



Pediatric Pain Management



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SCC Foreword

A National Standard of Canada is a standard developed by a Standards Council of Canada (SCC) accredited Standards Development Organization, in compliance with requirements and guidance set out by SCC. More information on National Standards of Canada can be found at www.scc.ca.

SCC is a Crown corporation within the portfolio of Innovation, Science and Economic Development (ISED) Canada. With the goal of enhancing Canada's economic competitiveness and social well-being, SCC leads and facilitates the development and use of national and international standards. SCC also coordinates Canadian participation in standards development, and identifies strategies to advance Canadian standardization efforts.

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This standard was developed in compliance with the Standards Council of Canada's Canadian Standards Development: Requirements & Guidance—Accreditation of Standards Development Organizations.



Working Group Members

Pediatric Pain Management

Working Groups are established by HSO project teams and Technical Committees to support the development of specific and specialized content for standards. Working Groups provide advice and recommendations for the development of the standard and recommend the standard to the overseeing Technical Committee for approval. The Technical Committee is ultimately responsible for approval of the standard for public review and publication.

Working Groups are diverse and are made up of representatives from multiple stakeholder groups, including people with lived experiences, care providers, clinicians, researchers, and policy makers. The development and publication of this standard would not have been possible without the contributions of the Working Group members listed below. Their generous time commitment and insights are greatly appreciated.

Advisors

Laura Gibson, BA, MA
Knowledge Broker, Solutions for Kids in Pain (SKIP) Atlantic Hub; Health Policy Specialist, IWK Health
Nova Scotia, Canada

Paula Robeson, RN, MScN
Knowledge Broker, Solutions for Kids in Pain (SKIP); Senior Advisor, Knowledge Mobilization, Children's Healthcare
Canada
Ontario, Canada

Patient / Family

Justina Marianayagam, MD, BHSc
BC Children's Hospital, University of British Columbia; Board Member, Solutions for Kids in Pain (SKIP); Patient
Northwest Territories, Canada

Natasha Murji
User Experience Designer; Patient Partner
Ontario, Canada

Stephanie Paravan
Family Partner
Ontario, Canada

Policy Makers / Product Users

Samina Ali, MD, FRCPC
Professor, Departments of Pediatrics & Emergency Medicine, Faculty of Medicine & Dentistry, University of Alberta
Alberta, Canada

Randi Dovland Andersen, RN, MScN, PhD
Special Advisor/Researcher, Telemark Hospital Trust; Associate Professor, Institute of Health and Society, Faculty of Medicine, University of Oslo
Norway

Sandy Baggott, CCLS
Child Life/Therapeutic Arts Discipline Lead, Alberta Children's Hospital
Alberta, Canada

Kathryn Birnie, PhD, RPsych (Chair)
Associate Scientific Director, Solutions for Kids in Pain (SKIP); Assistant Professor, Department of Anesthesiology, Perioperative and Pain Medicine, and Department of Community Health Sciences, University of Calgary
Alberta, Canada

Fiona Campbell, BSc, MD, FRCA
Director, Chronic Pain Program, Anesthesia & Pain Medicine & Co-director, SK Pain Centre, The Hospital for Sick Children; Professor, University of Toronto; Former Co-chair, Canadian Pain Task Force
Ontario, Canada

G. Allen Finley, MD, FRCPC, FAAP
Professor of Anesthesia and Psychology, Dalhousie University; Dr. Stewart Wenning Chair in Pediatric Pain, IWK Health; Solutions for Kids in Pain (SKIP) - Atlantic Hub Lead
Nova Scotia, Canada

Renee C.B. Manworren, PhD, RN-BC, APRN, PCNS-BC, AP-PMN, FAAN
Posy and Fred Love Chair in Nursing Research; Director of Nursing Research and Professional Practice, Ann & Robert H. Lurie Children's Hospital of Chicago; Associate Professor of Pediatrics, Northwestern University's Feinberg School of Medicine
Illinois, USA

Tim Oberlander, MD, FRCPC
Investigator, BC Children's Hospital; Attending Physician, Complex Pain Service, and Developmental Pediatrician, BC Children's Hospital and BC Women's Hospital & Health Centre; R. Howard Webster Professorship in Brain Imaging and Early Child Development; Professor, Division of Developmental Pediatrics, Department of Pediatrics, Faculty of Medicine, University of British Columbia
British Columbia, Canada

Kelly Thorstad-Cullen, MSc(A)N, PHCNP
Director of Nursing and Patient Services, Shriners Hospital for Children
Quebec, Canada

Susan M. Tupper, PT, PhD
Strategy Consultant, Pain Quality Improvement and Research, Saskatchewan Health Authority; Chair, Board of Directors, Saskatchewan Pain Society, Inc. (SaskPain)
Saskatchewan, Canada

Technical Committee Members

Pediatric Pain Management

HSO's Technical Committees lead the development of HSO's standards. The committees are diverse and are made up of representatives from multiple groups, including care providers, people with lived experiences, clinicians, researchers, and policy makers. Each Technical Committee works with an HSO project team to oversee the development of a standard, ensuring that all points of view are represented.

The development and publication of this standard would not have been possible without the contributions of the Technical Committee members listed below. The generous time commitment and insights each member provided are greatly appreciated.

Please note that the views of the Technical Committee members on HSO's Technical Committee TC004 – Medication Management are representative of their expertise and not of their respective organizations.

Policy Makers

Gwen Erdmann, BScN, MN, RN
Alberta Health Services
Alberta, Canada

Regis Vaillancourt (Chair) BPharm, PharmD
BCE Pharma
Ontario, Canada

Patient / Family

François Corriveau
Patient Partner, Lawyer, Mediator
Québec, Canada

Natasha Murji
User Experience Designer; Patient Partner
Ontario, Canada

Michael Sullivan
Transplant recipient
Ontario, Canada

Product Users

Barbara Schoen-Suchanek, BSc (Pharm)
Lower Mainland Pharmacy Services
British Columbia, Canada

Sonia Harris
Resident Care Pharmacy
Ontario, Canada

Rosemary Wilson, RN(EC), PhD
Queen's University
Ontario, Canada

General Interest

Jonathan Penm, BPharm (Hons), PhD,
GradCertEdStud (Higher Ed)
University of Sydney
New South Wales, Australia

Sherry Miyashita, RN, BScN, MN
Interior Health Regional Health Authority
British Columbia, Canada

Advisors

Andrew Morris, MD, SM, FRCPC
Sinai Health System and University Health Network
Ontario, Canada

Annie Pagé
Université de Montréal
Québec, Canada

Aaron Tejani, BSc (Pharm), PharmD
University of British Columbia
British Columbia, Canada

Preface

Health Standards Organization (HSO) develops evidence-informed health and social service standards, assessment programs, and quality improvement solutions. Recognized by the Standards Council of Canada as a Standards Development Organization, HSO works with leading experts and people with lived experiences from around the world, using a rigorous public engagement process to co-design standards that are people-centred and integrated, and that promote safe and reliable care. For more information, visit www.healthstandards.org.

HSO's People-Centred Care Philosophy and Approach

People-centred care is an integral component of HSO's philosophy and approach. It is defined by the World Health Organization as "an approach to care that consciously adopts the perspectives of individuals, families and communities, and sees them as participants as well as beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways. People-centred care requires that people have the education and support they need to make decisions and participate in their own care. It is organized around the health needs and expectations of people rather than diseases" (World Health Organization, 2016). People-centred care adopts the perspectives of all people involved in care, those providing care, and those receiving care.

People-centred care guides both what HSO does and how HSO does it. It calls for a renewed focus on the interaction and collaboration between people, leading to stronger teamwork, higher morale, and improved coordination of care (Frampton et al., 2017). This ensures people receive the right care, in the right place, at the right time, by the right people.

With a vision for safer care and a healthier world, HSO's mission is to empower and enable people around the world to continuously improve quality of care. HSO has developed the following guiding principles for people-centred care:

- **Integrity and relevance.** Uphold the expertise of people in their lived experiences of care; plan and deliver care through processes that allow mutual understanding of people's goals, needs, and preferences and facilitate outcomes that have been influenced by the expertise of all.
- **Communication and trust.** Communicate and share complete and unbiased information in ways that are affirming and useful; provide timely, complete, and accurate information to enable people to effectively participate in care and decision making.
- **Inclusion and preparation.** Ensure that all people have fair access to care and the opportunity to plan and evaluate services; encourage and support people to participate in care and decision making to the extent that they wish.
- **Humility and learning.** Encourage people to share problems and concerns to promote continuous learning and quality improvement; promote a just culture and system improvement over blame and judgment.

Equity, Diversity, and Inclusion Guiding Principles

Health equity, which includes equitable pain management, is an essential component of child and family health and well-being. Fostering child health equity and preventing child health care inequities are central principles of this standard.

Health equity is the absence of unfair and avoidable or remediable differences in health among population groups, whether those groups are defined socially, economically, demographically, geographically, or by other means (World Health Organization, 2008). Health equity is closely connected to the distribution of power and wealth within a society and the social conditions in which people live (World Health Organization, 2008). It “involves the fair distribution of resources needed for health, fair access to the opportunities available, and fairness in the support offered to people when ill” (Whitehead & Dahlgren, 2006).

While striving to improve health outcomes for all population groups, the pursuit of health equity seeks to reduce the excess burden of ill health among socially and economically disadvantaged populations (Whitehead & Dahlgren, 2006). Health equity can be impacted by various factors including a person’s ethnicity, geography, and socioeconomic status (World Health Organization, 2021b). Sir Michael Marmot, the former chair of the WHO Commission on Social Determinants of Health, has called for “equity for every child from the start” (Margot, 2011) as a fundamental aspect of addressing health inequities within and between countries. As per the United Nations Declaration on the Rights of Indigenous Peoples (United Nations General Assembly, 2007), health equity recognizes that individuals have the right to develop, determine, and improve their health, and that health policies and health systems play a critical role in the full realization of this right. Health care models must take into account the Indigenous concept of health and preserve and strengthen Indigenous health systems as a strategy to increase access and coverage of health care. This demands that clear mechanisms of cooperation among relevant health care professionals, communities, traditional healers, policy makers, and government officials be established.

Health inequities derive from the social, economic, environmental, and structural disparities that negatively impact certain groups in relation to others and result in differences in health outcomes, access to, and experience of quality services, including pain management (National Academies of Sciences, Engineering, and Medicine, 2017). Social determinants of health (e.g., race, ethnicity, age, religion, education, socioeconomic status, gender, gender identity, sexual orientation, language, community context [urban, rural, northern, remote]), and adverse childhood experiences affect health equity and exacerbate inequities. Ultimately, biological, psychological, social, environmental, cultural, historical, and other factors influence how pain is experienced, who develops pain, and how it is treated (Health Canada, 2021).

Individuals who are socially and/or economically disadvantaged are more likely to experience painful conditions and encounter substantive barriers to proper pain management (Craig et al., 2020). This includes Indigenous peoples (First Nations, Métis, and Inuk/Inuit), racialized peoples, refugees, children, people with mental illness, people who use substances, people with disabilities, people who are sexually and gender diverse, and girls and women. Key contributors to inequities in pain management include discrimination, racism, and bias from others, including health care professionals, family, friends, teachers, and strangers (Craig et al., 2020).

Improving equity in children’s pain management is a process through which societies can “make pain matter”; one of four transformative goals set forth by a 2021 Lancet Child & Adolescent Health Commission (Eccleston et al., 2021). In Canada, ensuring equitable approaches for populations disproportionately affected by pain was one of six primary goals outlined in the Canadian Pain Task Force Action Plan for Pain in Canada (Health Canada, 2021). Working with children and families to co-develop quality pain management ensures equitable pain management for all children in Canada, and this principle is reflected in the people-centred approach taken by this standard.

About HSO's Standards

HSO's standards are the foundation on which leading-edge accreditation programs and evidence-informed public policy are built. Our standards enable a strong people-centred health care system that the public, providers, and policy makers can rely on to enable people around the world to continuously improve quality of care.

HSO's standards are formatted using the following structure:

- **Section title.** A section of the standard that relates to a specific topic.
- **Clause.** A thematic statement that introduces a set of criteria.
- **Criteria.** Requirements based on evidence that describe what is needed by people to achieve a particular activity. Each criterion outlines the intent, action, and accountability.
- **Guidelines.** Additional information and evidence to support the implementation of each criterion.

About This Standard

CAN/HSO 13200:2023 (E) *Pediatric Pain Management* draws on findings from literature reviews, clinical expertise, evidence-informed practices, and those with lived experiences. The published evidence used to inform this standard can be found in the bibliography.

This standard guides the delivery of quality pediatric pain management. It focuses on how organizational leaders and dedicated teams should provide care based on the needs, goals, abilities, and preferences of children and their families. It does not prescribe a particular approach or intervention to pain management.

Foundational to the principles of this standard are the four transformative goals laid out by a 2021 Lancet Child & Adolescent Health Commission (Eccleston et al., 2021):

1. Make pain **matter**
2. Make pain **understood**
3. Make pain **visible**
4. Make pain **better**

The content of this standard is structured into the following sections:

1. Make Pain Matter: Establishing a Pediatric Pain Management Framework
2. Make Pain Understood: Professional Development to Create a Knowledgeable and Confident Workforce
3. Make Pain Visible: Comprehensive Pain Assessment and Reassessment
4. Make Pain Better: Co-developing an Individualized Care Plan
5. Make Pain Better: Multimodal Pain Management Strategies
6. Make Pain Matter: Continuous Quality Improvement for Pediatric Pain Management

This standard is intended to be used as part of a conformity assessment. This standard will undergo periodic maintenance. HSO will review and publish this standard on a schedule not to exceed five years from the date of publication.

Acknowledgements

This standard was developed in partnership with Solutions for Kids in Pain (SKIP). SKIP is a knowledge mobilization network funded by the Networks of Centres of Excellence, based at Dalhousie University, and co-led by Children's Healthcare Canada. SKIP seeks to bridge the gap between current treatment practices and evidence-informed solutions for children's pain in Canadian health care organizations serving children, youth, and their families. SKIP's mission is to improve children's pain management by mobilizing evidence-based solutions through coordination and collaboration. SKIP brings together Canada's world-renowned pediatric pain research community, front-line knowledge user organizations, and children and families.

Guided by diverse and experienced board members, SKIP capitalizes on the engagement of all Children's Healthcare Canada member organizations, over 100 additional multi-sector partners, six SKIP hubs (Halifax, Montreal, Toronto, Ottawa, Edmonton, and Calgary), and children and families (using a "Patients Included" approach) to collaborate and co-produce interconnected knowledge mobilization activities.

Users of this standard can refer to the SKIP knowledge mobilization network as a resource for evidence-based best practices for pediatric pain management. Visit their website for more information www.kidsinpain.ca.



Equity, Diversity, and Inclusion Consultation

HSO and SKIP are grateful to, and acknowledge the valuable contributions of, the following individuals for their review of the standard to ensure it reflects our commitment to principles of equity, diversity, and inclusion (EDI).

- Dr. Alison Gerlach, PhD, Assistant Professor, School of Child and Youth Care, University of Victoria, British Columbia, Canada
- Courtney Pennell, RN (BScN), MScN Candidate Dalhousie University, IWK Health Indigenous Health Consultant, Aboriginal Children's Hurt and Healing Initiative Research Nurse/Project Coordinator, Nova Scotia, Canada
- Dr. Kassia Johnson, MD, FRCPC Developmental Pediatrician; Assistant Clinical Professor, Department of Pediatrics, McMaster University, Ontario, Canada, Physician Co-lead Canadian Pediatric Society Antiracism Strategy, Director of Antiracism and Inclusion – Department of Pediatrics, McMaster University, Senior Medical Director - EDI - Hamilton Health Sciences, Ontario, Canada
- Dr. Margot Latimer, PhD, RN, Professor, Indigenous Health Chair in Nursing, School of Nursing, Dalhousie University, Nova Scotia, Canada
- Dr. Sharon Smile, MSc, MBBS, MD (Pediatrics), Developmental Pediatrician, Holland Bloorview Kids Rehabilitation Hospital; Associate Professor, Department of Pediatrics, University of Toronto, Ontario, Canada

Disclaimer

The intended application of this standard is stated below under Scope. Users of this standard are responsible for assessing its suitability for their particular purposes.

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Pediatric Pain Management

Introduction

As recently as the 1980s, it was believed the infant brain was too immature to perceive pain and, therefore, pain medication for infants was not a standard of care. In addition, pediatric pain in general was poorly recognized, resulting in gross inadequacies in pain management and causing short- and long-term harm (McGrath, 2011). Despite the exponential growth in scientific evidence related to pediatric pain, children continue to experience untreated and preventable pain in Canada.

Critical reasons to prioritize pediatric pain management include:

<p>Pervasiveness</p>	<p>All children experience acute pain and one in five children will experience chronic pain before adulthood (King et al., 2011). Hospitalized children experience up to six acutely painful medical procedures every 24 hours, and most of these are done without any pain management (Stevens, Abbott, et al., 2011; Stevens, Harrison, et al., 2012). Infants admitted to a neonatal intensive care unit undergo up to 14 acutely painful medical procedures a day (Campbell-Yeo et al., 2022). Inadequate post-surgical pain management is reported for children, with one in five children developing chronic pain after major surgery (Rabbitts et al., 2017).</p>
<p>Associated health care avoidance</p>	<p>Fear of pain and fear of needles commonly begin in childhood, due in part to past negative experiences with poor quality pain management (McMurtry et al., 2015; Taddio et al., 2012). Poor quality pain management during childhood contributes to the avoidance of medical care later in life (Pate et al., 1996), as well as vaccine hesitancy (Taddio et al., 2012).</p>
<p>Associated health risks</p>	<p>Children who have chronic pain are more likely to have chronic pain, mental illness, opioid use, and socioeconomic disparities into adulthood (Groenewald et al., 2019; Latimer et al., 2020; Murray et al., 2019; Walker et al., 2012). Short- and long-term consequences of painful experiences and poor quality pain management in infancy include increased pain sensitivity, and neurodevelopmental and socioemotional problems, particularly for infants born preterm cared for in a neonatal intensive care unit (Grunau et al., 2021).</p>
<p>Associated health system costs</p>	<p>The health care costs of pediatric chronic pain are greater than those associated with asthma and obesity, and are comparable to that of attention deficit hyperactivity disorder, the most costly chronic condition in children (Groenewald et al., 2015). The largest cost contributors due to chronic pain in children and adults are increases in hospitalizations and physician and emergency department visits (Groenewald et al., 2014; Hogan et al., 2016). In 2019, the estimated combined direct health care and indirect (lost production) costs of chronic pain in children and adults in Canada was about \$40 billion, and direct costs estimated to increase from \$17.2 billion to \$23.4 billion by 2030 (Health Canada, 2021). The incremental cost to manage chronic pain is estimated at \$1,742 per person per year, more than double the cost for a comparable person without chronic pain (Hogan et al., 2016).</p>
<p>Health inequities</p>	<p>The International Association for the Study of Pain 2019 <i>Global Year Against Pain in the Most Vulnerable</i> identified infants and children, and individuals with cognitive impairments, as two key populations at greatest risk of inequitable and poor quality pain management (International Association for the Study of Pain [IASP], 2019). Racism, oppression, social determinants of health (e.g., race, ethnicity, religion, education, socioeconomic status, gender, gender identity, sexual orientation, language, community context [urban, rural, northern, remote]), and adverse childhood experiences affect health equity and exacerbate health inequities.</p>

	In Canada, due to the constructs of racism, First Nations children are more likely to have pain-related conditions but are less likely to seek health care or receive a referral to a specialist (Latimer et al., 2018).
Human rights	Access to timely and effective pain management is a fundamental human right (IASP, 2010). While many evidence-informed strategies for pediatric pain exist, barriers to implementation include a lack of accessible resources and training for patients, caregivers, health care professionals, administrators, and policy makers; racism, a lack of public awareness and a failure of institutions to recognize and prioritize pain management (Chambers, 2018).

The Canadian Pain Task Force recommended that national standards be developed to ensure people in Canada have equitable and consistent access to a continuum of timely, equitable, evidence-informed, trauma- and violence-informed, and people-centred pain management and support across jurisdictions (Health Canada, 2021). Given children’s unique vulnerabilities and developmental considerations, this *Pediatric Pain Management* standard focuses specifically on children as they require different pain management than adults (Finley et al., 2014). The standard complements other national and international efforts to improve pediatric pain management, such as ChildKind International’s certification of health care organizations demonstrating excellence in pediatric pain management (ChildKind International, 2022).

To emphasize the importance of recognizing children as their own social agents, the technical content of the *Pediatric Pain Management* standard uses the term “child/children” (see Terms and Definitions) rather than patient. Where the term patient is used, this may be interpreted as referring to child or children.

This standard recognizes pain management as a fundamental human right, in alignment with Jordan’s Principle, which is a commitment that First Nations children receive the products, services, and supports they need, when they need them, to address a wide range of health, social, and educational needs. Jordan’s Principle is named in memory of Jordan River Anderson, a young boy from Norway House Cree Nation in Manitoba, Canada. Jordan was born in 1999 with multiple disabilities and stayed in the hospital from birth. When he was two years old, doctors said he could move to a special home that could accommodate his medical needs. However, the federal and provincial governments could not agree on who should pay for his home-based care. Jordan stayed in the hospital until he passed away at the age of five. In 2007, the Canadian House of Commons passed Jordan’s Principle in memory of Jordan (First Nations Health Authority, n.d.; Government of Canada, 2023).

In alignment with the United Nations Convention on the Rights of the Child (United Nations General Assembly, 1989), this standard recognizes that children have their own voice, agency, and right to participate in decisions that affect them, separate from those of their family. When deemed competent, children can make medical decisions for themselves, without the involvement of their family. Supporting children to participate in decision-making, regardless of whether they can make the final decision, optimizes their health outcomes (Davies & Randall, 2015; Ehrich et al., 2015; Moore & Kirk, 2010), improves their satisfaction with care, and allows for more informed resource allocation (Institute for Patient- and Family-Centered Care, 2018).

This standard uses the International Association for the Study of Pain definition of pain and its accompanying notes (Raja et al., 2020) to encourage a common understanding of the term (see Terms and Definitions). An individual’s conceptualization of pain may be informed by their historical (including past interactions with the health care system), cultural, spiritual, and/or other identities, and may be experienced from an individual, family, and/or community perspective (Latimer et al., 2020).

Scope

Purpose

This standard aims to enhance service excellence and continuous improvement in the quality of pediatric pain management. It offers organizational leaders and teams who provide care to infants, children, and adolescents (collectively defined as children) and their families, guidance on pediatric pain management practices, professional development, policy development, and quality improvement initiatives.

This standard is intended to provide:

- Organizational leaders and health care teams with foundational information on delivering equitable, high-quality, person-centred pediatric pain management, and ensuring continuity of care for children beginning at birth.
- Children, families, and communities with foundational information on what to expect and how to fully engage in and support quality pediatric pain management as integral members of the care team.

Implementation of this standard will:

- Demonstrate an organization's commitment to quality and equitable pediatric pain management
- Recognize children and families as equal members of the care team (referred to as "the team", see Terms and Definitions).
- Improve consistency and effectiveness of pain management for children and families across the continuum of care and health care settings.
- Ensure pain management is equitable and individualized to address the unique needs of each child and their family.

Applicability

This standard applies to hospital settings that provide inpatient, procedural, and/or outpatient services in children's, community/regional, and rehabilitation hospitals.

This standard is intended for use by organizational leaders and dedicated teams providing care to infants, children, and adolescents (birth to 19 years less one day) and their families.

Community-based clinics, palliative care, and primary care settings are out-of-scope of this standard. While much of the standard's content may be relevant and critical to these settings, they require additional consideration for pediatric pain management that are not addressed in this standard.

The following HSO standard may also be relevant:

- CAN/HSO 11013 *Cannabis Use for Medical Reasons: Inpatient Care Settings*
- CAN/HSO 22004 *Mental Health and Addictions Services*
- CAN/HSO 5064 *Suicide Prevention Program*

Normative References

There are no normative references in this standard.

Terms and Definitions

Below is a list of terms and definitions that are used throughout this standard.

Acute pain: Pain that is recent in onset and typically self-limiting, with a duration that typically ranges from a few hours to no more than 3 months (depending on the anticipated duration of the healing process) related to tissue injury, a medical procedure, and/or following surgery, acute illness, trauma, or other injuries. Children can experience acute and chronic pain concurrently.

Adolescent: See *child/children*.

Adverse childhood experiences: Potentially traumatic experiences that occur early in life and that are linked to differences in the function of the stress-response system including the neuroendocrine system, the parasympathetic nervous system, and the immune system. These changes are likely to have substantial long- and short-term impacts on health and well-being (Hostinar et al., 2014) and are substantial contributors to health inequities. Adverse childhood experiences can include racism; poverty; experiencing violence or witnessing violence; undergoing physical, sexual, and/or emotional abuse; experiencing harassment or bullying; witnessing friends or family members die or attempt to die by suicide; having an unsafe school or home environment; being subject to neglect; and growing up in an unstable or high-risk home environment (e.g., substance use by a family member, incarceration of a family member).

Child/children: For the purposes of this standard, persons from birth to 19 years of age, less one day.

Chronic pain: Pain that persists or recurs for longer than three months. The World Health Organization's International Classification of Disease (ICD-11) considers chronic pain as a disease in its own right (i.e., chronic primary pain) or secondary to an underlying disease (i.e., chronic secondary pain). It can include chronic cancer-related pain, chronic neuropathic pain, chronic secondary visceral pain, chronic post-traumatic and post-surgical pain, chronic secondary headache and orofacial pain, and chronic secondary musculoskeletal pain (Treede et al., 2019). Children can experience acute and chronic pain concurrently.

Community: All groups of people that an organization is responsible for serving as part of its mandate. Each group contributes to the diversity of the community and its cultures. Each group may have different intersecting identity factors, different access and functional needs, and may require different types and levels of services and support. Therefore, when engaging with its community, the organization identifies and works with all populations including underserved populations, Indigenous peoples, cultural groups, minority populations, and people and populations at a greater risk of having harmful experiences and/or outcomes. Further, the organization identifies and works with populations of all ages, abilities, genders and gender identities, races, colours, ethnicities, languages, locations, cultures, beliefs, histories, colonial legacies, migration statuses, employment statuses, income and social statuses, literacy levels, housing statuses, and health statuses in its community.

Cultural humility: A process of self-reflection/self-critique to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience (First Nations Health Authority, 2016). Cultural humility should be a lifelong process as well as a goal.

Cultural safety: An outcome of respectful engagement that is based on recognizing and working to address inherent power imbalances in the health system. It results in an environment free of racism and discrimination, where people feel safe when receiving and providing care, and when interacting with the health system (First Nations Health Authority, 2016). A culturally safe environment is one that is physically, socially, emotionally, and spiritually safe without challenge, ignorance, or denial of a person's identity (Turpel-Lafond, 2020). Practising cultural safety requires having knowledge of the colonial, sociopolitical, and historical events that trigger health disparities and perpetuate and maintain ongoing racism and unequal treatment (Allan & Smylie, 2015). For the purposes of this standard, this approach also applies to the design and delivery of culturally appropriate, person-centred services, environments, or methods of engagement and communication that respect the unique culture and beliefs of the child and their family.

Decision making capacity: The ability to provide informed consent. In the context of pain management, this includes the child's ability to understand the nature, benefits, and harms of the pain management strategy; the consequences of consenting or refusing; and understanding that the information being discussed as part of informed consent is in relation to oneself.

- When determining someone's capacity to consent, the presumption is that an individual of any age is capable, unless there are reasonable grounds to believe they are not. A child's capacity to understand information and make decisions can change with time and circumstances and should be evaluated with each decision.
- When a child's capacity is limited, the team determines the degree of incapacity (e.g., partial, total, temporary, permanent) in keeping with jurisdictional legislation. Specific regulations may apply when working with children, or anyone with limited capacity, and the role of a substitute decision maker.

Equitable pain management: One characteristic of quality pain management (see '*quality pain management*'), which aims to reduce barriers to accessing health care. Pain management is equitable when children and families receive care that is:

- anti-oppressive
- anti-racist
- anti-ableist
- culturally informed
- trauma- and violence-informed

Equity-seeking groups: Individuals and communities who experience discrimination and/or exclusion from health, social, economic, or political dimensions, due to unequal power dynamics and complex intersections of race, class, gender, sexuality, ethnicity, nationality, ability, and age. In Canada, these populations or groups may have an "increased likelihood [to] experience difficulties in obtaining needed care, receive less care or a lower standard of care, experience different treatment by health care providers, receive treatment that does not adequately meet their needs, or be less satisfied with health care services than the general population" (Health Canada, 2001).

Evidence-informed approach: An approach to informing policies, procedures, and practices that integrates research evidence with the expertise and lived experience of people participating in care (e.g., the team, child, family, designated support persons). Research provides knowledge that has been created through rigorous methods and can be quantitative or qualitative. Combining research, expertise, and lived experience is an inclusive and useful approach to ensure evidence reflects the person, the context, and the evolving nature of knowledge (Alla & Joss, 2021).

Family: One or more individuals identified by the child as an essential support, and who the child wishes to include in their encounters with the health care system, including extended family, guardians, friends, advocates, members of their community, and informal or hired caregivers. When the child is deemed capable of providing informed consent, as established through a competency assessment or based on jurisdictional age requirements, the child defines the makeup of their family and has the right to include or not include family members in their care. The child may also redefine the makeup of their family over time.

Health equity: The absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically, or geographically (World Health Organization, 2008). "Health equity seeks to reduce inequalities and to increase access to opportunities and conditions conducive to health for all" (Government of Canada, 2022). Health equity means people have a fair chance to achieve their best possible health.

Individualized care plan: A care plan developed collaboratively with the child and family. The care plan is based on the child's needs, goals, abilities, and preferences. It outlines the roles and responsibilities of each team member and how other teams within and outside the organization will be involved. The care plan is developed based on the child's history, ongoing assessments, diagnostic results, best possible medication history (BPMH), and previous crisis intervention plans.

Interdisciplinary committee: For the purpose of this standard, a committee dedicated in whole or in part to the oversight of the pediatric pain management framework. Membership includes representation from various health disciplines, care

settings, organizational leaders, equity-seeking populations, and children and families. The committee has a shared responsibility to co-create policies, procedures, education and training, and process for pediatric pain management.

Medication or drug: Prescription and non-prescription pharmaceuticals; biologically derived products such as vaccines, serums, and blood-derived products; tissues and organs; and radiopharmaceuticals.

Multimodal pain management strategies: An approach that integrates physical, psychosocial, and pharmacological strategies to prevent and manage acute and chronic pain, which may include traditional and/or alternative medicine.

Organization: A health and social service legal entity comprised of people in varied roles and responsibilities with the common goal of planning, delivering, and ensuring the provision of safe and quality services and care. An organization can include many service settings, is not limited to the physical boundaries of a single site or location, and serves a defined community.

Organizational leaders: People in an organization who work in a formal or informal leadership capacity to guide, manage, or improve their team, unit, organization, or system (Dickson & Tholl, 2014). While leaders can exist at all levels of an organization, and among family members, for the purposes of this standard the term organizational leaders includes executive and other senior leaders; it does not include an organization's governing body.

Pain: An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage (Raja et al., 2020). See also *acute pain*, *chronic pain*, and *procedural pain*.

The International Association for the Study of Pain provides accompanying notes to the definition as follows:

- Pain is always a personal experience that is influenced to varying degrees by biological, psychological, and social factors.
- Pain and nociception are different phenomena. Pain cannot be inferred solely from activity in sensory neurons.
- Through their life experiences, individuals learn the concept of pain and expression.
- A person's report of an experience as pain should be respected and believed.
- Although pain usually serves an adaptive role, it may have adverse effects on function and social, spiritual, and psychological well-being.
- Verbal description is only one of several behaviours to express pain; inability to communicate does not negate the possibility that a human or a nonhuman animal experiences pain (Raja et al., 2020).

Pain experience: See *pain*.

Pain expression: The way in which a child shows they are in pain. People can express pain verbally or through changes in behaviour, such as crying, moaning, groaning, grimacing, restlessness, agitation, or depression. Other examples of pain expression include trouble moving around (such as limping), guarding a painful area of the body, flinching when touched, and experiencing trouble sleeping or eating. The absence of observable behaviours should not be considered as an absence of pain. The presence of challenging behaviours may be a manifestation of pain in children who cannot communicate verbally. People may express pain in different ways depending on many external factors, including their family, social interactions, and culture (National Cancer Institute, 2022).

Pain management: See *quality pain management*

Pain measure: Quantitative and qualitative strategies used to assess a child's pain experience.

Patient safety incident: An event or circumstance which could have resulted, or did result, in unnecessary harm to a patient (e.g., for the purposes of this standard, the child). There are three types of patient safety incidents:

- Harmful incident: A patient safety incident that resulted in harm to the child. Replaces adverse event and sentinel event.
- Near miss: A patient safety incident that did not reach the child and therefore no harm resulted.
- No-harm incident: A patient safety incident that reached the child but no discernible harm resulted. (Canadian Patient Safety Institute, 2022).

Pediatric: See *Child/children*.

People-centred care: An approach to care that is designed to adopt individuals', caregivers', families', and communities' perspectives as participants in, and beneficiaries of, health systems that are organized around the comprehensive needs of people (World Health Organization, 2016).

Pharmacological strategies: Interventions that involve the use of medications to manage pain, including those obtained over-the-counter or by prescription to manage pain.

Physical strategies: Interventions intended to help the body function physically, which may include conditioning exercises, stretches, endurance activities, and nervous system retraining.

Policy: The documented rules and regulations of an organization. A policy provides guidelines to ensure consistency and compliance with required rules and regulations throughout an organization. It usually describes how jurisdictional regulations and legal requirements should be implemented in the organization.

Procedural pain: Pain associated with medical procedures (e.g., venipuncture, intravenous line insertion, blood draws, heel lances, lumbar punctures, urethral catheterizations, wound repair, needlesticks for vaccination or medication administration, medical imaging of fractures and dislocations).

Procedure: A written series of steps for completing a task, often connected to a policy. Procedures are standardized and evidence-informed.

Process: A series of steps for completing a task, which are not necessarily documented.

Psychosocial strategies: Interventions that harness the connection between mind and body by addressing thoughts (cognition), emotions, and behaviours/actions to help the child and their family directly or indirectly influence the experience of pain.

Quality improvement: A systematic and structured team effort to achieve measurable improvements in care delivery, experiences, and outcomes. Quality from an equity perspective recognizes and includes the perspectives, values, and ideals of diverse child and family populations.

Quality pain management: Pain management aims to alleviate or reduce the pain experience using a variety of strategies for prevention, assessment, and treatment of pain. Quality pain management must be:

- Accessible
- Consistent
- Equitable (see '*equitable pain management*')
- Evidence-informed
- Individualized to the unique needs of children and families
- Multimodal
- Safe and Effective

Self-report: An individual's expression of their symptoms, behaviours, experiences, beliefs, or attitudes. A test, measure, tool, question, interview, or survey may be used to elicit structured self-report data, using verbal, written, or electronic formats. Self-report data should be given particularly high value in the context of pain given the subjective nature of pain experiences and associated psychological states.

Shared decision making: A complex and dynamic process that is jointly shared by the child and family, and the health care professionals on the team. Shared decision making aims to ensure that children and families play active and central roles in decisions about the child's health care, including pain management. It involves the following series of steps:

- Recognizing that a decision can or must be made
- Identifying possible courses of action
- Listing the pros, cons, or other characteristics of each possibility

- Comparing the options and identifying one as probably better than the rest
- Accepting or rejecting options to get to the final choice
- Authorizing the final choice
- Implementing the final choice

Stereotype: A negative perception that results in discrimination (Canadian Mental Health Association, 2021). Stigma in itself is multifaceted and different types of stigma (e.g., related to race, sexual identity, ability) can interact to give rise to unique discriminatory structures that, in turn, have an impact on a person's health, socioeconomic status, and opportunities (Public Health Agency of Canada, 2019).

Team: People collaborating to meet the goals, abilities, and preferences of the child and family. The team includes the child, family, and workforce members involved in the child's pain management. Depending on the care needed, the team may also include organizational leaders, volunteers, learners, external service providers, and the community.

Timely/regularly: Carried out in consistent time intervals. The organization defines and adheres to appropriate time intervals for various activities based on best available knowledge.

Traditional medicine: The totality of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as to prevent, diagnose, improve, or treat physical and mental illness (World Health Organization, 2021a). Traditional medicine has a long history and Indigenous peoples have the right to their traditional medicines (United Nations General Assembly, 2007). Examples include incorporating Indigenous and other cultural healing and wellness practices into ceremonies; plant, animal, or mineral-based medicines; energetic therapies; or physical/hands-on techniques such as acupuncture. May also be referred to as traditional or alternative healing.

Transition in care: A change in health status, care needs, healthcare professionals, or location (within, between, or across settings).

Trauma- and violence-informed strategies: Approaches to care that focus on minimizing the potential for harm and re-traumatization as well as enhancing safety, control, and resilience. These approaches benefit everyone, regardless of whether they have experienced trauma or whether their personal history is known to health care professionals. Health care professionals and organizations who do not understand the complex and lasting impacts of violence and trauma may unintentionally re-traumatize. Embedding trauma- and violence-informed approaches into all aspects of policy and practice can create universal trauma precautions that provide positive support for everyone. They also provide a common platform that helps integrate services within and across systems and offers a basis for consistent ways of responding to people with such experiences (Ponic et al., 2016; Public Health Agency of Canada, 2018; Varcoe et al., 2016).

Two-Eyed Seeing approach: A term coined by Mi'kmaw Elders Albert and Murdena Marshall, indicating that both Indigenous and Western knowledge should be considered as equally beneficial to co-create new learnings that will be relevant to support the health and well-being of Indigenous peoples (Latimer et al., 2020).

Workforce: Everyone working in or on behalf of an organization on one or more teams, including those who are salaried and those who are paid hourly; those who are in temporary, term, or contract positions, including clinical and non-clinical staff, physicians, regulated and non-regulated health care professionals; and support personnel who are involved in delivering services in the organization.

Abbreviations

2SLGBTQ+ – Two-spirit, lesbian, gay, bisexual, transgender, queer, or questioning

HSO – Health Standards Organization

PCC – People-centred Care

SCC – Standards Council of Canada

SKIP – Solutions for Kids in Pain

WHO – World Health Organization

1 Make Pain Matter: Establishing a Pediatric Pain Management Framework

1.1 The organization aligns its mandate, values, priorities, and operational plans with the pediatric pain management framework.

1.1.1 The organizational leaders support the development of an organization-wide pediatric pain management framework with dedicated resources to improving pediatric pain management.

Guidelines

Prioritizing pediatric pain management at an organizational level may improve the child and family's perception of the quality of care, as well as their satisfaction and engagement with strategies and interventions. The pediatric pain management framework describes the organization's policies, processes, standards, and clinical pathways for access to and provision of pediatric pain management, and establishes the context through which the quality and equity of pediatric pain management services are evaluated.

At a minimum, the pediatric pain management framework includes/addresses:

- Principles of people-centred care and building trusting encounters with the health care system
- Policies dedicated to pediatric pain management
- A culture of patient safety and incident reporting
- A required pain education curriculum
- A variety of validated pain assessment tools
- Goals and objectives for continuous quality improvement for pediatric pain management

The amount of resources (e.g., human, financial, equipment, infrastructure, and/or informational resources) dedicated to the oversight of the pediatric pain management framework should be greater for organizations that exclusively serve children and adolescents (e.g., a standalone interdisciplinary pain committee at a children's hospital) versus those organizations that serve children as well as adult populations (e.g., an existing interdisciplinary leader and/or designated accountable leader at a community or regional hospital).

1.1.2 The organizational leaders assign accountability for the pediatric pain management framework to an interdisciplinary committee or a designated leader.

Guidelines

Responsibility for the development and implementation of the pediatric pain management framework's mandate is assigned to:

- An interdisciplinary pain committee that is exclusively dedicated to pediatric pain management
OR
- An existing interdisciplinary committee (e.g., quality and safety) that has pediatric pain management explicitly included as part of its mandate and as a standing agenda item
OR
- A designated accountable leader who acts as a liaison with child health care organizations that can provide subject matter expertise

The composition of the interdisciplinary committee varies depending on the organization's resources and populations served. The interdisciplinary committee or accountable leader seeks subject matter expertise from:

- Relevant health care professionals

- Organizational leaders and policy makers
- The community, including equity-seeking groups, and children and families
- Indigenous consultants and/or Indigenous health leaders

If Indigenous health consultants are not available, the interdisciplinary committee or accountable leader regularly engages Indigenous health leaders to provide recommendations and regularly reviews evidence to improve knowledge and practice related to pain assessment and management for Indigenous children.

1.1.3 The organizational leaders maintain up-to-date organization-wide policies specific to pediatric pain management.

Guidelines

Organization-wide policies for pediatric pain management are essential for guiding the provision of quality and equitable pain management.

At a minimum, the organization-wide policies specific to pediatric pain management include:

- Comprehensive pain assessment and reassessment
- Pain prevention, including procedural sedation, topical analgesics, and oral sucrose
- Timely access to pain management services and/or referrals, including waitlist management
- Requesting and/or providing external consultation
- Administration and management of medications for pain management, including opioids
- Use of multimodal pain management strategies
- Admission, discharge, and transitions in care
- Patient safety incident reporting for preventable, untreated or unmanaged pain (see criterion 1.1.5)

The organization-wide pediatric pain management policies:

- Identify the role or position of individual(s) responsible for implementation and sustainability
- Are regularly reviewed, in partnership with children and families, and the community as subject matter experts, to ensure content is current and relevant
- Are equitable, evidence-informed, people-centred, culturally informed, trauma- and violence-informed, anti-racist, and anti-oppressive
- Are regularly evaluated, using quantitative and qualitative measures, to ensure the content continues to meet the needs of the organization and the community

1.1.4 The organizational leaders ensure pediatric pain management policies recognize the child and family as equal members of the team who are fully engaged as part of person-centred care.

Guidelines

Establishing a person-centred approach to the delivery of pediatric pain management services ensures the child and family have an individualized care plan. Active engagement and shared decision making throughout the continuum of care improve communication between the child and family and the other team members.

The organization-wide pediatric pain management policies promote the child's and family's participation and collaboration as equal members of the team by:

- Documenting and honouring the child's and family's individualized care plan with regard to pain management
- Sharing complete, unbiased, antiracist, anti-oppressive, and evidence-informed knowledge
- Ensuring there is access to or a means to access traditional medicine practitioners or resources if requested by the child and family

- 1.1.5 The organizational leaders establish a system for reporting preventable, untreated, and unmanaged pain as patient safety incidents.

Guidelines

Untreated or unmanaged pain can cause trauma and is a risk factor for short- and long-term harm:

- Pain sensitization
- Neurodevelopmental outcomes
- Chronic pain
- Mental health concerns for children and family, including but not limited to anxiety, depression, and post-trauma stress
- Substance use
- Health care avoidance and distrust of health care professionals

Preventable pain is pain that can be anticipated and avoided or significantly minimized through preventive measures, such as from medical procedures. If pain cannot be prevented, due to a child's underlying medical condition or injury, pain should be managed as soon as possible.

The extent to which pain is deemed to be managed is determined by the team, which includes the child and family. The child and family are the starting point for determining if the child's pain is managed effectively.

A patient safety incident has occurred when the child's pain is:

- Untreated, meaning no measures have been implemented or offered to prevent pain or manage pain.
- Not treated or managed in a timely manner, in accordance with the organization's policies.
- Unmanaged, meaning the strategies implemented were deemed ineffective by the team, including the child and the family, AND any one of the following are true:
 - The measures used are not evidence-informed
 - The measures used do not reflect the clinical needs, preferences, goals, or abilities of the child and family (i.e., does not reflect the child's individualized care plan, if developed)
 - Pain was not regularly or comprehensively assessed, or pain was not assessed at all
 - Results of the child's pain assessment(s) were not documented in the health record and/or not used to inform the child's individualized care plan

- 1.1.6 The organizational leaders provide teams with access to validated tools for pain assessment to inform individualized care plans for all children and communities served by the organization.

Guidelines

Pain assessment tools are used to measure a child's self-reported pain experience (e.g., pain intensity) and/or family-report of the child's pain expression. Quantitative pain measures are documented in the child's health record as part of the child's individualized care plan.

A variety of validated pain assessment tools are available to ensure the child's pain is assessed consistently and in a manner appropriate for the child's needs and abilities. Teams have access to appropriate pain assessment tools to provide equitable and quality pediatric pain management, which consider factors such as the child's:

- Age
- Development
- Cognitive and communication abilities
- Cultural identity
- Preferences, and/or
- Pain characteristics.

The team recognizes that pain intensity, as identified using pain assessment tools, is only one aspect of the child's pain experience and only one aspect of the comprehensive pain assessment and ongoing reassessments (see section 3).

Additional Information:

- See Informative Annex B *Components of Comprehensive Pain Assessment and Reassessment*.

- 1.1.7 The organizational leaders facilitate external consultation if the necessary pediatric pain management expertise is not available internally.

Guidelines

In some contexts, the team may need additional expertise to support continuity of care for quality and equity of pain management. Factors such as the population served, geographic location, and human resources may influence an organization's need to establish external networks to support quality pain management for children that is closer to home.

Most health services delivered to children occur outside of tertiary care organizations and there is a limited number of specialty pediatric pain services in Canada that are located predominantly in large urban centres. As such, access to quality pediatric pain management is a challenge and there is benefit for organizations to build capacity for quality and equitable pain management external to their organization. Tertiary children's health organizations may provide consultation services through specialty pain services, as appropriate, while the child and family remain under the primary care of another health care professional, service, or organization. This consultation could occur on an individual level and/or in larger case consultation formats, such as supporting communities of practice. Alternatively, specialty pain services may recommend the child be referred and come under the primary care of their team, if eligible.

2 Make Pain Understood: Professional Development to Create a Knowledgeable and Confident Workforce

2.1 The organization establishes an evidence-informed education curriculum for pediatric pain management.

- 2.1.1 The interdisciplinary committee or accountable leader verifies that the education on pediatric pain management provided to teams is evidence informed and comprehensive.

Guidelines

The interdisciplinary committee or accountable leader reviews internal (e.g., the organization) and external (e.g., regulatory bodies, educational institutions) education provided to teams on pediatric pain management for accuracy and comprehensiveness to ensure quality and equity of pain management. If gaps are identified, the interdisciplinary committee or accountable leader creates evidence-informed materials to fill the identified gaps, in partnership with equity-seeking groups.

- 2.1.2 The organizational leaders ensure that teams are regularly provided with required education and training about equitable, quality pediatric pain management.

Guidelines

Including pediatric pain management competencies in professional development, education, and training helps the team better create an individualized care plan for the child and family that provides quality and equitable pain management.

In the context of this standard, core competencies are evidence-informed knowledge, skills, abilities, or other characteristics deemed essential for teams to possess in order to provide children and families with quality and

equitable pediatric pain management. Core competencies may be specific to team members' role or discipline or may be more general and apply to all team members, and may vary to reflect the specific needs of the communities served by the organization.

Required education and training should aim to develop the following skills and abilities:

- Selecting and interpreting pain assessment tools to assess and infer each child's pain experience, including how to maximize self-report wherever possible
- Special considerations, and current evidence-informed practices to assess pain for:
 - Infants and neonates
 - Children who may have difficulty communicating due to visual, hearing, or other impairment, and/or who do not speak or understand the language of the assessment
- Physical, psychosocial, and pharmacological strategies to manage acute and chronic pain
- Practices to document pain measures in the health record and track a child's pain over time
- A conceptualization of pain that considers the interaction between biological, psychological, and social factors (i.e., a biopsychosocial framework)
- Information on anti-racism, microaggression, and implicit bias, to address racial bias in pain assessment and management
- Training on safe practices to manage and prescribe opioids for pediatric pain management, including the ability to appropriately prescribe, monitor, taper, and discontinue opioids; and recognize and know how to seek support for children and families with risk factors for opioid misuse or opioid use disorder (see criteria 5.1.4, 5.1.5, and 5.1.6).

Additional Information:

- See Informative Annex A: *Core Pediatric Pain-Related Competencies*
- See Informative Annex B: *Components of Comprehensive Pain Assessment and Reassessment*

2.1.3 The organizational leaders ensure that teams are regularly provided with required education and training about factors contributing to health inequities in pediatric pain management.

Guidelines

Equitable pain management is required for quality pain management. Equitable pain management can help to reduce health inequities and improve pain management outcomes for all children. By providing education and training on the factors contributing to health inequities, organizational leaders can help their teams understand the root causes of these health inequities. This understanding can inform the development of individualized care plans that are tailored to the unique needs of each child and family.

The required education and training include pain management for children and families from equity-seeking groups such as:

- Indigenous peoples (First Nations, Métis, Inuit)
- Black people and other people of colour
- Immigrants, refugees, and newcomers to Canada
- Families whose first language is not English or French
- 2SLGBTQIA+ people
- People with disabilities (such as neurodiversity and/or developmental disabilities) and those who are nonverbal
- Other equity-seeking and sovereignty-deserving groups

Equitable pain management requires engaging with and learning from the child and family about the child's pain experience to tailor pain prevention, assessment, education, and treatment. Required education and training should aim to develop an understanding of how the following factors contribute to health inequities, and strategies for tailoring pain care to address the unique needs of each child:

Adverse childhood experiences	It is important for teams to be aware of the potential impact of adverse childhood experiences (e.g., war, trauma, death, separation, racism) on a child’s perception and expression of pain, and its association with chronic pain.
Racism, discrimination, and implicit bias	How racism fuels health disparities and mistrust of the health system through stereotyping, stigma, and biases. How equity-seeking groups may delay seeking care or feel unsafe in the health care system as a result of systemic exclusion and harm in health care settings.
Cultural safety and humility	Training in cultural safety and humility to improve the teams’ understanding of a child’s and family’s culture and how it might influence their experience of care; their trust in the health care system; their conceptualizations and expressions of pain; and traditional remedies and foods that may be incorporated, as desired, into an individualized pain management plan. Information about First Nations, Inuit, and Métis peoples who access services, the historical and ongoing impact of colonization both locally and nationally, and the privileges of White settlers, including how it pertains to pain management and health care access and provision more broadly.
Access to pain management as a human right	Strategies to assess and manage pain for children with neurodiversity and/or developmental disabilities, including children who are non-verbal. Knowledge of different jurisdictional coverage (and additional costs that may not be covered by the health system, such as medications, and treatments – see criterion 4.1.2).

2.2 The organization implements evidence-informed education for pediatric pain management.

2.2.1 The organizational leaders ensure the education methods used support successful implementation of pediatric pain management knowledge into practice.

Guidelines

Education methods that support successful implementation of pediatric pain management knowledge into practice include:

- Role play and drama
- Real testimonies and cases from children and families
- Clinical simulation
- E-learning modules
- Small group work

2.2.2 The organizational leaders provide access to, and resources for, the team to participate in external education and training to further their pediatric pain management competencies.

Guidelines

In addition to core competencies for pediatric pain management, the team may benefit from developing more advanced pain management competencies to meet the needs of specific pediatric populations. To provide the team with education and training that is tailored to the needs, roles, and responsibilities of specific health care disciplines, the organizational leaders ensure resources are available, including flexible work hours, for the team to pursue such opportunities.

External education and training opportunities include:

- Conferences or symposia
- Best practice guidelines or libraries
- Online learning or webinars

Additional information:

- See Informative Annex A: *Core Pediatric Pain-Related Competencies*

3 Make Pain Visible: Comprehensive Pain Assessment and Reassessment

3.1 The team conducts comprehensive pain assessments and ongoing reassessments.

3.1.1 The team conducts an initial comprehensive pain assessment to understand the factors contributing to a child's unique pain experience to inform the individualized care plan.

Guidelines

Pain assessments often rely on pain measures (e.g., clinical observations of the child's pain expression, pain intensity scores) to assess and infer the child's pain experience, which is subjective and cannot be directly observed.

A comprehensive pain assessment must include both qualitative and quantitative pain measures. Relying on either alone may lead to miscommunication, an unsatisfactory health care experience, or unmanaged pain.

A timely, accurate, and comprehensive pain assessment is a required first step for:

- Early identification of a child's pain
- Determining potential cause(s) of pain
- Selecting appropriate treatments and/or referral for services
- Informing an individualized pain care plan
- Improving short- and long-term health outcomes and the child's and family's satisfaction
- Reducing the child's fear and distress

At a minimum, the initial pain assessment includes measurement of the following aspects of pain:

- Intensity
- Location
- Temporal features
- Sensory features
- Emotional features and social determinants of health
- Functional consequences

As part of a comprehensive pain assessment, the team should:

- Perform a physical examination
- Consult best practice guidelines to determine the validated pain assessment tools that will be used to measure and track pain
- Arrange for special additional testing, as needed
- Generate and document a best possible medication history (BPMH), in partnership with the child and family

Additional Information:

- See Informative Annex B: Components of Comprehensive Pain Assessment and Reassessment

3.1.2 The team conducts ongoing pain reassessments and updates the individualized care plan.

Guidelines

Pain assessment is ongoing, individualized, and documented so that all involved in the child's care can understand the child's pain experience and goals of care. Delays or failures to report a change in health status and, in particular, a deterioration in a child's pain or condition are significant barriers to safe and effective care and services.

Following the initial comprehensive pain assessment, the team regularly reassesses clinically relevant aspects of the child's pain, to monitor the child's recovery, health status, and effectiveness of treatment. At a minimum, reassessments occur:

- On admission to care
- At new healthcare encounters (e.g., outpatient appointments)
- Before and after medical procedures and as part of pain management interventions
- During care transfers
- Prior to discharge or transitions in care

Additional Information:

- See Informative Annex B: *Components of Comprehensive Pain Assessment and Reassessment*

3.2 The team consistently documents pain assessment results and individualized care plans in the health record to enhance the quality and equity of pain management.

3.2.1 The team documents the results of the child's pain assessments in the child's health record, in accordance with organizational procedures.

Guidelines

Documentation of pain assessments is essential for communication among team members and to support better transitions in care and can be used to evaluate the impact of pain management strategies. Results of pain assessments and changes in health status are documented in the child's health record to support access to quality and equitable pain management. Failing to report a change in health status, such as a deterioration in a child's pain or condition, is a significant barrier to quality pain management.

To facilitate communication and track pain over time, the team at minimum documents the following in the child's health record:

- Pain measures, including changes in pain intensity since previous assessments
- When the assessment was conducted
- Level of alertness at the time of the assessment (e.g., level of sedation, sleep state)
- Changes in health status
- Child's risk factors for potentially poor pain management (e.g. language barriers, racial identity, social determinants of health factors)
- The child's best possible medication history (BPMH)
- Multimodal pain management strategies used and the child's response to the intervention.
- Any adjustments needed to the individualized care plan in response to the intervention

- International Classification of Diseases (ICD-11) diagnostic codes to document primary or secondary pain and pain-related diagnoses

3.2.2 The team documents the individualized care plan in the health record, in accordance with organizational procedures.

Guidelines

Documentation of the child's individualized care plan is essential for communication among team members, to support better transitions in care and to evaluate the impact of pain management.

At a minimum, the team documents the following details of the child's individualized care plan in the child's health record:

- Pain management preferences, goals and expected results of care, including timelines for achieving and monitoring results
- Roles and responsibilities of the team including, if applicable, traditional healers
- Location(s) where pain management services will be provided
- Frequency of pain management strategies, including timelines for initiation and completion of services
- Methods and strategies to enhance pain self-management for the child and family
- Methods and strategies to support the child's meaningful and active participation in the pain management plan, according to the child's developmental abilities
- Strategies and supports identified to facilitate safe use of opioids, if applicable
- Culturally relevant healing practices including traditional medicine, as determined by the child and family
- Considerations related to the child and family's past experiences with pain and/or medical care (e.g., adverse childhood experiences, trauma, racism)
- Systemic factors that have the potential to affect the child's pain expression (e.g., language, race, income)
- If applicable, information about the child's care transition plan (see criterion 4.1.3)

3.3 The team creates a safe space for children and families to share their pain experience.

3.3.1 The team accepts the child's self-reported pain experience as accurate source of information.

Guidelines

By its very nature, pain is a personal experience and, as such, can only be known by the person experiencing the pain. Self-report is the primary source of information for pain assessment and measurement of pain intensity in most children aged three to four years and older. Self-reports are interpreted in relation to observation, family reports, and clinical context.

Better health care experiences and outcomes result when relationships are built on trust in a safe space, tapping into the cultural characteristics of connectedness and resilience.

Children's self-report of their pain experience can be maximized by:

- Asking typically developing children as young as six years old to rate their own pain verbally using validated numeric or faces scales
- Using the term "hurt" instead of "pain" and yes/no questions for typically developing children as young as three or four years old
- Integrating augmentative and assistive communication technology and/or other methods of communication for children who cannot communicate verbally

When determining a child's ability to report their pain, the team considers the child's age and developmental, cognitive, and communication abilities. If the child is unable to report their pain, family-report should be considered in lieu of self-reported pain. Family members are recognized as possessing unique insight into a child's pain relative to health care professionals due to their expertise and familiarity with the child in their day-to-day functioning.

- 3.3.2 The team provides appropriate support to the child and family to ensure effective communication that maximizes the child's ability to self-report their pain experience.

Guidelines

While families can provide valuable insight into the child's perspective, they tend to underestimate the child's experience of pain as compared to the child's self-reported pain experience.

If the child and/or family has difficulty communicating due to visual, hearing, or other impairment, or if they do not fluently speak or understand the language of the assessment, appropriate support may be needed to ensure effective communication.

Providing access to interpretation services and/or augmentative and assistive communication technology supports equitable and quality pain management. Support may include access to professionally trained interpreters or other care professionals whose role is to assist the child and/or family during the assessment, with a focus on ensuring that the child and family's views are considered and discussed.

- 3.3.3 The team considers self-reported pain in relation to observation of behavioural cues, family and/or designated support person(s)-report, and clinical context.

Guidelines

Because a child's pain experience is an internal subjective experience, the team uses self-report, when available, as the primary source of pain assessment. Self-reported pain is one aspect of the comprehensive pain assessment and must be considered in the context of other aspects such as observation, family-report, and the clinical context. A child's pain experience and pain expression are influenced by many factors, including their previous pain experiences and interactions with the health system.

Self-reported pain is considered the primary source of information for pain assessment, followed by:

- Probable sources of the child's pain experience
- Observation of the child's behaviour and/or pain expression
- Family-reported pain expression
- Trialing pain-relieving treatment(s)

For children who are non-verbal and/or have a developmental or intellectual disability, the team asks the family (or others who regularly spend time with the child) about changes in the child's behaviour.

Behavioural cues (e.g., withdrawal or stoicism, overt expressions of distress, automatic or controlled behavioural elements), though not always present, can be an indication of the child's pain. Context is important when assessing a child's behaviour and/or pain expression, as children often suppress their pain expression.

- 3.3.4 The team discusses the results of the pain assessment and reassessments with the child and family in a timely manner.

Guidelines

Discussing the results of the assessment and reassessments helps clarify the team's understanding and reduces service duplication. The child's and family's understanding of the child's pain assessment is an important part of pain education and a foundational part of equitable and quality pain management.

Results of pain assessments are provided to the child and family in a timely manner and in a way that is easy for them to understand; and is tailored to the child and family's literacy level, language, and culture. The child and family are encouraged to actively participate in the discussion about the results and actions or decisions that need to be made based on the results.

4 Make Pain Better: Co-Developing an Individualized Care Plan

4.1 The team co-develops individualized care plans to support a shared understanding of equitable and quality pain management for each child and family.

- 4.1.1 The team provides the child and family with information about potential benefits and harms prior to initiating a pain management strategy.

Guidelines

The central premise of informed consent is that the child and family are part of a shared decision making process and have accountability within that process. Obtaining informed consent before beginning care protects children and families' fundamental right to bodily autonomy. The team follows jurisdictional requirements for obtaining informed consent.

The team:

- Confirms a comprehensive pain assessment was conducted, to guide the child's individualized care plan
- Provides information to the child and family about the benefits, risks, side effects, alternative courses of care, anticipated outcomes, and likely consequences of not having the care.
- Gives the child and family time to consider the information, understand it, and have questions answered before being asked to provide consent
- Reviews the child's best possible medication history (BPMH)
- Recognizes the colonial structures that impede and bias many modes of communication within health care practices
- If applicable, discusses strategies for minimizing and managing procedure-related pain, including the potential benefits and harms of each option
- Documents all required information in the child's health record

- 4.1.2 The team co-develops an individualized care plan with the child and family, to address the child's unique pain management needs.

Guidelines

The individualized care plan is co-developed following a process of shared decision making with the child and family. Individualized care plans improve the quality and equity of pain management, and reduce the likelihood of the child and family needing to access emergency services for pain-related reasons.

To ensure the care plan is based on the child's needs, goals, abilities, and preferences:

- It is critical the team fosters safe spaces for open dialogue about appropriate strategies (e.g., physical, psychosocial, and pharmacological—including traditional and alternative medicine), to manage the child's pain.
- The child and family are encouraged to actively participate in the discussion to inform the individualized care plan and are provided information about appropriate strategies in a way that is easy to understand and tailored to the child and family's literacy level, language, and culture.
- Trusting relationships are built in a safe space, tapping into the cultural characteristics of connectedness and resilience.

The resulting individualized care plan and adjustments made in response to the chosen pain management strategies are documented in the child's health record.

- 4.1.3 The team reviews potential additional costs not covered by the health system with the child and family, following a shared decision making process.

Guidelines

Co-development of the child's individualized care plan uses a process for shared decision making, which includes reviewing possible out-of-pocket costs to the family for pain management services.

Children and families face direct and indirect costs associated with pain management, such as the cost of accessing (parking, transportation), physical therapy or psychosocial health care professionals, medications and other interventions, and lost work hours. This may also depend on their health insurance situation.

For families, understanding the implications of specific pain management decisions related to needing to take time off work or the caregiving burden, for example, can help them make decisions or prepare for these implications. Some pain management strategies may not be covered by the child and family's public or private insurance provider. It is important for families to understand cost implications associated with a specific pain management strategy, and if changes to the strategy can be made to reduce costs to the family while still achieving the same health outcomes for the child.

- 4.1.4 The team includes care transition planning as an integral part of the child's individualized care plan, in accordance with organizational procedures.

Guidelines

Many families of children who require coordinated pain management often indicate there is a burden placed on them to coordinate care both internal and external to organizations.

Continuity of care is improved when the team is proactive and when the child and family actively and meaningfully participate in care transition planning and preparation and have comprehensive information about transitions in care.

Discussing care transitions helps all team members understand the process, provides an opportunity to ask questions, and helps ensure information is accurate and complete and the child's and family's wishes are respected.

The care transition plan is co-developed with the child and family through a process of shared decision making. Once complete, the care transition plan is communicated in writing to:

- The child and family
- Internal and external teams that are providing care to the child

The care transition plan should include:

- The child’s full name and other identifiers
- The child’s individualized care plan, including pain management strategies used, goals of care, and safety concerns
- Reason for discharge and an assessment of the child’s risk for readmission
- Signs or symptoms of declining health status
- If applicable, an opioid tapering and discontinuation plan
- Contingency plans to be implemented, and by whom, if the child experiences pain flares
- Contact information for the community health care professionals if the child’s strategies for pain management are no longer effective post-discharge
- Follow-up appointments, referrals to community-based services, and pain self-management strategies
- If applicable, information about allergies, medications, diagnoses, test results, medical procedures, and advance directives
- Indirect support needs related to issues such as transportation, food, or parking

The care transition plan for Indigenous children should be shared in writing with relevant community health centre(s). The care transition plan is also communicated to:

- Indigenous hospital liaison/navigator
- Hospital discharge coordinator

5 Make Pain Better: Multimodal Pain Management Strategies

5.1 The team uses a multimodal approach to manage acute and chronic pain, including physical, psychosocial, and pharmacological strategies.

5.1.1 The team uses physical strategies to manage the child’s pain.

Guidelines

Physical strategies can be used to address the child’s pain and improve function. They can also help maintain strength, mobility, or range of motion, and prevent pain progression.

To choose the most appropriate physical strategies and maximize the potential benefits, the team considers the needs, abilities, and preferences of the child and family.

Psychosocial strategies may reduce distress and help enhance the child’s engagement in physical strategies.

Acute pain	Chronic pain
<ul style="list-style-type: none"> • Breastfeeding, oral sucrose, and/or kangaroo care for infants • Comfort positioning, facilitated tucking, or touch • Techniques to reduce stimulation, such as minimizing harsh lighting and/or noise • Joint and tissue protection and positioning strategies such as braces, splints, and/or orthotics, and seating assessment • Assistive or adaptive devices • Mobility aids • Thermal applications 	<ul style="list-style-type: none"> • Goal setting and gradual return to functioning • Physical activity or exercise • Passive movement or positioning for children unable to self-mobilize • Culturally informed healing practices (e.g., equine-assisted therapy, pow wow dancing, crafting) • Energy conservation • Joint and tissue protection and positioning strategies such as braces, splints, and/or orthotics • Assistive or adaptive devices • Mobility aids • Manual therapies such as joint mobilization and/or massage

<ul style="list-style-type: none"> • Manual therapies such as joint mobilization and/or massage • Transcutaneous Electrical Nerve Stimulation (TENS) <p>Restraining or holding children down during potentially painful medical interventions is unethical and increases distress, pain, and trauma for children and families.</p>	<ul style="list-style-type: none"> • Thermal applications • Desensitizing techniques such as vibration or constant pressure
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Educating the child and family about the potential benefits of physical treatments including traditional and alternative pain management strategies and how to conduct them safely helps the child and family manage pain at home and in community settings.

5.1.2 The team uses psychosocial strategies, including traditional medicine or ceremonial practices, to manage the child’s pain.

Guidelines

Psychosocial strategies can be used to address the child’s pain and improve function. They can also help address the significant impact of pain on distress and mental health, peer and family relationships, and sleep. Psychosocial strategies may reduce the need for additional or higher-risk pharmacological pain treatments. They can also enhance the child’s engagement in physical strategies.

To choose the most appropriate psychosocial strategies and maximize the potential benefits, the team considers the needs, abilities, and preferences of the child and family. Some psychosocial strategies may be viewed as less desirable or unwelcome in the context of certain religions and cultures.

Acute pain	Chronic pain
<ul style="list-style-type: none"> • Distraction • Guided imagery • Relaxation • Positive language and reinforcement • Memory reframing • Cognitive strategies • Medical hypnosis • Traditional medicine or ceremonial practices, such as smudging ceremonies for certain Indigenous children and families who may ask to have this practice accommodated • Music (singing, listening, playing instruments) <p>The use of phrases such as “don’t worry” and “you’re okay” as repeated reassurance is associated with increased distress during an acutely painful procedure. Distraction and/or praising the child’s use of other psychosocial strategies as listed above can be more effective.</p>	<ul style="list-style-type: none"> • Pain science education • Psychoeducation • Mindfulness • Guided imagery • Relaxation • Cognitive strategies • Goal setting and a gradual return to functioning • Traditional medicine or ceremonial practices, such as smudging ceremonies for certain Indigenous children and families who may ask to have this practice accommodated • Music (singing, listening, playing instruments) <p>Children with chronic pain are at higher risk than their peers for mental health disorders, including anxiety, depression, post-traumatic stress disorder, and substance use.</p>

Providing information to the child and family about the availability and potential benefits of psychosocial strategies delivered virtually, such as online self-management and virtual individual or group appointments or, and how to access them helps the child and family manage pain at home and in community settings.

5.1.3 The team uses pharmacological strategies to manage the child's pain.

Guidelines

Pharmacological strategies (e.g., medications) to minimize the child's experience of pain can be preventive or therapeutic. However, medications are often not curative or pain eliminating, and providing the child and family with this information will help manage expectations and can lead to improved treatment adherence and effectiveness of the medication.

To choose the most appropriate pharmacological strategies and maximize the potential benefits, the team considers the needs, abilities, and preferences of the child and family, in addition to an understanding the underlying pain mechanism and clinical judgement.

Acute pain	Chronic pain
<ul style="list-style-type: none"> • Local or topical analgesics • Non-steroidal anti-inflammatory drugs (NSAIDs) including COX-2 inhibitors • Acetaminophen • Adjuvant analgesia (e.g., anticonvulsants, antidepressants, N-methyl-D-aspartate (NMDA) antagonists such as ketamine) • Opioids 	<ul style="list-style-type: none"> • Local anesthetics • NSAIDs including COX-2 inhibitors • Acetaminophen • Adjuvant analgesia (e.g., anticonvulsants, antidepressants, NMDA antagonists such as ketamine) • Opioids <p>Medical cannabinoids: There are promising findings from studies in adults that suggest cannabinoids may have a place in treating chronic pain, but there is little research to directly support the use of cannabinoids to treat pediatric chronic pain at this time. However, as there is currently no absolute contraindication to use in this age group, authorized prescribers must use their evidence-informed clinical judgement to weigh the potential benefits and harms on a case-by-case basis.</p> <p>There is limited direct evidence evaluating pharmacological strategies for chronic pain in children.</p>

The child and family are considered active partners in the management of the child's medications and provided with information about the medications in a format and language they understand.

As part of quality pain management, all medications prescribed to the child, including those prescribed for pain management, are regularly reviewed by the team. The child and family are encouraged to keep an up-to-date medication list and share it, as appropriate, with the team.

5.1.4 The team discusses information about safe medication use with the child and family.

Guidelines

Given the role of family in dispensing medication to the child, informing the child and family about safe medication use is crucial for harm prevention and reduction, and to improve treatment adherence and effectiveness.

At a minimum, the team provides the child and family with information about:

- Potential side effects the child may experience, and how to manage common side effects
- Safe storage and disposal
- Safe administration, tapering, and discontinuation
- Signs of overdose and oversedation

In addition, the team also provides the following information to the child and family if opioids are prescribed as co-therapy for managing the child's pain:

- Resources and instructions for how to safely dispose of unused medications
- Potential benefits and harms of opioids as a co-therapy in the context of shared decision making
- Symptoms of opioid misuse or opioid use disorder

5.1.5 The team assesses the child and family for risk of opioid misuse or opioid use disorder to identify if individualized supports are needed prior to prescribing opioids.

Guidelines

Opioids should never be withheld in situations where they are clinically indicated. When a child with risk factors for opioid misuse or opioid use disorder requires opioids to manage their pain, the team should provide additional support to facilitate safe use of opioids, which may include:

- Referral to or consultation with other internal or external healthcare professionals involved in the child's care, including offering psychosocial support.
- Modified prescribing or dispensing schedules to optimize benefits and minimize potential harm or burden to families, with timely monitoring by the authorized prescriber.
- Co-prescribing naloxone when opioids are prescribed as co-therapy for chronic pain, and providing education on the use of naloxone as a harm reduction approach, although evidence on the benefits of this practice has not been established.

Documentation of the child's individualized care plan is essential for communication among team members, to support better transitions in care and to evaluate the impact of pain management. The team documents strategies and supports identified to facilitate safe use of opioids.

Identifying risk factors associated with opioid misuse or opioid use disorder includes both the child and family, in the context of shared decision making. Risk factors include the child's mental health status and past child and/or family history of:

- Substance use (non-opioid prescription or non-prescription medications)
- Opioid misuse or opioid use disorder

The authorized prescriber must have information assessing the child and family's risk for opioid misuse or opioid use disorder as part of quality pain management. However, there are currently no valid measures to identify children who are at greatest risk for opioid misuse, opioid use disorder, or overdose prior to first prescribed opioid exposure. As such, teams must rely on clinical judgment with consideration of the following:

- Screening tools for opioid risk have been developed, but these rely heavily on a child or family's history of opioid misuse or opioid use disorder and are not predictive.
- No screening tool is sufficiently accurate to be used as the sole method of identifying risk factors for opioid misuse or opioid use disorder.
- The opioid risk assessment process should consider the potential influence that conscious and unconscious bias (e.g., based on race, gender, socio-economic status, or other similar factors), racism, and colonialism may have on the assessment.

5.1.6 The team uses opioids as co-therapy to manage the child's pain when indicated.

Guidelines

Opioids can be used as a co-therapy for managing moderate-to-severe pain in children. The goal of using opioids is to obtain pain relief. When used correctly, opioids are safe and effective.

Most pain can be successfully managed using a combination of physical, psychosocial, and non-opioid pharmacological strategies. Opioids should not be routinely prescribed for pain in children unless physical, psychosocial, and non-opioid pharmacological strategies are therapeutically inadequate.

The team should be sensitive to and consider potential conscious and unconscious biases (based on race, gender, socio-economic status, or other similar factors) when prescribing opioids for pain management.

Acute pain	Chronic pain
<ul style="list-style-type: none"> • Use the lowest effective dose of the most appropriate opioid for the shortest duration necessary for managing the child's pain. Typically, a duration of three days or less is required for uncomplicated procedures or injuries. • For children who regularly take opioids, consider the risk of long-term opioid use and tolerance when prescribing opioids for acute pain. • Communicate and coordinate care with the clinicians prescribing the child's long-term opioids, and create a plan to taper to the original dose. • Plan for discontinuation, safe storage and disposal, and tapering if needed. 	<ul style="list-style-type: none"> • Set goals with the child and family for pain management and improved functioning for the child to guide ongoing opioid therapy. • The need for ongoing opioid therapy should be guided by an understanding of pain mechanism and whether opioids are appropriate. • Do not use mandatory deprescribing, as deprescribing should be done in the context of shared decision making with the child and family. • If there is a need for long-term opioid use for chronic pain, establish a clear plan that identifies a single prescriber (only one person) and includes regular follow-up (monitoring symptoms and function), communication and record keeping.

6 Make Pain Matter: Continuous Quality Improvement for Pediatric Pain Management

6.1 The organizational leaders and teams demonstrate an ongoing commitment to quality improvement in pediatric pain management.

6.1.1 The organizational leaders have dedicated resources for pediatric pain management quality improvement activities.

Guidelines

Quality improvement is a systematic and structured team effort to achieve measurable improvements in care delivery, experiences, and outcomes.

The organizational leaders and teams identify pediatric pain management quality improvement priorities that align with the pediatric pain management framework and guided by organizational vision, mission, and values. The organizational leaders ensure pediatric pain management quality improvement initiatives are supported with protected time, resources, and information systems to collect the data needed to implement quality improvement activities. Elements of quality improvement plan should link to key areas of the pediatric pain management framework including:

- Organizational policies for pediatric pain management
- Resources and leadership commitment
- Education and training

- Access to and consistent use of validated tools for pain assessment
- Process for reporting untreated, unmanaged pediatric pain as patient safety incidents
- Documentation and communication

The organization recognizes and engages with teams comprising health care professionals, children and families, and quality improvement champions who have the experience, expertise, and support or are provided with the information and assistance needed to engage in quality improvement activities.

Organizational leaders may use a variety of methods to effectively engage with children and families in quality improvement activities, including identifying opportunities for improvement and co-designing solutions, for example:

- Convening focus groups or interviews on children's and families lived experience of pain management
- Setting up feedback kiosks
- Having conversations with children and families at the point of care related to pain management
- Collecting feedback upon completion of care or service
- Engaging children and families to co-design improvements

Aggregated data collected through surveys, ongoing feedback from teams, observational audits, and surveillance data, as well as quantitative data collected from documentation and reports, are used to inform the plans.

The organizational leaders encourage teams to develop a quality improvement plan by setting improvement aims, establishing measures, selecting and testing changes and actions, and implementing, sustaining, and spreading successful change strategies, using rapid improvement cycles.

The organizational leaders ensure teams engage in quality improvement activities that address pediatric pain management quality of care and enable a knowledgeable and competent workforce.

6.1.2 Teams participate in a quality improvement plan for improving quality of care related to pediatric pain management.

Guidelines

The systematic, continuous collection of information, including feedback from teams can support the organization in improving the quality of care related to pediatric pain management. including the implementation of the pediatric pain management framework.

Teams are equipped by the organizational leaders to use a quality improvement plan to set aims, measures, and actions for improving children's pain management quality of care that:

- Prevents untreated/unmanaged preventable pain for children,
- Engages the child and family actively in decision-making as essential team members throughout the continuum of care,
- Fosters trustful relationships including those with children and families and the workforce, and
- Provides teams with the relevant validated tools and resources for pediatric pain management across the continuum of care.

Teams are supported by organizational leaders to collect a variety of quantitative and qualitative data on pediatric pain management. Data sources may include child's individualized care plans, day-to-day interactions with children and families, annual quality-of-care surveys, safety incident reports, or committee activities.

Examples of pediatric pain management quality of care indicators include, but are not limited to:

- Wait times for outpatient pain management services
- Type of information shared in care transitions plans and at transfers of care

- Reported patient safety incidents of untreated/unmanaged pain
- Reported experience measures
- Documented use of pain assessment tools, pain intensity scores, and evidence to guide decision-making
- Adherence to organization-wide procedures for pediatric pain management
- Completion of required education and training
- Number of pediatric pain management consultations provided to external organizations

Aims, measures, actions, and outcomes to improve pediatric pain management quality of care are documented in the quality improvement plan and comply with jurisdictional requirements. Quality improvement actions that demonstrate positive change are implemented, sustained, and spread.

6.1.3 The organizational leaders have a quality improvement plan to enable a knowledgeable and confident workforce.

Guidelines

Data on the workforce and feedback on their core- and equity-oriented pain management education help the organizational leaders understand the needs of the workforce and identify actions to support their knowledge and confidence.

The organizational leaders collect quantitative and qualitative data on the workforce and their professional development to set aims, measures, and actions for improving the knowledge and competencies of the workforce that:

- Demonstrate improved competencies of the workforce through ongoing learning opportunities;
- Promote a respectful, compassionate, and equity-informed culture;
- Provide the workforce with consistent and supportive leadership; and
- Increase workforce confidence with regard to pediatric pain management service excellence;

Actions to enable a knowledgeable and confident workforce are documented in the quality improvement plan and comply with jurisdictional requirements.

6.1.4 The organizational leaders include patient safety incidents for preventable, untreated or unmanaged pain as a component of organizational quality improvement initiatives.

Guidelines

Patient safety incident reporting means collecting incident data with the goal to improve patient safety and care quality.

In accordance with jurisdictional requirements for patient safety incident management, organizational leaders produce incident reports to assist the organization and teams to address factors contributing to pain-related patient safety incidents. Data collected helps organizational leaders identify:

- Contributing factors to guide future development of strategies and interventions to mitigate and reduce the risk of exposing children and families to potential harm.
- Potential barriers to quality and equitable pediatric pain management, and as necessary, enables information to be shared with provincial or territorial governments.

- 6.1.5 The organizational leaders communicate pediatric pain management quality improvement outcomes to the community.

Guidelines

Communicating the results of quality improvement activities to all involved in care—including the child and family, other members of the team, and the broader community—builds trust, promotes transparency, and demonstrates the organizational leaders' and the teams' commitment to providing high-quality and safe care. Communicating the results of pediatric pain management quality improvement initiatives is essential to successfully move towards a culture of safe, equitable, and quality pediatric pain management.

The results of quality improvement activities are shared in a timely manner and in a format that is clear and appropriate for each audience.

The organizational leaders ensure the communication of quality improvement outcomes complies with jurisdictional requirements.

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Annex A (Informative)

Core Pediatric Pain-Related Competencies

Pain in general	Biopsychosocial conceptualization of pain Mechanisms and neurobiology of pain Development of children’s pain perception and communication (social, cultural, cognitive, biological, emotional/affective, behavioural) Goals and purposes of pediatric pain prevention, pain assessment, and pain treatment Strategies to prevent acute, procedural, and chronic pediatric pain
Pain management strategies and care planning	The rationale for, the evidence to support, and implementation of multimodal approaches to pain management (i.e., physical, psychosocial, and pharmacological) Evidence-informed treatment approaches Child and family participation in shared decision making Tailored approaches that are contextualized based on child-specific factors (e.g., developmental level, emotional functioning) and social and family factors (e.g., historical trauma [Indian residential schools], adverse childhood experiences and settings) Child- and family-friendly written and verbal communications that use plain language, are adapted to children’s developmental abilities, and are available in the language understood by the child and family Realistic goals and expectations related to children’s pain and pain management, especially when the outcome of pain management is uncertain Pain-related peer support for children and families
Health equity	Implicit bias Impact of racism on pediatric pain management–related health inequities Short- and long-term impacts of pain treatment on specific populations Impacts of social determinants of health on children’s pain and pain management, including seeing pain through a cultural lens and adverse childhood experiences Cultural safety and humility training to improve understanding of a child and family’s culture and how it might influence their experience of care; their trust in the healthcare system; their expressions of pain; and traditional remedies and foods that may be incorporated, as desired, into a comprehensive pain management plan The relationship between adverse childhood experiences and pediatric pain Trauma- and violence-informed care Integrative health care or integrative medicine Traditional medicine Complementary or alternative medicine
Comprehensive assessment and reassessment	Comprehensive pain assessment that considers pain and its impact on function Evidence-informed pain assessment tools, including pain scales, child self-report, and behavioural observation by the team Cultural and language-based tools relevant to the child and family
Safety	Administration, storage, and disposal of medications used to manage pediatric pain

Annex B (Informative)

Components of a Comprehensive Pain Assessment and Reassessment

Comprehensive pain assessments:

- Are streamlined and straightforward so children and families are not required to repeat information to multiple team members, to avoid triggering and re-traumatizing children and families
- Are tailored to the family and the developmental capacity of the child (e.g., type of tools, language used) to enable a meaningful partnership for the child’s pain management
- Include a dedicated place in the child’s health record for documentation about the assessment
- Allocate sufficient time for assessment or reassessment, and documentation
- Are culturally informed, anti-racist, and follow trauma- and violence-informed care practices

Following the initial comprehensive pain assessment, the team regularly reassesses clinically relevant aspects of the child’s pain to monitor the child’s recovery, health status, and effectiveness of treatment.

A comprehensive pain assessment may include the following:

<p>Pain history</p>	<p>Verbal and non-verbal expression of pain relative to factors such as culture and developmental abilities Cause(s) of pain (e.g., illness/disease, medical procedures) Pain location(s) Pain intensity Pain onset and duration Pain frequency Pain quality (e.g., words used to describe the pain such as stabbing, throbbing, sharp) Impact of pain on functioning (e.g., emotional and physical functioning, sleep, social and family functioning, school functioning) Alleviating factors (i.e., factors associated with decreased pain) Triggering factors (i.e., factors associated with the onset of pain) Exacerbating factors (i.e., factors associated with increased pain) Information or observations from the family that they deem relevant to the child’s pain Source of the pain assessment (e.g., child self-report, name of the team member who observed the child’s behaviour) Understanding how the child and family define pain Pain management strategies used in the past or currently to treat pain and the perceived efficacy</p>
<p>Physical health</p>	<p>Physical exam, which may include a dental exam if appropriate Health status and history Allergies Nutritional status (eating, feeding history)</p>

	<ul style="list-style-type: none"> Palliative care needs Dietary needs Sleep behaviour Use of adaptive equipment
<p>Psychosocial elements</p>	<ul style="list-style-type: none"> Functional and emotional status Family involvement Communication and self-care abilities and strengths Mental health status, including personality and behavioural characteristics Environment (e.g., home, hospital, other) Cognitive status Fear of pain and treatment-related fear Past negative pain experiences or trauma (including cultural or historic trauma) Socioeconomic status Cultural and spiritual beliefs and needs Recent stressors Past history of medication abuse

Users of this standard can refer to Solutions for Kids in Pain (SKIP) knowledge mobilization network as a resource for evidence-based best practices for pediatric pain management. Visit their website for more information www.kidsinpain.ca

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