# FLACC scale

## Face, Legs, Activity, Cry, Consolability

| Criteria | Score 0 | Score 1 | Score 2 |
|---|---|---|---|
| **Face** | No particular expression or smile | Occasional grimace or frown, withdrawn, uninterested | Frequent to constant quivering chin, clenched jaw |
| **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 | Arched, 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 being talked to, distractable | Difficult to console or comfort |

Used to measure and assess pain for **children** between ages of two months to seven years or **individuals unable to communicate** their pain.

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# Sedation score

| | |
|---|---|
| Alert, no sedation | **0** |
| Easily roused, **occasionally** sleepy | **1** |
| Easily roused, **frequently** sleepy | **2** |
| Difficult to rouse, deeply sedated | **3** |

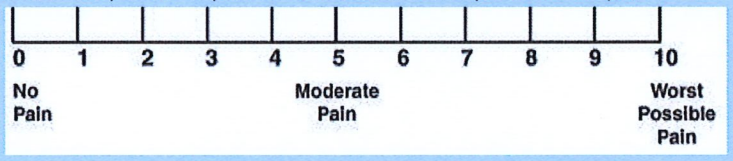
| CRITICAL-CARE PAIN OBSERVATION TOOL | | |
|---|---|---|
| The following pain assessment tool may be used for assessing intubated and nonintubated critically ill adults. It consists of four pain indicator areas scored from 0 to 2, with a total score ranging from 0 to 8. A score above 2 indicates pain.[45] Keep in mind that behavioral pain scales such as this are useful for detecting pain but not for understanding its intensity.[45] | | |
| **Indicator** | **Description** | **Score** |
| Facial expression | No muscular tension observed | Relaxed, neutral — 0 |
| | Frowning, brow lowering, orbit tightening, and levator contraction | Tense — 1 |
| | All of the above plus eyelid tightly closed | Grimacing — 2 |
| Body movements | Doesn't move at all (doesn't mean absence of pain) | Absence of movements — 0 |
| | Slow, cautious movements, touching, or rubbing pain site, seeking attention through movements | Protection — 1 |
| | Pulling tube, attempting to sit up, moving limbs/thrashing, not following commands, striking at staff, trying to climb out of bed | Restlessness — 2 |
| Muscle tension (evaluate by passive flexion and extension of upper extremities) | No resistance to passive movements | Relaxed — 0 |
| | Resistance to passive movements | Tense, rigid — 1 |
| | Strong resistance to passive movements; inability to complete them | Very tense or rigid — 2 |
| Compliance with the ventilator (intubated patients) | Alarms not activated, easy ventilation | Tolerating ventilator or movement — 0 |
| | Alarms stop spontaneously | Coughing but tolerating — 1 |
| | Asynchrony; blocking ventilation, alarms frequently activated | Fighting ventilator — 2 |
| **OR** | | |
| Vocalization (nonintubated patients) | Talking in normal tone or no sound | Talking in normal tone or no sound — 0 |
| | Sighing, moaning | Sighing, moaning — 1 |
| | Crying out, sobbing | Crying out, sobbing — 2 |
| **Total score** | | |
| Reprinted with permission from: Stites, M. (2013). Observational pain scales in critically ill adults. Critical Care Nurse, 33, 68–79. Accessed September 2016 via the Web at http://ccn.aacnjournals.org/content/33/3/68.full.pdf+html | | |

## PAIN SCALES

Various pain assessment tools exist. Be sure to choose a facility-approved tool that's appropriate for the patient's condition.

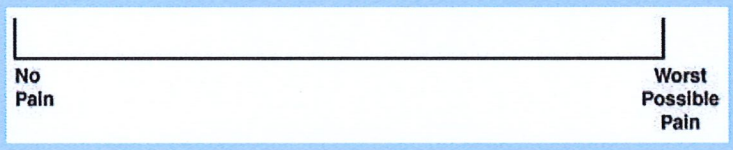
### Numeric Pain Scale

A numeric pain scale is a self-report tool. To use it, the patient must have a concept of numbers and their relationship to each other. The scale can be used vertically or horizontally. The numbers range from 0 to 10, where 0 is no pain and 10 is the worst possible pain. The nurse should ask the patient to pick which number corresponds to his pain level.




### Visual Analog Scale

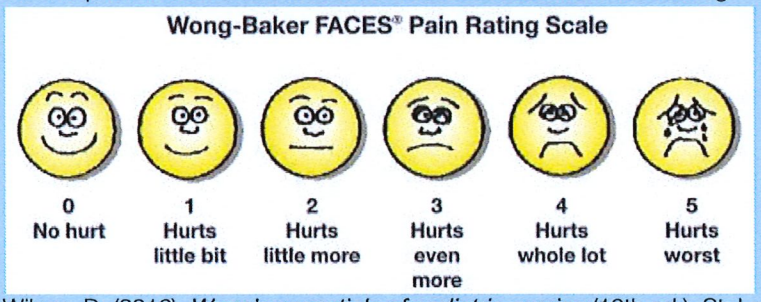
A visual analog scale is a self-report tool that consists of a straight line of a certain length (for example, 10 cm). One end is labeled "No Pain" and the other end is labeled "Worst Possible Pain." The patient marks a line at a place on the scale that best describes his pain. The nurse then measures the distance from the "No Pain" end to the mark that the patient made to determine his pain level. This measurement should be documented and later used to compare subsequent pain levels and evaluate the effectiveness of the pain management plan.




### Wong-Baker FACES Pain Rating Scale

The Wong-Baker FACES Pain Rating Scale can be used with patients who have mild dementia or for those who are unable to understand a numeric pain scale. It's a self-report tool in which the patient points to the face that corresponds to his pain intensity. It can be used with a 0 to 5 or a 0 to 10 scale. Explain to the patient what each face means before having him rate his pain.

To use the FACES scale, explain to the patient that each face represents a person who feels happy because he has no pain or is sad because he has some or a lot of pain. Face 0 is very happy because he doesn't hurt. Face 1 hurts just a little bit. Face 2 hurts a little more. Face 3 hurts even more. Face 4 hurts a whole lot. Face 5 hurts as much as you can imagine, although you don't have to be crying to feel this bad. Ask the patient to choose the face that best describes how he is feeling.




*From* Hockenberry, M. J., & Wilson, D. (2016). *Wong's essentials of pediatric nursing* (10th ed.). St. Louis, MO: Mosby. Reprinted with permission.