BEHAVIORAL-PHYSIOLOGICAL PAIN SCALE FOR NONVERBAL OR PREVERBAL PATIENTS

Score	Assessment Guideline
0	No Signs of Irritability or Pain Exhibited
+	Signs of Irritability • Intermittent vocalizations, 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 • Increased arousability, more awake than usual • Unexplained mild changes in respiratory pattern, HR and BP
++	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 • Attempts to withdraw limb from pain or tries to touch hurt area • Unexplained duskiness/decreased oxygen saturations • Unexplained changes in RR, HR and BP

Developed at Fountain Valley Regional Hospital and Medical Center, CA by F Box RN, MJ Wainwright RN and L Thompson RN, rev 3/97

This tool should be used as a guideline for healthcare providers attempting to assess irritability and pain in nonverbal or preverbal patients.

Instructions for use of Assessment Guideline: *Evaluate all patients at regular intervals.*

Score 0 Patients are identified as those who do not exhibit one or more of the behaviors listed in the (+) or (++) boxes.

Score + Patients demonstrate one or more of the behaviors listed in the (+) box. Use age-appropriate comforting measures. *Re-evaluate.*

Score ++ Patients demonstrate one or more of the behaviors listed in the (++) box. Consider trial of pain medication. *Re-evaluate.*

There is no reliable tool yet developed that accurately measures pain in patients that are unable to verbalize their pain. It is possible that the patient may be experiencing pain and **not** show any of the behaviors listed above. Whenever pain is suspect, pain medication may be indicated.

References:

Broome, M (1990) Differentiating Between Pain and Agitation in Premature Neonates. Journal of Perinatal and Neonatal Nursing (pp 53-60).

Halsinski, MF (1992) Assessment and Management of Pain in Children. In MF Halsinski Nursing Care of the Critically Ill Child (pp 80-83), St. Louis: Mosby.

Watson, J (et al) (1992) Clinical Judgment in Assessing Children's Pain. In J Watson (Ed) Pain Management: A Nursing Perspective (pp 243-246), St. Louis: Mosby.

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POLICY:

- Gavage feeding is a means of providing food via a catheter into the stomach. A physician's order is necessary and should include type of solution or formula, volume and frequency of feeding.
- The infant's abdomen will be assessed every three to four (3-4) hours for bowel sounds and abdominal girth. An increase greater than one (1) centimeter in abdominal girth will be reported to the infant's physician.
- The infant will never be left alone during a gavage feeding.

PURPOSE:

To feed babies who are unable to take nourishment by any other method.

EQUIPMENT:

- Formula/breast milk
- French feeding tube, #5 (infants weighing less than 1500 grams)
- French feeding tube, #8 (infants weighing greater than 1500 grams)
- Measuring tape
- Sterile syringes, 5 mL, 10 mL
- Stethoscope
- Tape

SPECIAL PRECAUTIONS:

This procedure is initiated by physician order and is usually used for small, premature infants, but may be used on ill newborns or "problem feeders". Keep the baby warm and handle gently. Application of clean technique, including hand hygiene, is absolutely essential. This procedure is to be conducted by licensed personnel only.

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PURPOSE:

To ensure that medical equipment used for patient care is clean, functional, safe, available and properly inventoried.

POLICY:

- Infusion pumps for patient use are electrical with battery operation backup support. The infusion pumps are computerized which allows the delivery of specific doses of medications as ordered by the patient's licensed independent practitioner. All infusion pumps utilized in the facility will have free-flow alarm systems and dose-registration locking devices.

- These protocols are to be followed when cleaning and checking the unit:

  - Activities to be performed in the decontamination room:

    - Remove any tape from machine, used tubing, etc., and discard in the appropriate biohazard waste container

    - Moisten cleaning cloth with approved cleaning agent

    - Wipe all surfaces with moist cloth until clean, and air dry

    - Unlock unit and clean inside plastic panel, per manufacturers instructions

    - Return clean unit to the equipment room

  - Activities to be performed in equipment room by the Biomedical Engineering Department:

    - Test pump for working condition of all alarms within the pump as a system, including assurance that pump contains working free-flow protection alarm.

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SUBJECT: PATIENT-VENTILATOR MAINTENANCE MONITORING - RECOMMENDED PARAMETER	REFERENCE #2153
	PAGE: 1
DEPARTMENT: NICU	OF: 9
	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

It is the policy of ___________________ Hospital to provide patient-ventilator maintenance/ monitoring, as ordered by patient's physician.

PROCEDURE:

- Patient-ventilator maintenance/monitoring is a documented evaluation of a mechanical ventilator and of the patient's response to mechanical ventilatory support. This procedure is often referred to as a ventilator check.

- Objectives:

  - Evaluate and document the patient's response to mechanical ventilation at the time that the check is performed.

  - Ensure and document the proper operation of the mechanical ventilator.

  - Verify and document that the ventilator is functioning and is properly connected to the patient.

  - Verify and document that the appropriate alarms are operational prior to use.

  - Verify and document that the appropriate alarms are activated when in use.

  - Verify and document that inspired oxygen concentration is measured with every change in FiO_2 or, at least, every 24 hours.

  - Verify and document that inspired gas is properly heated and humidified.

  - Verify and document that ventilator settings comply with physician orders.

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ANNUAL COMPETENCY CLINICAL SKILLS ASSESSMENT
EVALUATION OF CLINICAL PERFORMANCE
NICU REGISTERED NURSE

1 = Cannot Perform Skills Independently
2 = Requires Some Assistance to Perform Skills
3 = Can Perform Skill Independently
NA = Not Applicable

• What are the normal ranges for the neonate's vital signs?	1	2	3	NA
• What is the procedure for drawing blood cultures?	1	2	3	NA
• Upon what criteria do you update care plans? How often are care plans updated?	1	2	3	NA
• What are the procedures for infant security?	1	2	3	NA
• When is patient discharge planning instituted?	1	2	3	NA
• What do you do if you miss a punch in the computerized punch time system?	1	2	3	NA
• What are the five (5) rights of medication administration?	1	2	3	NA
• What procedure do you follow to care for the infant born out of asepsis?	1	2	3	NA
• Explain the different types of transfusion reactions.	1	2	3	NA
• What process do you follow if you suspect a drug reaction?	1	2	3	NA
• What are the court hold guidelines?	1	2	3	NA
• What procedure do you follow for the care of the neonate who has been circumcised?	1	2	3	NA
• What is the procedure of handwashing scrub?	1	2	3	NA
• What is the protocol for HBsAg?	1	2	3	NA
• How do you assess the neurological status of the infant?	1	2	3	NA
• Demonstrates knowledge of the nursing process; assessment, intervention, pain assessment and management, etc.	1	2	3	NA
• Demonstrates strong accurate decision making capabilities.	1	2	3	NA
• Demonstrates thorough knowledge of infection control practices.	1	2	3	NA

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