Child Life 101 for EDs and Emergency Care Providers: Using Nonpharmacologic Methods to Manage Pain and Anxiety

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Disclosures

Phyllis Hendry, MD, FACEP, FAAP (Principal Investigator)
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- Nothing to disclose

*Presentation includes materials from the Pain Assessment and Management Initiative (PAMI), a free access educational project. Funding provided by Florida Medical Malpractice Joint Underwriting Association, Alvin E. Smith Safety of Health Care Services Grant 2014-2018*
Course Description:

- Pain is a common presenting complaint to EDs and EMS and painful procedures are often necessary. Although mainly used in children, many nonpharmacologic techniques and tools are also helpful in adult patients. The majority of emergency care providers (physicians, nurses, and paramedics) are not trained in nonpharmacologic means of managing pain and anxiety.

- Most EDs do not have child life specialists, psychologists, or other resources to assist patients in pain or during procedures.

- ED=Emergency Department, EMS=prehospital setting, air and ground
Learning Objectives

1. Discuss nonpharmacologic techniques for managing painful procedures, painful conditions, or anxiety including distraction, imagery, comfort positions and others

2. Determine components of a “Distraction Toolbox” for use in ED and EMS settings

3. Explain basic concepts of nonpharmacologic pain and anxiety management that can be incorporated into emergency care settings

4. Determine child life, hospital and community resources that can be incorporated into an ED pain management initiative
ED and EMS Basics

- Crowded, chaotic settings where varying teams are forced together to develop rapid management plans and communication between the medical providers, patient, and caregiver(s)
- Lack of pre-existing physician-patient relationships or knowledge of past medical and medication history
- Pressure to see patients rapidly, especially those perceived to be more critical, which hinders time for adequate pain assessments and management
ED and EMS Basics

- Responsible for diagnosis and management of hundreds of different disease states and injuries from a premature infant to a ninety year old
- See a unique population of patients often with mental illness, substance abuse, and co-morbidities leading to biases and burnout
- Not ideal setting for trying certain forms psychological and physical methods of pain management
Pain in the ED and EMS Settings

- Pain is the most common reason for seeking health care and as a presenting complaint accounts for 42 - 78% of ED visits.
- Acute pain is a common reason for 911 calls.
- U.S. studies have found that about 30% of all EMS transports have moderate to severe pain. Total % unknown.
- Pain is often untreated in ED/EMS settings:
  - Especially in children, women, African-Americans, and Hispanics.
Emergency Care Providers Unprepared to Recognize and Manage Pain

- ED team members having variable pain expertise and experience
- Tertiary and Children’s Hospitals may have:
  - Social workers, counselors, child life specialists, and other ancillary services
- Limited pain education in medical, paramedic and other professional schools
  - "Veterinary schools require at least five times more education on how to handle pain than medical schools."

Nora D. Volkow, Director of National Institute on Drug Abuse
Basic Tenants of ED Pain Management

- Approach to pain has dramatically changed over past 3 years due to opioid crisis, new research and awareness
- Pain and anxiety are twins
- Treat pain like any other abnormal VS or disease

Actions of ED and EMS providers regarding acute pain management:
- Set the tone for the entire hospital experience
- Affect future pain experiences and possible development of chronic pain
New Emphasis on Nonpharmacologic Methods of Treating Pain in the ED

- Better patient response and satisfaction
- Decreases use of opioids and other medications
- Decreases time for procedures and adverse events
  - Especially in pediatric patients
Nonpharmacologic Management in Pediatric ED and EMS Patients

- 80% of US children are seen in general EDs that will not have child life and other pediatric specific resources
- Emergency care providers are more likely to be motivated to use and learn nonpharmacologic methods for children
- Extrapolate experience to adult pain management
- Pediatric Education for Prehospital Professionals (PEPP) recommends a Distraction Toolbox
So What is This Thing Called Child Life?

Certified Child Life Specialist (CCLS)
Child Life Services

Professionals who provide developmental, educational and therapeutic interventions for children and their families.

— Employed by hospitals/clinics with significant pediatric focus
— Psychosocial preparation for diagnosis, tests, surgeries and procedures

With appropriate preparation, distraction, +/- topical or local analgesia, a child may be capable of remaining still for ED procedures with minimal medications or restraint
The Need for Child Life Specialists

- 2014 American Academy of Pediatrics policy statement:
  
  *Child life Services (CLS) should be delivered as part of integrated patient- and family-centered model of care and included as a quality indicator in delivery of services for children and families in health care settings*

- Most EDs cannot provide CLS and certainly not 24/7 nor can EMS

- Problem Solution:
  
  “Child Life 101 for Emergency Care Providers” course and a “Distraction Toolbox”!
Components of Child Life 101 Course for Emergency Care Providers

- Stepwise approach to pain
- Behavioral responses to pain by developmental stage
- Conversation and acknowledgment of pain
- Therapeutic language
- Psychological & cognitive-behavioral interventions
- Physical (sensory) interventions
- Distraction and comfort “toolbox” components
- Case scenarios and videos
Determination of When to Use Nonpharmacologic Pain Management

- Stepwise approach to the situation
- Acute or chronic pain
- Pain and/or anxiety
- Age and past experiences
Overview of PAMI Stepwise Approach (Can Be Adapted for Adults and Other Settings)

Step 7. Monitoring & Discharge
Step 6. Management Checkpoint
Step 5. Patient Assessment Checkpoint
Step 4. Facility Checkpoint
Step 3. Family Dynamic Checkpoint
Step 2. Developmental or Cognitive Checkpoint
Step 1. Situation Checkpoint
What Are You Trying to Accomplish or Manage?

Step 1. Situation Checkpoint*

- Pain only
- Pain and anxiety or agitation
- Anxiety only
- Agitation only
- Procedure that will induce pain or anxiety
- Chronic pain condition exacerbation
- Nonpharmacologic only or in combination with medication

*Accomplished after a brief triage, history and/or exam
Step 2. Perform a Developmental or Cognitive Checkpoint

What is the developmental stage?
Is it normal for age?
- Developmental delay
- Autism
- Special health care needs
- Mental health concerns
- Recent traumatic events
Step 2. Perform a Developmental or Cognitive Checkpoint

What are characteristics of the patient’s developmental stage in response to pain?

How do you adapt your nonpharmacologic approach?

Kids and teens don’t always follow the charts!
# Understanding and Behavioral Responses to Pain by Age or Development - Example

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Understanding of Pain</th>
<th>Behavioral Response</th>
<th>Verbal Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3–6 years (preoperational)</td>
<td>Pain is a hurt; Does not relate pain to illness; may relate pain to an injury; <em>Often believes pain is punishment</em>; Unable to understand why a painful procedure will help them feel better or why an injection takes the pain away</td>
<td>Active physical resistance, directed aggressive behavior, strikes out physically and verbally when hurt, low frustration level</td>
<td>Preschoolers Has language skills to express pain on a sensory level; Can identify location and intensity of pain, denies pain, may believe his or her pain is obvious to others</td>
</tr>
<tr>
<td>7–9 years (concrete operations)</td>
<td>Doesn’t understand cause of pain; Understands simple relationships between pain and disease and need for painful procedures to treat disease; May associate pain with feeling bad or angry; recognize psychologic pain related to grief and hurt feelings</td>
<td>Passive resistance, clenches fists, holds body rigidly still, suffers emotional withdrawal, engages in <em>plea bargaining</em></td>
<td>School-Age Children Can specify location and intensity of pain and describes pain physical characteristics in relation to body parts</td>
</tr>
<tr>
<td>10–12 years (transitional)</td>
<td>Better understanding of relationship between an event and pain; More complex awareness of physical and psychologic pain, (moral dilemmas, mental pain)</td>
<td>May pretend comfort to project bravery, <em>may regress with stress and anxiety</em></td>
<td>Able to describe intensity and location with more characteristics, able to describe psychologic pain</td>
</tr>
<tr>
<td>13–18 years (formal operations)</td>
<td>Has a capacity for sophisticated and complex understanding of causes of physical and mental pain; Recognizes pain has qualitative and quantitative characteristics; <em>Can relate to pain experienced by others</em></td>
<td>Want to behave in socially acceptable manner -like adults; controlled response; May not complain if given cues from other healthcare providers</td>
<td>Adolescents More sophisticated descriptions with experience; may think nurses are in tune with their thoughts, so don’t need to tell nurse about their pain</td>
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<td>1–3 years</td>
<td>Doesn’t understand what causes pain and why they might be experiencing it</td>
<td>Localized withdrawal, resistance of entire body, aggressive behavior, disturbed sleep</td>
<td>Cries and screams, can’t describe intensity / type of pain; Use words for pain such as owie and boo-boo</td>
</tr>
</tbody>
</table>
Step 3. Family Dynamic Checkpoint

- Who is with the child- parents, siblings?
- Who is the legal guardian?
- Who actually cares for the child?
- Culture, past experience?
- Other priorities- another injured child?
- Family personality and stress level?
Step 4. Facility or Community Checkpoint

- Staffing and setting
  - Community, rural, children’s hospital
- Experience
  - Pediatric
  - Team capabilities and expertise
- Existing pain management policies
- ED acuity and overcrowding
- Other priorities- MCI, etc.
- Availability of distraction and comfort supplies
Step 5. Patient Assessment Checkpoint

- Review risk factors from history and assessment
  - CSHCN, genetic syndromes, etc.
- Chronic illness
- Psychiatric and mental considerations
- Any contraindications?
Step 6. Management Checkpoint

- No magic recipe, must individualize and adjust “ingredients”
- Pharmacologic “ingredients”
  - Topical, local anesthetics or blocks
  - Oral, nasal, IV medications
- Nonpharmacologic “ingredients”
  - Everyone needs a few “child life recipes”
    - distraction, swaddling, etc.
  - Engage caregivers, parents, volunteers, etc.

*Usually need both pharmacologic and nonpharmacologic options!*
Step 7. Monitoring & Discharge Checkpoint

- Document reassessments and pain scores after intervention(s)
- Make necessary adjustments
- Child should be back to baseline at discharge but difficult situation when after bedtime
- Fall prevention, transportation
- Hospital Joint Commission standards and EMRs
Nonpharmacologic pain therapy refers to interventions that do not use medications.

Most of these can be utilized for children and adults.

Options not appropriate for ED/EMS: aromatherapy, hypnosis, TENS.
Nonpharmacologic Intervention Categorization

cognitive-behavioral and physical (sensory)

<table>
<thead>
<tr>
<th>Cognitive-Behavioral Interventions</th>
<th>Physical (Sensory) Interventions</th>
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<tbody>
<tr>
<td>Psychologic preparation, education, and “orienting” information</td>
<td>Positioning</td>
</tr>
<tr>
<td>Distraction (passive or active): Video games, TV, movies, blowing bubbles, toy, etc.</td>
<td>Cutaneous stimulation</td>
</tr>
<tr>
<td>Relaxation techniques</td>
<td>Nonnutritive sucking</td>
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<td>Music</td>
<td>Pressure</td>
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<tr>
<td>Guided imagery</td>
<td>Hot and cold treatments</td>
</tr>
<tr>
<td>Training and coaching, coping statements</td>
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Cognitive Development

- Because young children are cognitively immature, physical comfort measures and distraction activities are more effective than verbal reasoning.
- Children do not have sufficient cognitive development to understand strangers trying to reassure them until age 5-7 years.
Physical (Sensory) Interventions: Inhibit Nociceptive Input and Pain Perception

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Nonnutritive Sucking

- Pacifier in conjunction with sucrose has analgesic effect in neonates undergoing venipuncture and reduces crying in infants < 6 months of age
- Easy to use in ED and EMS settings
Heat Therapy

Active warming may reduce pain, anxiety, nausea, and heart rate in patients with pain related to mild trauma, cystitis, urolithiasis, cholelithiasis, appendicitis, and colitis

- Applied in 20 minute time periods to affected areas
- Beware of extreme heat and burns

- Heat acts by:
  1. increasing blood flow to skin
  2. dilating blood vessels, increasing oxygen and nutrient delivery to local tissues; and
  3. decreasing joint stiffness by increasing muscle elasticity
Benefits of Keeping Patients Warm

- EDs and ambulances often are cold and drafty
- Cold exposure is especially painful in patients with Raynaud’s Disease, collagen vascular diseases like Lupus and Scleroderma, and patients on cardiovascular and blood thinning medications
- 5-10% of the general population has primary or secondary Raynaud’s Disease or symptoms
- Consider warmed blankets, fluids, or gel packs

5 Symptoms of Raynaud’s Disease or Raynaud’s Phenomenon

1. Cold fingers and toes
2. Color changes to your skin in response to cold or stress (usually white or blue)
3. Numbness or tingling in the fingers and toes (can be on the ears or nose)
4. Stinging or throbbing pain upon warming or stress relief
5. Ulcers in the tips of fingers and/or toes

*This can occur in more severe cases*
Cold Therapy Treatments: RICE for Musculoskeletal Injuries

Ice or cold packs reduce swelling and pain in strains, sprains, and fractures

Do not put directly on bare skin
Cutaneous Stimulation

- Rubbing or vibration
- Applying localized pressure
- Skin to skin contact with mother or breastfeeding during a procedure
Cutaneous Stimulation

- Vibrating palm-sized devices with removable ice wings available commercially. Studied for injections and IVs with relief similar to topical analgesic cream or spray
- Dentist jiggling the jaw before a dental block
Comfort Positioning

- Why use positioning for comfort?
  - Sitting position promotes sense of control and reduces anxiety
  - Puts child in a secure, comforting hold
  - Promotes close contact with caregiver
  - Provides caregiver with an active role

May be prohibited in trauma patients requiring immobilization and transport
Examples that Can be Posted in EDs
(Used With Permission)
### Cognitive-Behavioral Techniques

<table>
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<tr>
<td>Psychologic preparation, education, information</td>
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<td>Distraction (passive or active): Video games, bubbles, movies, phone</td>
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<tr>
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<td>Music</td>
</tr>
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<td>Guided imagery</td>
</tr>
<tr>
<td>Training and coaching</td>
</tr>
<tr>
<td>Coping statements: “I can do this” or “this will be over soon”</td>
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</table>
Distraction

- Most common type of cognitive-behavioral method
- Distraction can lead to reduction in procedure times and number of staff required for procedures. Hypothesis is that children cannot attend to >1 significant stimulus at a time

Does not require advanced training
Works with all developmental levels
Involves anxious parents and caregivers

Distraction is most effective in mild to moderate pain
(difficult to concentrate when pain is severe)
Conversation and Distraction

Interactive distraction is better for managing pain and anxiety than passive distraction.

Conversation helps reduce anxiety and pain through distraction. Pain can be reduced by up to 25% with distraction alone.

Conversation topic starters: family, hobbies, vacation, sports

Two Types of Distraction

1. Passive Distraction - attention redirected to a stimulus or object
   - Storytelling
   - Showing a toy

2. Active Distraction - encourage participation in activities during procedure
   - Blowing bubbles
   - Playing a game
   - Interacting with electronic device

Can be used together or alone
Distraction versus “Planned Alternative Focus”

- Distraction:
  Diverting attention to reduce anxiety due to medical environment

- “Planned alternative focus”:
  Concept of using patient’s volition to successfully complete procedures for sense of mastery and ownership

Step 1 - Assessing patient and family for optimal coping

- Is parent’s anxiety feeding into the child’s?
- Will parent be a helpful, calm, supportive presence?

Step 2 - Does patient need to have attention shifted from procedure or to take an active role

“Would you like to watch the IV start or play ‘I-Spy’ instead?”

- Distraction example - Playing a game on iPad or talking about family pets or favorite movie
- Active Planned Alternative focus: “Can you pick out your Band-Aid: Frozen or Star Wars?”
  “Can you please open this alcohol wipe and help me clean your arm?”
Need Distraction and Comfort Supplies, Toolbox, Cart or Room

Parents/kids will remember the Wikki Stix before they remember your new, expensive monitor, equipment, uniform, etc.
Guided Imagery

- Helps patients use imagination to divert thoughts from the pain or procedure to a more pleasant experience
- Help the patient use their imagination to create a descriptive story
  - Ask questions about a favorite place, upcoming events, or vacations to keep the patient engaged
  - Options
Option 1- Visit a “relaxing” place and change image of pain or turn off pain with a “pain switch” in the brain. Ask patient to locate the pain switch and turn down level of pain to a more comfortable level.

Option 2- Identify a “pain” color and a “comfort” color. Ask patient to breathe in the “comfort” color and breathe out “pain” color OR ask patient to associate their pain with a color then view the painful part of their body in that color. Imagine shrinking, fading, or dispersing the painful color, or even sending it away in a balloon.

Option 3- Symbolic imagery can be used in adults and adolescents. If a patient with severe arthritis pain complains of pain in one joint, ask them to think about how the pain feels. Does it feel like a knife? Imagine pulling the knife out and throwing it away. Focusing on an affirmation can also help. “I am removing the knife and throwing it away”.

PAINWEEK
Relaxation Techniques

Goal is to produce the relaxation response, “a physical state of deep rest that changes physical and emotional responses to stress e.g. decreased HR, BP, RR, and muscle tension.”

- Progressive muscle relaxation
- Diaphragmatic breathing
Progressive Muscle Relaxation (PMR)

- Helps patients recognize difference between tensed and relaxed muscle groups

How to use

- In a calm voice, instruct patient to tighten and relax muscles. Start with the forehead and gradually move down the muscle groups in the body. Example: Forehead, jaw, back, etc.
Diaphragmatic Breathing (Belly Breathing)

- Patient breathes through abdomen (belly) instead of chest and counts slowly with each breath in and out to a predetermined number. This works best with at least 8 breaths per minute.

How to use

- Instruct patient to place hands on abdomen and watch their hands rise and fall with each breath. Seeing hands move up and down provides instant feedback. Best to implement during an IV attempt or with an anxious child (or parent!).
Music Therapy

Beneficial in reducing pain, anxiety and stress in EDs, waiting rooms, procedure rooms, and during transport

- Additionally benefits parents and health care providers caring for the anxious patient
- Many larger hospitals have music therapists or volunteers
  - Request ED time
- Ways to implement:
  - Play in waiting areas
  - Have patient select music from available electronic devices or their own - keep supply of disposable headphones or earbuds
A recent study found that children who choose their own music or audiobook to listen to after major surgery experience less pain.

http://www.npr.org/sections/health-shots/2015/06/22/415048075/to-ease-pain-reach-for-your-playlist-instead-of-popping-a-pill
Therapeutic Language - 12 Tips

- Ask about and acknowledge the pain
- Recognize the value of listening
- Pace the process respectfully
- Define pain by framing it with hope not doom
- Avoid negative words and those that conjure fear
- Reframe the child’s distress
- Replace pain-loaded words with more tolerable words
Therapeutic Language

- Draw on language or words that have worked for you
- Note the parts of the body that are not in pain
- Use language that implies positive change
- Let patient know that what they are experiencing is normal and not life-threatening or result of a terrible disease (if true)
- Remind patient that pain will come to an end (if true)

Adapted from: Lenora Kuttner, PhD.
A Child in Pain—What Health Professionals Can Do to Help. 2010
## Suggested ED Language

<table>
<thead>
<tr>
<th>Language to Avoid</th>
<th>Language to Use</th>
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<tr>
<td>This is going to hurt/this won’t hurt (vague; negative focus)</td>
<td>It might feel like a pinch (sensory information)</td>
</tr>
<tr>
<td>The nurse is going to take some blood (vague information)</td>
<td>First, the nurse will clean your arm, you will feel the cold alcohol pad, and next... (sensory and procedural information)</td>
</tr>
<tr>
<td>Tell me when you are ready (too much control)</td>
<td>When I count to three, blow the feeling away from your body (coaching to cope; distraction, limited control)</td>
</tr>
<tr>
<td>You are acting like a baby (criticism)</td>
<td>Let’s get your mind off of it; tell me about that movie... (distraction)</td>
</tr>
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</table>
Training and Coaching

- Healthcare providers should:
  - Coach and prepare parents & caregivers for procedure, exam, transport, etc.
  - Provide “orienting” information
  - Discuss how to assist in their loved one’s coping ability
  - Initially discuss procedure away from child, if possible
ONE VOICE Summary

- Purpose of ONE VOICE philosophy is to remind health care professionals to be cognizant of environment we expose children to during medical procedures. Each letter of ONE VOICE stands for a different component of the environment.

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Phone: (402) 250-4824
Debbie@onevoice4kids.com
http://www.onevoice4kids.com
ONE VOICE
One voice should be heard during the procedure.
Need for parental involvement.
Educate the patient before the procedure about what is going to happen.
Validate a child with your words.
Offer the patient the most comfortable, non-threatening position.
Individualize your game plan.
Choose appropriate distraction/coping techniques to be used.
Eliminate unnecessary staff who are not actively involved with the procedure.

EMS transport is a “procedure”
Putting It All Together by All Together by
Age and Developmental Levels

Course will include options for:
- Infants
- Toddlers
- Preschoolers
- School Age Child
- Adolescent
Nonpharmacologic Measures: Infants

- Swaddling
- Holding
- Rocking
- Sucking
  - Sucrose pacifier (24% sucrose solution)
  - Non-nutritive sucking
- Dim lighting
- Music
- Toys
  - Key chains
  - Rattles
  - Blocks
Nonpharmacologic Measures: Adolescent

- Apply cold or hot pack
- Suggest repositioning or positions of comfort
- Encourage talking about favorite places or activities
- Light touch or massage
- Listen to music or video
- Read
- Coach about ED/EMS process and procedures
- Relaxation techniques
- Squeeze balls
- Encourage making choices
- Play with electronic games or tablets
Developing a Distraction Toolbox

What's in your TOOLBOX?
"Toolbox" of Distraction and Comfort Devices

- Lighted motion toy
- Vibration or cold device
- Puzzles or cubes
- Art supplies
- Glitter wands
- Liquid-in-motion toy

Must be easy to disinfect or disposable with no small parts
**ED versus EMS Toolbox**

- **EMS:**
  - Limited space on the ambulance
  - Toolbox – small and heavy duty
  - Designated area

- **ED**’s
  - Have more space: a designated room, closet, cart, or toolbox
  - Volunteers and additional staff
  - Can incorporate many different options
  - Beware of siblings or other children in the room
Patient Safety Considerations

- **Infection Control**
  - Can chose to let child keep the toy (teddy bear, pacifiers, teethers, Wikki Stix, ice packs)
  - Ensure item can be sanitized for multiple use (local policies)

- **Choking Hazards**
  - Make sure item is age appropriate
  - No small pieces or easily breakable toys (<3 years or older if developmentally delayed)
  - Ensure items with gel or liquid ingredients are nontoxic
Special Safety Situations

- Extremely anxious parents
- Abusive behavior
- Patient with suicidal tendencies or mental illness
- Children with no caregiver present
How to Implement and Fund a Program

- Identify champions and stakeholders
- Host a training program or provide Childlife 101 training materials
  - National EMS Week occurs annually the 3rd week in May
- Identify community partners
  - Almost everyone loves to help injured or ill children
- Determine grants and donor sources
  - Manufacturers of distraction products
  - Restaurants
  - State and local grants
  - Foundations
Distraction Supply Resources

- Amazon - create a wish list
- Specific manufacturers - often donate to nonprofit causes
  - Wikki Stix - www.wikkistix.com
- Dollar stores
- Art supply stores
Adult Case Scenario

- Rescue arrives at the home of an 85 yo female who fell down the stairs. Medics perform a quick assessment and determine that her left ankle is swollen and tender. She appears anxious and in pain, reported as a 9/10.
- They immobilize her ankle and establish an IV. During transport the patient begins to cry and states “now my children will make me sell my house and go into a nursing home.”

What other treatments and techniques can be used to address this patient’s anxiety and pain in addition to IV medications?
Adult Case Scenario Discussion

- Nonpharmacologic options:
  - distraction
  - splinting
  - elevation of affected extremity
  - ice packs (if available)

- Interactive distraction
  - Distraction through conversation while performing secondary assessment during transport to hospital
  - Conversation starters include family, hobbies, etc.
  - Orienting information: where you are taking patient, what to expect, offer to call family or friends
Adult Case Scenario

- The patient is handed off to the ED team. Treatments and techniques started in the field are continued in the ED and the patient’s anxiety and pain improves to a 3/10. Daughter arrives at the ED and thanks EMS for calling. Patient is admitted with ankle and hip fractures. One month later, patient writes a letter to her local newspaper praising the county EMS service.
Pediatric Case Scenario

You are called to the residence of a 3 yo female who pulled a pot of boiling water off the stove. She has second degree burns on her arms, chest and face. She is screaming and running away from you.

Questions to Consider
• How would you assess her pain?
• What are your treatment options?
**Pediatric Case Scenario**

You decide to use the FLACC pain scale and determine she has a pain rating of 8. Patient likely would benefit from pharmacologic and nonpharmacologic management.

<table>
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<th>0</th>
<th>1</th>
<th>2</th>
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<tbody>
<tr>
<td><strong>1</strong> Face</td>
<td>No particular expression or smile.</td>
<td>Occasional grimace or frown, withdrawn, disinterested.</td>
<td>Frequent to constant frown, clenched jaw, quivering chin.</td>
</tr>
<tr>
<td><strong>2</strong> Legs</td>
<td>Normal position or relaxed.</td>
<td>Uneasy, restless, tense.</td>
<td>Kicking, or legs drawn up.</td>
</tr>
<tr>
<td><strong>3</strong> Activity</td>
<td>Lying quietly, normal position, moves easily.</td>
<td>Squirming, shifting back and forth, tense.</td>
<td>Arched, rigid or jerking.</td>
</tr>
<tr>
<td><strong>4</strong> Cry</td>
<td>No crying (awake or asleep).</td>
<td>Moans or whimpers; occasional complaint.</td>
<td>Crying steadily, screams or sobs, frequent complaints.</td>
</tr>
<tr>
<td><strong>5</strong> Consolability</td>
<td>Content, relaxed.</td>
<td>Reassured by occasional touching, hugging or being talked to, distractible.</td>
<td>Difficult to console or comfort.</td>
</tr>
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</table>
Pediatric Case Scenario - Management Determined Using Stepwise Approach

Step 1. Situation Checkpoint
Step 2. Developmental or Cognitive Checkpoint
Step 3. Family Dynamic Checkpoint
Step 4. Facility Checkpoint
Step 5. Patient Assessment Checkpoint
Step 6. Management Checkpoint
Step 7. Monitoring & Discharge
Pediatric Case Scenario - Management and Conclusion

1. Interactive distraction- show a lighted toy
2. Comfort positioning- caregiver presence
3. Using developmentally-sensitive language-
   “You are brave” instead of “I am sorry”
4. Attempt IV x 1
5. Give IN fentanyl and cover burn
6. Pain level decreases to a 6 which makes it easier for trauma center staff to attempt IV access upon arrival and keep family calm
Nonpharmacologic Pain Management in Special Populations

- Nonpharmacologic measures are excellent adjuncts in other special populations including:
  - Adult patients with autism or developmental delay
  - Chronically ill patients that have undergone numerous past painful experiences
  - Patients with anxiety or mental disorders
  - Chronic pain patients or patients already on high dosages of pain or other medications
Resources

Managing Procedural Anxiety in Children

Coping with Healthcare Procedures
http://www.chop.edu/health-resources/coping-healthcare-procedures#VxE0q7p_y_el
Videos

Managing Procedural Anxiety in Children
https://www.youtube.com/watch?v=hkJEiBTbchM

It Doesn’t Have to Hurt: Distraction
https://www.youtube.com/watch?v=KgVhYSYafps
News Reports

Distraction therapy: Hospital room designs help ease tension

- Many excellent resources available
- Childlife 101 for Emergency Care Providers and PAMI website will include a list of resources and references with easy access links if public domain
- Let us know if you have suggestions

Distraction therapy: Hospital room designs help ease tension

http://triblive.com/lifestyles/morelifestyles/8416076-74/says-rooms-hospital
Questions and Comments

Child Life 101 for Emergency Care Providers and
ED/EMS Distraction Toolbox

Coming soon
Pilot Trials October 2016
Roll out EMS Week May 2017
Contact Information

We welcome your feedback and suggestions!

Email: emresearch@jax.ufl.edu or Phyllis.Hendry@jax.ufl.edu

Call: 904-244-4986.

For more information please visit http://pami.emergency.med.jax.ufl.edu/
References


References


References


