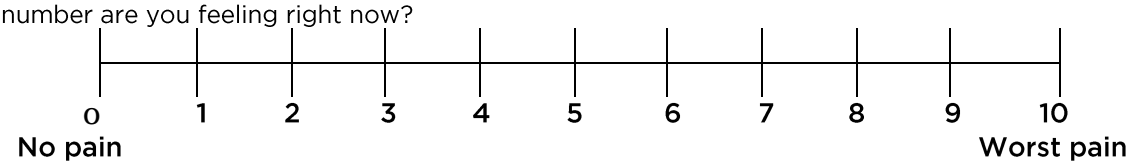
Assessing Children's Pain

Pain intensity assessment tools

This handout explains the five 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?



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 or pre-verbal patients unable to self-report their level of pain. Rate your child in each of the five measurement categories, add together, and document total pain score (0 – 10).

	0	1	2
Face	No expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arches, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	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
Crying Irritability	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)
Behavior	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)
Facial Expression	Mouth is relaxed No expression	Minimal expression with stimuli	No sedation No signs of pain	Any pain expression intermittent	Any pain expression continual
Arms and Legs Tone	No grasp reflex Limp (flaccid) tone	Weak grasp reflex Decrease in muscle tone	No sedation No signs of pain	Occasional clenched toes, fists or fingers spread out (splay) Body is not tense	Continual clenched toes, fists, or fingers spread out (splay) Body is tense
Vital Signs: Heart Rate, Respiratory Rate, Blood Pressure, Oxygen Saturation (SaO2)	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_2 76-85% with stimuli – quick increase	Increase greater than 20% from baseline SaO_2 less than or equal to 75% with stimuli – slow increase Out of sync/fighting vent

r-FLACC (revised FLACC) PAIN RATING SCALE for children with developmental disability unable to self-report their level of pain

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

	0	1	2
Face	No expression or smile	Occasional grimace or frown, withdrawn, disinterested; appears sad or worried	Frequent to constant frown, clenched jaw, quivering chin; distressed looking face; expression of fright or panic Individualized behavior described by family: _____
Legs	Normal position or relaxed; usual muscle tone and motion to arms and legs	Uneasy, restless, tense; occasional tremors	Kicking, or legs drawn up; marked increase in spasticity; constant tremors or jerking; Individualized behavior described by family: _____
Activity	Lying quietly, normal position, moves easily; regular rhythmic breaths (respiration)	Squirming, shifting back and forth, tense or guarded movements; mildly agitated (head back and forth, aggression); shallow, splinting breaths (respirations); occasional sighs	Arches, rigid, or jerking; severe agitation; head banging; shivering (not rigors); breath holding, gasping, or sharp intake of breaths; severe splinting Individualized behavior described by family: _____
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint; occasional verbal outburst or grunt	Crying steadily, screams or sobs, frequent complaints; repeated outbursts; constant grunting Individualized behavior described by family: _____
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or "talking to"; Can be distracted	Difficult to console or comfort; pushing away caregiver; resisting care or comfort measures Individualized behavior described by family: _____

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.

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