

## C The voice of babies and non-speaking children about their healthcare needs in a hospital setting

### 11 How infants<sup>1</sup> and non-speaking children are involved in decision-making about their healthcare needs in emergency departments that treat children.

When an infant or non-speaking child presents with their parents or carers at the Emergency Department, the triage nurse will assess the infant or child using the following steps:

1. Take a history or account of the problem from the parent/guardian. The nurse will also ask the parent/carer if they think the child is in pain or uncomfortable.
2. Assess the vital signs of the infant or child.
3. Use the r-FLACC Scale [(F) Face, (L) Legs, (A) Activity, (C) Cry, (C) Consolability], a behavioural observational pain scale tool, to analyse the behaviour of the infant or non-speaking child and determine if she/he is calm, comfortable, responsive and alert. This scale is used for children up to six years of age and children with cognitive impairment<sup>xxv</sup>.

<b>(REVISED) FLACC Scale SCORING</b>			
<b>Categories</b>	<b>0</b>	<b>1</b>	<b>2</b>
Face	No particular expression or smile.	Occasional grimace or frown, withdrawn, disinterested, Sad, appears worried.	Frequent to constant quivering chin, clenched jaw, distressed looking face, expression of fright/panic.
Legs	Normal position or relaxed; usual tone and motion to limbs.	Uneasy, restless, tense, occasional tremors.	Kicking, or legs drawn up, marked increase in spasticity, constant tremors, jerking.
Activity	Lying quietly, normal position, moves easily, regular, rhythmic respirations.	Squirming, shifting back and forth, tense, tense/guarded movements, mildly agitated, shallow/splinting respirations, intermittent sighs.	Arched, rigid or jerking, severe agitation, head banging, shivering, breath holding, gasping, severe splinting.
Cry	No cry (awake or asleep)	Moans or whimpers: occasional complaint, occasional verbal outbursts, constant grunting.	Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting.
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to: distractible.	Difficult to console or comfort, pushing caregiver away, resisting care or comfort measures.
Each of the five categories (F) Face; (L) Legs; (A) Activity; (C) Cry; (C) Consolability is scored from 0-2, which results in a total score between zero and ten.			
References: Merkel, S. <i>et al.</i> The FLACC: A Behavioural Scale for Scoring Postoperative Pain in Young Children, <i>Pediatric Nurse</i> 23(3): 293-297, 1997. Copyright: Jannetti Co. University of Michigan Medical Centre. Malviya, S., Vopel-Lewis, T. Burke, Merkel, S., Tait, A.R. (2006). The revised FLACC Observational Pain Tool: Improved Reliability and Validity for Pain Assessment in Children with Cognitive Impairment. ( <i>Pediatric Anesthesia</i> 16: 258-265).			

<sup>1</sup> Children under the age of 1 year are referred to as 'infants' in paediatric medical practice.

4. The triage nurse assigns a score for each category of the infant or child's behaviour and enters these scores into the triage computer system.
5. If the infant or child has a total score of 7-10, she/he is assigned a Category 2 rating, which means the infant or child will be seen by a doctor in under 10 minutes.
6. If the infant or child has a total score of 4-6 and there are no additional concerns, she/he is assigned a Category 3 rating, which means the infant or child will be seen by a doctor within one hour.
7. If the infant or child has a total score of 0-3 and there are no additional concerns, she/he is assigned a Category 4 rating, which means the infant or child will be seen by a doctor within two hours.

### **How the r-FLACC Scale enables infants and children to be given Space, Voice, Audience and Influence on decisions about their care in emergency departments in Irish hospitals**

#### **Space**

- Infants and non-speaking children can feel safe to show how they feel because they are being assessed on the basis of their own actions and behaviour, on what their parents or guardians tell the triage nurse and on their vital signs.
- The nurse is listening to and observing all aspects of the child's behaviour by using the r-FLACC Scale.
- Every infant and non-speaking child is assessed by using the r-FLACC Scale.

#### **Voice**

- The triage nurse is supporting infants and non-speaking children to show how they feel by taking their actions and behaviour seriously.
- Infants and non-speaking children can act, react and behave in whatever way they feel while the nurse is assessing them using the r-FLACC Scale.
- Infants and non-speaking children can show how they feel in many different ways, crying, screaming, arching, kicking, smiling, being relaxed or calm, showing no expression and other ways.

#### **Audience**

- The triage nurse shows that she/her is ready and willing to take the actions and behaviour of the infant or non-speaking child seriously by using the r-FLACC Scale to assess their voice (how they feel).

## Influence

- Infants and non-speaking children have significant influence on decisions being made about their healthcare needs, because the triage nurse uses the r-FLACC Scale to determine how urgently they need to be seen by a doctor, who administers and advocates for the child to be given analgesia.
- Infants and non-speaking children and their parents/guardians are given feedback on how soon they will be seen by a doctor on the basis of the r-FLACC Scale rating assigned to the infant or non-speaking child.
- Once the infant or non-speaking child is seen by a doctor, decisions about further treatment for the child will be explained to the parents/guardians.
- The r-FLACC Scale tool is also used to reassess children to ensure analgesia is effective and they are more comfortable.

