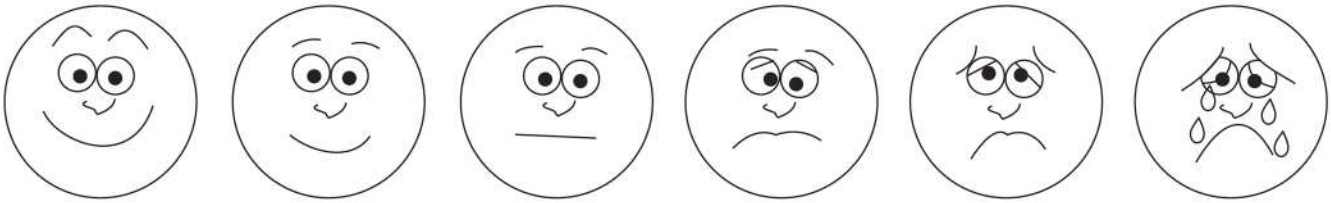
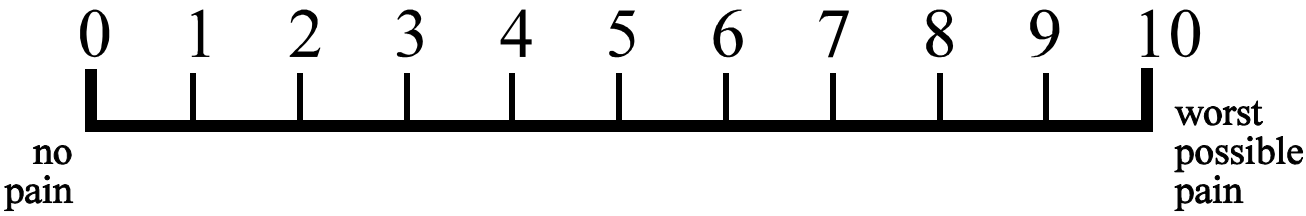
Faces Pain Scale



0	2	4	6	8	10
Very happy, no hurt	**Hurts just a little bit**	**Hurts a little more**	**Hurts even more**	**Hurts a whole lot**	**Hurts as much as you can imagine (don't have to be crying to feel this much pain)**

Visual Analog Scale (VAS)



Pain Assessment of Infants

Pain Score	Degree of Pain	Behavioral Assessment
0	No Apparent Pain	Not Crying, Resting, Calm, Sleeping Relaxed Body Posture Comfortable Without Intervention Within Baseline HR, B/P, Respiratory Frequency & Pattern
1	Uncomfortable	Intermittent Whimpering, Cry, Restlessness, But Able to Sleep Intermittently Tense Muscles Comforts, Calms Self Increase in HR by 5-10 BPM
2	Mild Pain	Whimpering Cry, Moaning, Restless, Irritable, But Able to Sleep Tense Muscles Difficult to Distract and Console, Increase in HR by 10-15 BPM, Periodic Breathing
3	Moderate Pain	Sobbing, Strong, Loud Cry, Continuous Restlessness, Irritability, Sleep Disruption Tense, Rigid Body Only Intermittently Distractible Increase in HR by 15-25 BPM, Increase in BP by 10mm Hg
4	Severe Pain	High Pitched Scream Thrashing, Tremulous Unable to Sleep, Very Still Increase in HR by >25 BPM, Apnea or Tachypnea

Nonverbal Pain Assessment

Items*	0	1	2	Score
Breathing independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respirations.	
Negative vocalization	None	Occasional moan or groan. Low-level speech with a negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.	
Facial expression	Smiling or inexpressive	Sad. Frightened. Frown.	Facial grimacing.	
Body language	Relaxed	Tense. Distressed pacing. Fidgeting.	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.	
Consolability	No need to console	Distracted or reassured by voice or touch.	Unable to console, distract or reassure.	
			Total**	

* Five-item observational tool - see the description of each item below.

Breathing

1. Normal breathing is characterized by effortless, quiet, rhythmic (smooth) respirations.
2. Occasional labored breathing is characterized by episodic bursts of harsh, difficult or wearing respirations.
3. Short period of hyperventilation is characterized by intervals of rapid, deep breaths lasting a short period of time.
4. Noisy labored breathing is characterized by negative sounding respirations on inspiration or expiration. They may be loud, gurgling, or wheezing. They appear strenuous or wearing.
5. Long period of hyperventilation is characterized by an excessive rate and depth of respirations lasting a considerable time.
6. Cheyne-Stokes respirations are characterized by rhythmic waxing and waning of breathing from very deep to shallow respirations with periods of apnea (cessation of breathing).

Negative vocalization

1. None is characterized by speech or vocalization that has a neutral or pleasant quality.
2. Occasional moan or groan is characterized by mournful or murmuring sounds, wails or laments. Groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
3. Low level speech with a negative or disapproving quality is characterized by muttering, mumbling, whining, grumbling, or swearing in a low volume with a complaining, sarcastic or caustic tone.
4. Repeated troubled calling out is characterized by phrases or words being used over and over in a tone that suggests anxiety, uneasiness, or distress.
5. Loud moaning or groaning is characterized by mournful or murmuring sounds, wails or laments in much louder than usual volume. Loud groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
6. Crying is characterized by an utterance of emotion accompanied by tears. There may be sobbing or quiet weeping.

Facial expression

1. Smiling is characterized by upturned corners of the mouth, brightening of the eyes and a look of pleasure or contentment. Inexpressive refers to a neutral, at ease, relaxed, or blank look.
2. Sad is characterized by an unhappy, lonesome, sorrowful, or dejected look. There may be tears in the eyes.
3. Frightened is characterized by a look of fear, alarm or heightened anxiety. Eyes appear wide open.
4. Frown is characterized by a downward turn of the corners of the mouth. Increased facial wrinkling in the forehead and around the mouth may appear.
5. Facial grimacing is characterized by a distorted, distressed look. The brow is more wrinkled as is the area around the mouth. Eyes may be squeezed shut.

Body language

1. Relaxed is characterized by a calm, restful, mellow appearance. The person seems to be taking it easy.
2. Tense is characterized by a strained, apprehensive or worried appearance. The jaw may be clenched (exclude any contractures).
3. Distressed pacing is characterized by activity that seems unsettled. There may be a fearful, worried, or disturbed element present. The rate may be faster or slower.
4. Fidgeting is characterized by restless movement. Squirming about or wiggling in the chair may occur. Repetitive touching, tugging or rubbing body parts can also be observed.
5. Rigid is characterized by stiffening of the body. The arms and/or legs are tight and inflexible. The trunk may appear straight and unyielding (exclude any contractures).
6. Fists clenched is characterized by tightly closed hands. They may be opened and closed repeatedly or held tightly shut.
7. Knees pulled up is characterized by flexing the legs and drawing the knees up toward the chest. An overall troubled appearance (exclude any contractures).
8. Pulling or pushing away is characterized by resistiveness upon approach or to care. The person is trying to escape by yanking or wrenching him or herself free or shoving you away.
9. Striking out is characterized by hitting, kicking, grabbing, punching, biting, or other form of personal assault.

Consolability

1. No need to console is characterized by a sense of well being. The person appears content.
2. Distracted or reassured by voice or touch is characterized by a disruption in the behavior when the person is spoken to or touched. The behavior stops during the period of interaction with no indication that the person is at all distressed.
3. Unable to console, distract or reassure is characterized by the inability to sooth the person or stop a behavior with words or actions. No amount of comforting, verbal or physical, will alleviate the behavior.

**Total scores range from 0 to 10 (based on a scale of 0 to 2 for five items), with a higher score indicating more severe pain (0="no pain" to 10="severe pain").

Adapted from: Warden V, Hurley AC, Volicer L. Development and psychometric evaluation of the pain assessment in advanced dementia (PAINAD) scale. *Journal of the American Medical Directors Association* 2003;4:9-15.

Neonatal Infant Pain Scale
(NIPS)
Ages Birth - One Year

The Neonatal Infant Pain Scale (NIPS) is a behavioral scale and can be utilized with both full-term and pre-term infants. The tool was adapted from the CHEOPS scale and uses the behaviors that nurses have described as being indicative of infant pain or distress. It is composed of six (6) indicators.

- facial expression
- cry
- breathing patterns
- arms
- legs
- state of arousal

Each behavioral indicator is scored with 0 or 1 except "cry", which has three possible descriptors therefore, being scored with a 0, 1 or 2. See the NIPS scale for the description of infant behavior in each indicator group. Infants should be observed for one minute in order to fully assess each indicator.

Total pain scores range from 0-7. The suggested interventions based upon the infant's level of pain are listed below. The difficulty with any tool that is not self-report is the ability to differentiate between pain and agitation, however, the non-pharmacological intervention may help differentiate between these two (i.e. changing the wet diaper, feeding the infant, repositioning, etc.).

Pain Level	Intervention
0-2 = mild to no pain	None
3-4 = mild to moderate pain	Non-pharmacological intervention with a reassessment in 30 minutes
>4 = severe pain	Non-pharmacological intervention and possibly a pharmacological intervention with reassessment in 30 minutes

Pain Assessment Tools
Neonatal/Infant Pain Scale (NIPS)

(Recommended for children less than 1 year old) - A score greater than 3 indicates pain

Pain Assessment		Score
Facial Expression		
0 – Relaxed muscles	Restful face, neutral expression	
1 – Grimace	Tight facial muscles; furrowed brow, chin, jaw, (negative facial expression – nose, mouth and brow)	
Cry		
0 – No Cry	Quiet, not crying	
1 – Whimper	Mild moaning, intermittent	
2 – Vigorous Cry	Loud scream; rising, shrill, continuous (Note: Silent cry may be scored if baby is intubated as evidenced by obvious mouth and facial movement.	
Breathing Patterns		
0 – Relaxed	Usual pattern for this infant	
1 – Change in Breathing	Indrawing, irregular, faster than usual; gagging; breath holding	
Arms		
0 – Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	
1 – Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	
Legs		
0 – Relaxed/Restrained	No muscular rigidity; occasional random leg movement	
1 – Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	
State of Arousal		
0 – Sleeping/Awake	Quiet, peaceful sleeping or alert random leg movement	
1 – Fussy	Alert, restless, and thrashing	