific pain score tools are used
- ✓ Assessment of pain in children requires interpretation of behavioural cues
- ✓ The child's carers should be encouraged to assist in pain assessment
- ✓ Physiological signs of pain include
  - changes in **heart rate, respiratory rate** and **blood pressure**
- ✓ Behavioural signs of pain include - **facial expression, posture, tone** and **vocalization**
- ✓ Pain, sedation, nausea and vomiting scores must be recorded regularly
- ✓ Pain assessment must be translated into pain measurement using pain scales
- ✓ Good communication by all members of the multidisciplinary team is essential for satisfactory pain management.

PAEDIATRIC ANALGESIA GUIDE

When prescribing **Paracetamol and Ibuprofen** for paediatric and neonatal patients, please refer to the ASPH Paracetamol and Ibuprofen Prescription Powerplan for recommended dosages.

STEP ONE: **MILD PAIN** (PAIN SCORE 1-3)	Regular paracetamol PO / PR QDS ***Plus or minus:*** Regular PO NSAID: e.g. Ibuprofen OR diclofenac ***Plus*** **PRN** Immediate release oral morphine sulphate (see guide below)	Check for allergy status / NSAID contra-indications Ibuprofen is 1st choice NSAID except for sickle cell crisis where diclofenac may be considered
STEP TWO: **MODERATE-SEVERE PAIN** (PAIN SCORE 4–10)	Regular paracetamol PO / PR QDS ***Plus*** Regular NSAID – Ibuprofen 1st line ***Plus*** **REGULAR** opioid: Immediate release oral morphine sulphate (or immediate release oxycodone hydrochloride as second line) **Or** Dihydrocodeine **Note:** **If pain score 8-10 despite above steps consider** IV PCA / NCA (see individual protocols)	Consider regular macrogol (Movicol, Laxido) if giving opioids for >24hrs No IV opioid boluses to be given on wards (excluding HDU area on Ash Ward and A&E) except via NCA or PCA Use protocols when prescribing PCA/NCA and ***always*** prescribe adjuvant drugs for PCA/NCA including naloxone & oxygen

When prescribing opioids please ensure *regular* laxatives and PRN anti-emetics are prescribed

Suggested ORAL morphine and dihydrocodeine doses for corrected gestational age

DRUG	AGE	DOSE	TIMING
Oral Morphine Sulphate	Neonates	0.05 mg/kg	4 hourly
	1-3 **months**	0.05-0.1 mg/kg	
	4-6 **months**	0.1-0.15 mg/kg	
	7-12 **months**	0.2 mg/kg	
	1-12 **years**	0.2-0.3 mg/kg	
	>12 **years**	5-10 mg	
Dihydrocodeine	1-4 years	0.5 mg/kg	6 hourly
	5-12 years	1 mg/kg	
	>12 years	30 mg	

NON-PHARMACOLOGICAL METHODS

Physical/Sensory	Psychological	Environmental
Repositioning – Of patient +/or pillows/bedding	Parental presence	Awareness of adverse effects of light, noise, music, alarms etc.
Physical Activity	Distraction	Encourage normal sleep cycle and rest periods
Heat Compress	Reassurance, information and explanation to child and parents	
TENS	Quiet, calm, child-orientated environment	
Ice Pack	Play	
Physiotherapy	Allow choices	
Breast Feeding	Guided Imagery	
Non-nutritive Sucking (dummy)	Relaxation Techniques	
Sucrose		

GENERAL ADVICE

Pain management is an essential part of paediatric care.
Babies (and many older children) cannot verbally communicate their pain but will show physiological and psychological responses to painful events.

Key points for successful paediatric pain management are:

1) Pre-emptive pain relief – e.g. topical anaesthetic before procedure
2) Regular analgesia
3) Regular re-assessment of pain scores
4) Regular adjustment of analgesic prescriptions according to requirements

When prescribing analgesics for neonates *(i.e. full term babies up to one month of age, or preterm babies up to 60 weeks post conceptual age),* **the following must be considered:**
•Immaturity of renal and hepatic function.
•Increased sensitivity to the sedative and respiratory depressant effects of drugs.
•Longer drug elimination times increase the risk of accumulation on repeated dosing.
•Continuous infusions of opioids may be associated with problems of tolerance, accumulation and withdrawal syndromes.

Routes of Administration of Analgesics:

- Enteral (oral, NGT, PEG, PEJ) – preferred route where possible.
- Rectal (PR) – requires informed consent by child's legal guardian.
- Intravenous (IV) (e.g. bolus dose / infusion / PCA / NCA)
- Subcutaneous (SC) (for opiates where IV access is unavailable or inappropriate)
- Epidural / Caudal
- Transdermal - e.g. fentanyl patches
- Inhalation – Entonox (nitrous oxide)
- Sublingual – e.g. fentanyl lozenges
- Intranasal (IN) – e.g. diamorphine
- Intramuscular (IM) – NOT recommended and to be avoided

Key Points:

- ✓ Give analgesia regularly, rather than as required (PRN), for optimum effect.
- ✓ Administer via most appropriate route / formulation (ideally oral).
- ✓ Pain management must be tailored to the individual child.
- ✓ Reassess pain score frequently and adjust analgesia accordingly.

WHO Recommendations for Paediatric Pain Management

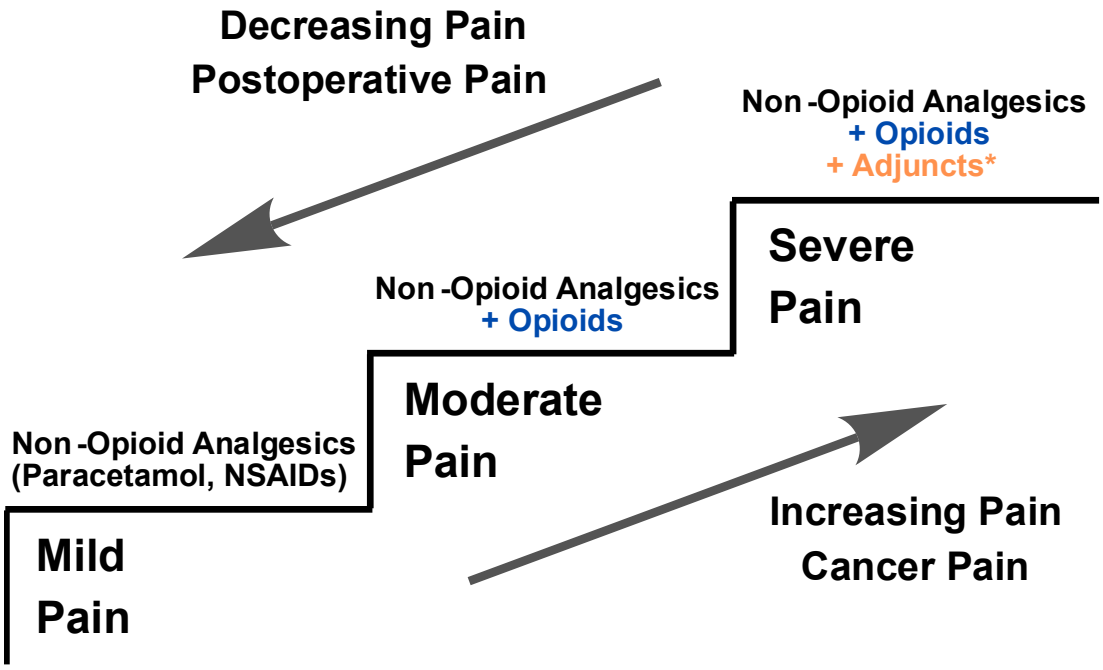
WORLD HEALTH ORGANISATION ANALGESIA LADDER FRAMEWORK
(WHO 2012 – Cancer pain relief and palliative care in children.)

Codeine is no longer recommended for use in children and should not be prescribed. Dihydrocodeine replaces codeine in APAGBI recommendations

The WHO analgesic ladder has 2 steps:
1. MILD PAIN: Paracetamol +/- adjuvant e.g. NSAID (Non-Steroidal Anti Inflammatory Drug)
2. MODERATE-SEVERE PAIN: Paracetamol +/- adjuvant + strong Opioid e.g. morphine sulphate

Modification of the analgesic ladder:
The analgesic ladder is designed to be used for cancer pain and palliative care.
Acute pain requires a modification of the ladder and it may be used to step up / step down analgesia as appropriate, using a multimodal approach.

NSAIDs are not recommended for analgesia in neonates. Use with caution in children with asthma sensitive to NSAIDs and in those with renal dysfunction.



***Adjuncts** – Refer to non-opioid analgesia such as clonidine, ketamine and gabapentinoids

BASIC PAEDIATRIC PAIN PHYSIOLOGY

Ciara Murphy. Paediatric analgesia and pain assessment, Don't Forget the Bubbles, 2020. Available at: https://doi.org/10.31440/DFTB.23666

To achieve the best pain management for our patients, we first have to have a basic grasp of pain physiology.

Nociceptive pain follows a sequence where 4 events take place:

1) **PAIN TRANSDUCTION** – a painful stimulus eg trauma causes tissue damage – this leads to the release of chemical mediators in the tissue, e.g. prostaglandins/substance P etc. These trigger an action potential.
2) **TRANSMISSION** – the action potential moves along the nerve fibres, travelling from the peripheral site of injury to the spinal cord.
3) **PERCEPTION** – the action potential travels along the spinothalamic tract to the brain, where it is relayed to the areas involved in pain perception (limbic system, somatosensory cortex, parietal and frontal lobes)
4) **MODULATION** – the midbrain releases endorphins/serotonin etc to mitigate pain

We can target each part of the sequence in our treatment of pain, as long as we remember that analgesia is multi-modal, and does not just revolve around drugs.
****Anxiety frequently plays a major role in paediatric pain management****

1) Transduction

We can intervene at this stage by employing basic first aid measures – for example

- If the child has a burn – run it under cool/room temperature water. This will provide pain relief as well as arresting further tissue damage
- If a limb is obviously deformed or clinically has a fracture – splint or backslab the limb during your initial assessment and before sending the child for x-rays
- If there is a suspicion of a clavicular or shoulder injury give the child a sling
- If they have a swollen area ?soft tissue injury e.g. ankle – place an ice pack and get them to elevate the ankle.

These things may seem like common sense, but all too often they are forgotten in favour of pharmacological interventions which will not have as immediate an effect.

2) Perception

A child can be distracted much more easily than an adult, and we need to use this to our advantage in the context of pain management. Employing distraction techniques can affect and reduce a child's perception of pain.

There are many options available and you can get the carers involved also. Distraction techniques obviously vary in their effectiveness depending on the age of the child, but they include: story-telling; singing a song; balloons; stickers; bubbles; playing a video on a smartphone.

For older children, guided imagination can be used to great effect. Letting them listen to their own music on their phone via earphones is also a good idea. Virtual reality headsets for older children undergoing painful procedures appears to be a very successful method of distraction and may be an avenue to explore in the future.

3) Transmission

Pharmacological agents act to interrupt the transmission of the painful stimulus. There are many agents available, depending on the child's age and the level of pain described. E.g. Topical anaesthetics, non-opioid analgesia and opioid analgesia. These will be described in more detail later on in this guideline.

OTHER ANALGESICS FOR TREATMENT OF ACUTE PAIN

****Only to be prescribed after discussion with the Inpatient Pain Team****
(For further details please refer to BNF for Children and ASPH Paediatric Formulary)

Tramadol
May be used in older children to relieve moderate to severe pain and produces analgesia by means of an opioid-type effect and also by enhancement of serotonergic and adrenergic pathways. Tramadol has less opioid-related side effects but psychiatric reactions have been reported.

Oxycodone
May be considered for selected cases via oral or intravenous (PCA or NCA) routes, ONLY after discussion with the Inpatient Pain Team. The immediate release form of oral oxycodone is nearly ***twice as potent*** as immediate release morphine. Its use may be considered in the following clinical settings:
- As a 2nd/3rd line opioid when morphine or fentanyl are not tolerated due to adverse effects e.g. sedation, severe itching, hallucinations, persistent nausea and vomiting.
- In moderate or severe renal impairment. Consult Pharmacy or the Renal Drugs Database https://renaldrugdatabase.com/. Convert to immediate release oral morphine solution as soon as renal function improves.
- For 'opioid rotation' for specific patients who have become tolerant to morphine on the advice of the Inpatient pain team or Chronic Pain Consultant.
- Following specialist pain/palliative care team advice
- As per medicines reconciliation (patient admitted on oxycodone)

Clonidine
May be administered by oral route as a regular TDS dose as an adjuvant to opioid analgesia where pain is not adequately controlled with morphine alone.
Only to be prescribed after discussion with inpatient pain team.
A centrally acting alpha-2 agonist has sedative and anxiolytic properties. Clonidine has good analgesic effect with much less sedation than opioids and an opioid sparing effect.

Recommended dose 1mcg/kg PO TDS (max 50mcg per dose, 150mcg/24hrs)
Pharmacokinetics: half-life is 9 hours, 50% metabolised in the liver, 50% excreted in the urine
Side Effects: Dry mouth, sedation (though much less than opioids), bradycardia, hypotension, headache, Raynaud's phenomenon, sudden withdrawal can cause a hypertensive crisis
– No weaning required if taken for less than 2 weeks.

Gabapentinoids (Gabapentin & Pregabalin)
Used in the management of neuropathic pain
Advise discussion with Inpatient Pain Team prior to prescription
Specific indications for the use of these medications

Diamorphine/Fentanyl (Intranasal)
ONLY USED IN PAEDIATRIC EMERGENCY DEPARTMENT. NOT FOR WARD USE.
Powerful opioid analgesic which can be given via intranasal route.
Indications: Acute pain in emergency settings; procedural pain.
N.B. Only to be prescribed and used under consultant supervision.

Please see Paediatric Emergency Department SOP:
Intranasal Analgesia (Fentanyl and Diamorphine) for children and young people in the Paediatric Emergency Department

REFERENCES

Evelina Children's Hospital - Paediatric Acute Pain Management Guidelines

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Guidance for the administration of codeine and alternative opioid analgesics in children. 2013

https://starship.org.nz/guidelines/paediatric-pain-assessment/

https://www.bsuh.nhs.uk/library/wp-content/uploads/sites/8/2021/07/Paediatric-prescribing-guideline-Acute-Pain-Management-2021.pdf

https://foi.avon.nhs.uk/Download.aspx?r=2&did=5813&f=Paediatric%20Pain%20Service%20Acute%20Pain%20Management-14.pdf

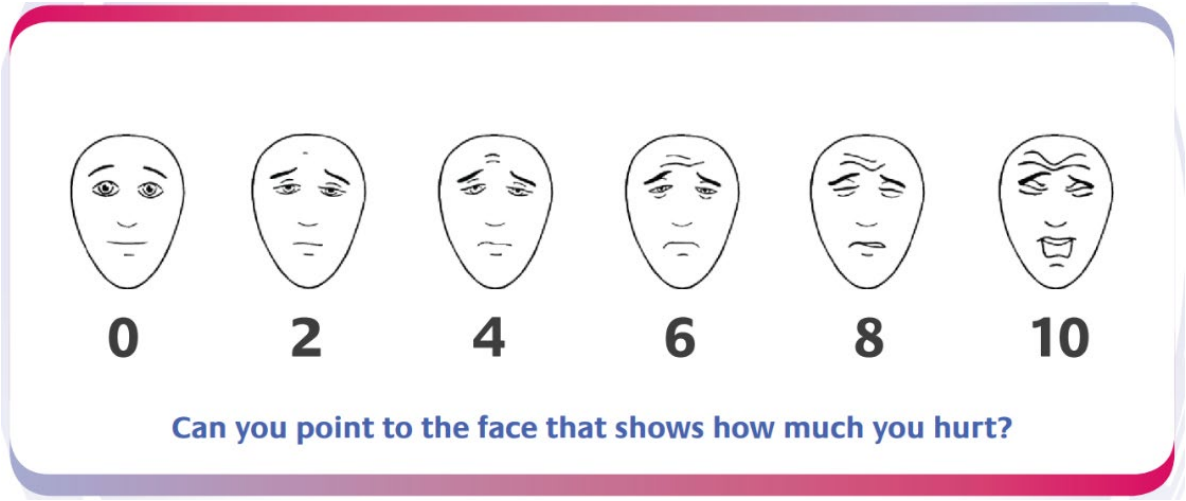
Ciara Murphy. Paediatric analgesia and pain assessment, Don't Forget the Bubbles, 2020. Available at: https://doi.org/10.31440/DFTB.23666

Appendix 1

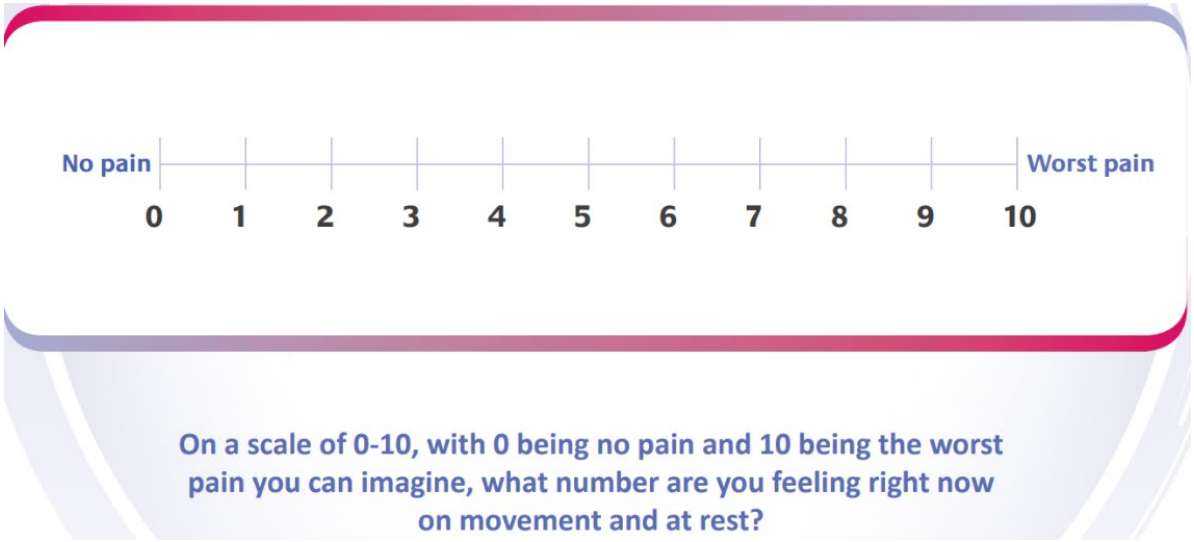
Paediatric Pain Assessment Tools

https://starship.org.nz/guidelines/paediatric-pain-assessment/

Faces Pain Rating Scale (3 – 18 yrs old)



Visual Analogue Scale (Numeric Rating Scale) >7yrs old



FLACC - 2 months – 8 years

The FLACC (Face, Legs, Activity, Cry, Consolability) is a behavioural pain assessment scale for use for non-verbal or pre-verbal patients unable to self-report their level of pain. Rate your child in each of the five measurement categories, add together, and document total pain score (0 – 10).

	0	1	2
Face	No expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arches, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or "talking to"; Can be distracted	Difficult to console or comfort

Children who are awake: Observe for at least 1-2 minutes. Observe legs and body uncovered. Reposition patient or observe activity, assess body for tenseness and tone. Initiate consoling interventions if needed.

Children who are asleep: Observe for at least 2 minutes or longer. Observe legs and body uncovered. If possible, reposition the patient. Touch the body and assess for tenseness and tone.

r-FLACC (revised FLACC) Pain Rating Scale for children with cognitive impairment – Up to 18yrs

	0	1	2
Face	No expression or smile	Occasional grimace or frown, withdrawn, disinterested; appears sad or worried	Frequent to constant frown, clenched jaw, quivering chin; ***distressed looking face; expression of fright or panic*** *Individualised behaviour described by family:*
Legs	Normal position or relaxed; usual muscle tone and motion to arms and legs	Uneasy, restless, tense; occasional tremors	Kicking, or legs drawn up; ***marked increase in spasticity; constant tremors or jerking*** *Individualised behaviour described by family:*
Activity	Lying quietly, normal position, moves easily; regular rhythmic breaths (respiration)	Squirming, shifting back and forth, tense or guarded movements; mildly agitated (head back and forth, aggression); shallow, splinting breaths (respirations); occasional sighs	Arches, rigid, or jerking; ***severe agitation; head banging; shivering (not rigors); breath holding, gasping, or sharp intake of breaths; severe splinting*** *Individualised behaviour described by family:*
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint; occasional verbal outburst or grunt	Crying steadily, screams or sobs, frequent complaints; ***repeated outbursts; constant grunting*** *Individualised behaviour described by family:*
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or "talking to"; Can be distracted	Difficult to console or comfort; ***pushing away caregiver; resisting care or comfort measures*** *Individualised behaviour described by family:*

The revised FLACC can be used for all non-verbal children
The additional descriptors (in italics) are descriptors validated in children with cognitive impairment. The nurse can review with parents/caregivers the descriptors within each category. Ask the parents/caregivers if there are additional behaviours that are better indicators of their child experiencing pain. Add these behaviours to the tool in the appropriate category.

Children who are awake: Observe for at least 1-2 minutes. Observe legs and body uncovered. Reposition patient or observe activity, assess body for tenseness and tone. Initiate consoling interventions if needed.

Children who are asleep: Observe for at least 2 minutes or longer. Observe legs and body uncovered. If possible, reposition the patient. Touch the body and assess for tenseness and tone.

Appendix 2

Equality Impact Assessment Summary

Background
The aim of all guidelines within the Inpatient Pain Service are to support and guide staff in the delivery of safe and effective acute pain management and to ensure that all patients, where possible, have equal access to the most appropriate method of acute pain control. All guidelines developed by the Inpatient Pain Service consider national guidance, frameworks and evidence to ensure that best practice is encouraged and developed. This EIA is part of an overarching assessment for current guidelines that are in place for acute pain management for inpatients in the trust as these guidelines have the common aim as stated above. The RADAR principles (Responsibility, Anticipation, Discussion, Assessment, Response) of acute post-operative pain management are encouraged to ensure good communication and forward planning in relation to acute pain wherever possible. Patients undergoing surgical procedures are generally assessed by anaesthetist prior to the procedure to ensure that they are prepared for the use of methods such as patient controlled analgesia. If for any reason a patient is deemed unsuitable for a particular method of analgesia, then this is communicated by the anaesthetist to other staff caring for the patient. For patients who have acute pain but who are not undergoing surgery, their suitability for specific methods of pain control are assessed by the Inpatient Pain Service or by the wider team caring for them with advice from the Inpatient Pain Service. Occasionally a patient may not be able to have a particular method of pain control due to the clinical area in which they are being managed but systems are in place to highlight this to the Inpatient Pain Service so that the patient can be moved to enable them to have the most appropriate analgesia. Patients are not excluded in relation to their gender, sexual orientation or religion. A patient's race or ethnic origin may affect their ability to understand the use of some methods of acute pain control due to language barriers or personal beliefs about the meaning of pain. Information leaflets incorporate advice on how to obtain information in different languages and interpreting services can be accessed if needed. Patients with a disability may be unable to use particular pieces of equipment and alternatives will be sought for such patients unless a piece of equipment can be adapted for them. Patients with learning disabilities are supported through local guidance and the use of a specific 'Patient Passport' where necessary. Patients who undergo emergency treatment rather than elective treatment may initially require a type of pain control that may not be of their choice as the priority will be to act in the best interest of the patient at that time. However, this is reviewed as soon as the patient is able to make a choice. Patients with certain medical conditions may not be able to have some methods of acute pain control which may pose a risk to their overall health. **Examples:** • patients with clotting abnormalities are excluded from having neuraxial blockade methods such as intrathecal and epidural injections • patients who are physically unable or who are cognitively impaired, may not be able to manage the patient control aspect of a patient controlled analgesia pump and therefore will not be able to utilise this method

- patients who do not speak English may also not understand patient controlled analgesia and therefore may not be suitable to use it unless an interpreter can be sought to explain how to correctly use this method of pain relief
- patients for whom pain is something they feel they must endure, be this for cultural or religious reasons, may not get the full benefit of acute pain control methods and this is accepted to be their choice

Methodology

This EIA has been reviewed by Monica Thompson–Senior Specialist Nurse Inpatient Pain Service.
Guidelines are developed through appraisal of available evidence. Level 1 evidence from randomised controlled trials is considered to be the gold standard for evidence but the team also develop guidance through experience at trust level, using national guidelines from professional bodies such as the Royal College of Anaesthetists and through expert opinion at national and international level
The consultation process: the development of this guideline involved close consultation between the anaesthetic staff and the Inpatient Pain Service.

Key Findings

There may be a group of patients who are identified as being unable to manage particular acute pain methods such as a Patient Controlled Analgesia. Should this be the case then it may be necessary for the patient to be offered an alternative method of analgesia. Patients who may fall into this category may include those with disability, cognitive impairment, language barriers or personal/cultural beliefs.

Conclusion

Guidelines developed by the Inpatient Pain Service for the management of acute pain offer the majority of patients appropriate pain relief. Patients who cannot have easy access to acute pain relief methods are helped to manage their pain with an alternative method of analgesia. Staff are aware of how to access help with pain management from the Inpatient Pain Service and the anaesthetic department and how to access help for specific patient groups such as those with a learning disability

Inpatient Pain Service guidelines will not have any impact with regards to gender or sexual orientation. Any potential impact relating to race, ethnic origin, culture or religious beliefs will be managed on an individual basis

Recommendations

No changes need to be made to any guidelines in light of the EIA process but all guidelines will continue to be reviewed after 2 years or sooner if new clinical evidence, risk or equal access emerges and requires action before then

Guidance on Equalities Groups

Race and Ethnic origin (includes gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)	**Religion or belief** (include dress, individual care needs, family relationships, dietary requirements and spiritual needs for consideration)
Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)	**Sexual orientation including lesbian, gay and bisexual people** (consider whether the policy/service promotes a culture of openness and takes account of individual needs)
Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)	**Age** (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist, for example, using titles of senior or junior)
Culture (consider dietary requirements, family relationships and individual care needs)	**Social class** (consider ability to access services and information, for example, is information provided in plain English?)

PROFORMA FOR RATIFICATION OF POLICIES PROCEDURES and GUIDELINES BY RATIFYING COMMITTEE

Policy/Guidelines Name:	**Management of Acute Pain in Children: Best Practice Guidelines For Paediatric Inpatients**
Name of Person completing form:	Richard Hawkins
Date:	November 2022
Author(s) *(Principle contact)*	Richard Hawkins
Name of author or sponsor to attend ratifying committee when policy/guideline is discussed	Monica Thompson
Date of final draft	Nov 2022
Has this policy/guideline been thoroughly proof-read to check for errors in spelling, typing, grammar and consistency? *(delete as necessary)*	Yes
By whom:	
Is this a new or revised policy/guideline? *(delete as necessary)*	New
Describe the development process used to generate this policy/guideline. *Who was involved, which groups met, how often etc.?*	Guidelines based on Evelina Children's Hospital Acute Pain Guideline. Local discussion within the Inpatient Pain Service and Paediatric Services.
Who is the policy/guideline primarily for?	All clinical staff
Is this policy/guideline relevant across the Trust or in limited areas?	Across the trust. All areas caring for children.
How will the information be disseminated and how will you ensure that relevant staff are aware of this policy/guideline?	Via trust intranet, direct communication with staff by the Inpatient Pain Service
Describe the process by which adherence to this policy/guideline will be monitored. *(This needs to be explicit and documented for example audit, survey, questionnaire)*	Through audit
Is there a NICE or other national guideline relevant to this topic? If so, which one and how does it relate to this policy/guideline?	No
Has the policy been checked against minimum requirements for NHS LA Standards (if applicable)	N/A
What (other) information sources have been used to produce this policy/guideline?	Communication with other trusts.
Has the policy/guideline been impact assessed with regard to disability, race, gender, age, religion, sexual orientation?	Yes – see core EIA
Other than the authors, which other groups or individuals have been given a draft for comment? *(e.g. staff, unions, human resources, finance dept., external stakeholders and service users)*	Anaesthetists, Pharmacist, Inpatient Pain Service, Paediatricians, Paediatric Nursing Staff and Allied Health Professionals.
Which groups or individuals submitted written or verbal comments on earlier drafts?	Anaesthetists
Who considered those comments and to what extent have they been incorporated into the final draft?	The team considered all previous comments
Have financial implications been considered?	N/A
Proposed review date	2 years from ratification