

# Assessing Children's Pain Pain intensity assessment tools

This handout explains the four pain scales that are used at Seattle Children's. **Developmental level determines which scale is most appropriate.** Use age only as a guide.

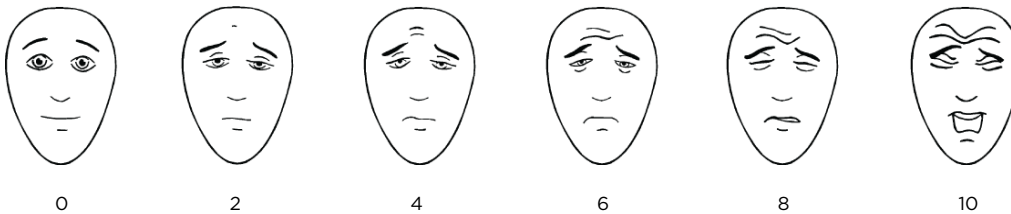
## 0-10 SCALE for children over age 7

On a scale of 0 to 10, with '0' being no pain and '10' being the worst pain you can imagine, what number are you feeling right now?

0 ..... 10  
No pain ..... Worst pain

## FACES PAIN SCALE - REVISED (FPS-R) for children over age 3

Point to the face that shows how much you hurt.



These faces show how much something can hurt. The left-most face shows no pain. The faces show more and more pain up to the right-most face - it shows very much pain.

## FLACC PAIN RATING SCALE for children 1 to 3 years of age

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

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	No expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin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

## N-PASS NEONATAL PAIN, AGITATION AND SEDATION SCALE for infants less than 1 year

The Neonatal Pain, Agitation, and Sedation Scale (N-PASS) is a pain assessment scale used for infants. The clinical team will partner with you to assess your child in each of the five categories; add together and document total pain score (0 to 10) and total sedation score (0 to -10) as appropriate.

**Premature pain assessment: +1 if less than 30 weeks/corrected age.**

Assessment Criteria	Sedation		Sedation/Pain	Pain/Agitation	
	-2	-1	0/0	1	2
<b>Crying Irritability</b>	No cry with painful stimuli	Moans or cries minimally with painful stimuli	No sedation No signs of pain	Irritable or crying with breaks Can be comforted (consolable)	High-pitched or silent-continuous cry Cannot be comforted (inconsolable)
<b>Behavior</b>	No waking up to stimuli No movement	Wakes up minimally to stimuli  Little movement	No sedation No signs of pain	Restless, squirming Wakes up often	Arching, kicking Constantly awake or wakes up minimally No movement (not sedated)
<b>Facial Expression</b>	Mouth is relaxed No expression	Minimal expression with stimuli	No sedation No signs of pain	Any pain expression intermittent	Any pain expression continual
<b>Arms and Legs Tone</b>	No grasp reflex Limp (flaccid) tone	Weak grasp reflex Decrease in muscle tone	No sedation No signs of pain	Intermittent clenched toes, fists or fingers spread out (splay) Body is not tense	Continual clenched toes, fists, or fingers spread out (splay) Body is tense
<b>Vital Signs: Heart Rate, Respiratory Rate, Blood Pressure, Oxygen Saturation (SaO2)</b>	No change with stimuli Hypoventilation or apnea	Less than 10% change from baseline with stimuli	No sedation No signs of pain	Increase 10-20% from baseline SaO <sub>2</sub> 76-85% with stimuli - quick increase	Increase greater than 20% from baseline SaO <sub>2</sub> less than or equal to 75% with stimuli - slow increase Out of sync/fighting vent

**Acknowledgements:**

**Faces Pain Scale – Revised (FPS-R)** (2001) Hicks CL, von Baeyer CL, Spafford P, van Korlaar I, Goodenough B. Faces Pain Scale-Revised: Toward a Common Metric in Pediatric Pain Measurement. *Pain* 93:173-183. With the instructions and translations as found on the website: <http://www.usask.ca/childpain/fpsr/>. This figure has been reproduced with permission of the International Association for the Study of Pain® (IASP®). The figure may not be reproduced for any other purpose without permission.

**FLACC Pain Rating Scale** Source: Merkel SI, et al. (1997). Practice applications of research. The FLACC: a behavioral scale for scoring postoperative pain in young children. *Pediatric Nursing* 23(3):293-297.

**N-PASS Neonatal Pain, Agitation and Sedation Scale** © Loyola University Health System, Loyola University Chicago, 2009 (Rev. 2/10/09) Pat Hummel, MA, APN, NNP, PNP. All rights reserved. No part of this document may be reproduced in any form or by any means, electronic or mechanical without written permission of the author. This tool is currently undergoing testing for validity and reliability, and the authors cannot accept responsibility for errors or omission or for any consequences resulting from the application or interpretation of this material.

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This handout has been reviewed by clinical staff at Seattle Children's. However, your child's needs are unique. Before you act or rely upon this information, please talk with your child's healthcare provider.

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