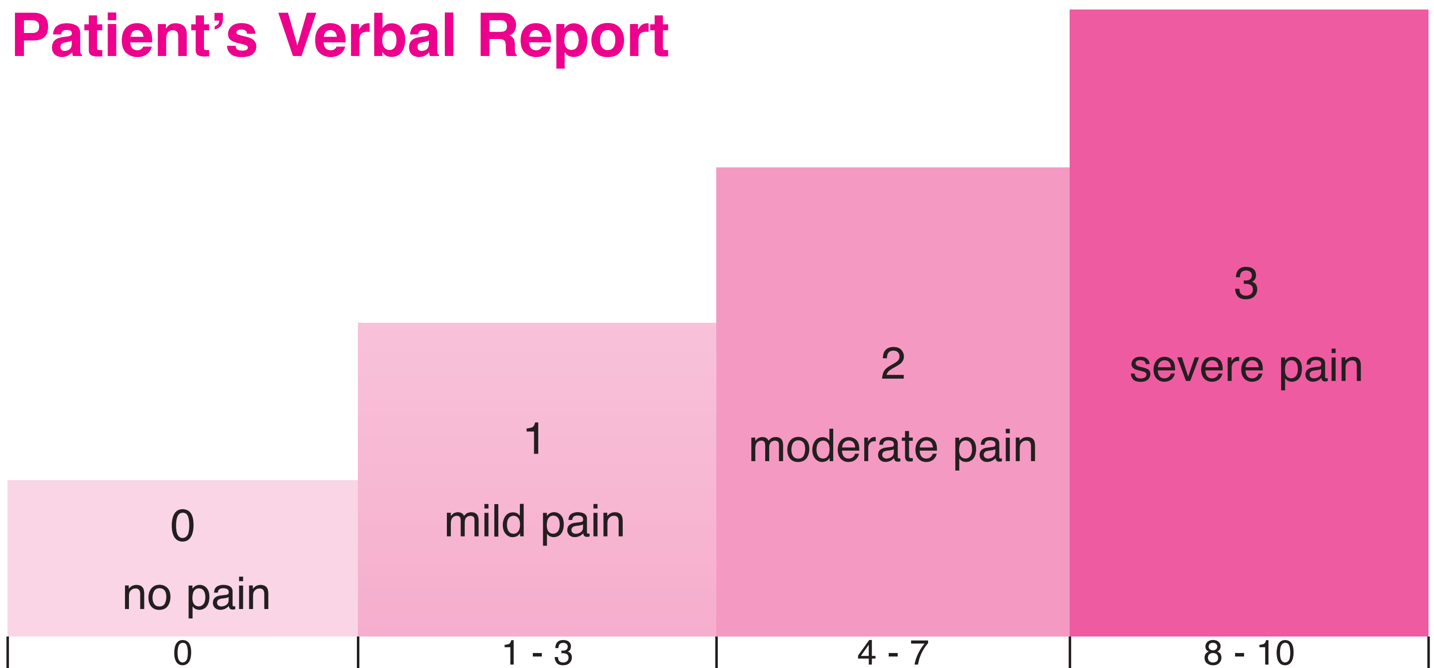
Pain Assessment Tool

Pain is the 5th vital sign

- ✦ Assess pain and document score on TPR chart
- ✦ Please use one of the assessment tools below
- ✦ Self reporting scores are more reliable than behavioural scores
- ✦ Use the most appropriate for the patient
- ✦ Treat if moderate or severe pain. Reassess every 30 mins until resolved
- ✦ If moderate to severe pain persists, patient should be reviewed by medical team and analgesic regime reviewed

Patient's Verbal Report



VAS (Visual analogue Score).

Ask the patient to indicate on the line the severity of their pain.

FLACC Score : non-verbal adults

Categories	Scoring		
	0	1	2
Face	No particular expression or smile, eye contact and interest in surroundings	Occasional grimace or frown, withdrawn, disinterested, worried look to face, eyebrows lowered, eyes partially closed, mouth pursed	Frequent to constant quivering chin, clenched jaw, deep furrows on forehead, eyes closed, mouth opened, deep lines around nose and lips
Legs	Normal position or relaxed	Uneasy, restless, tense, increased tone, rigidity, intermittent flexion/extension of limbs	Kicking, or legs drawn up, hypertonicity, exaggerated flexion/extension of limbs, tremors
Activity	Lying quietly, normal position, moves easily and freely	Squirming, shifting back and forth, tense, hesitant to move, guarding, pressure on body part	Arched, rigid or jerking, fixed position, rocking, side to head movement, rubbing of body part
Cry	No cry / moan (awake or asleep)	Moans or whimpers, occasional cries, sighs, occasional complaint	Crying steadily, screams or sobs, moans, grunts, frequent complaints
Consolability	Calm, content, relaxed, does not require consoling	Reassured by occasional touching, hugging or being talked to. Distractible	Difficult to console or comfort

Assess the five categories: **(F)** Face; **(L)** Legs; **(A)** Activity; **(C)** Cry; **(C)** Consolability. Total score between zero and ten. Evaluate the total using scale parameters.

Pain Team
August 2006

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