



Family Nursing & Home Care

Pain Assessment Policy

May 2024

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Version Control/Changes Made

Date	Version	Summary of changes	Author
August 2020	1	New policy	Lara Deer and Richard Deer
May 2024	2	Reviewed and updated Updated and additional definitions of pain NEWS updated to NEWS2 Director of Governance and Care role added Additional section - pain assessment at the end of life Addition of symptom and care chart Inclusion of WHO analgesic ladder Addition of PAINAD assessment tool FLACC tool updated to Revised FLACC Updating of pain assessment tools Addition of S-LANSS pain scale	Ann Morgan

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1 INTRODUCTION

1.1 Rationale

Pain is one of the most common symptoms for people to seek medical attention, it defies age boundaries but with an increasing aging population the prevalence of co-morbid pain is increasing (Sturesson et al, 2016; Kang and Demiris, 2018). However, despite raised awareness and much research, pain remains significantly underreported as many consider it a normal consequence of aging, yet it is also commonly underestimated and undertreated amongst the paediatric population (Scholfield, 2018; Kang and Demiris, 2018; Bettramini, 2016; Royal College of Emergency Medicine, 2017). Pain has also recognised as a neglected in disabled patients (Twycross et al, 1999). Tatman and Ralston (1997) report assessing pain in children with developmental delay has been identified as difficult.

Pain occurs throughout all clinical settings and, at times, continues to be poorly assessed despite effective assessment being pivotal to optimal management and improving patient outcomes (Motov and Khan, 2008; Royal College of Nurses, 2015; Schofield, 2018). The International Association for the Study of Pain (IASP) Declaration of Montreal (IASP 2010) cites the right of all people with pain to have access to appropriate assessment by adequately trained health care professionals. This is reflected within Royal College of Nurses (RCN) guidance highlighting the assessment and management of pain as essential components of nursing practice (RCN, 2015). The Nursing and Midwifery Council (2018) state that the Registered Nurse should, 'observe and assess comfort and pain levels' and 'take appropriate action to reduce or minimise pain or discomfort.'

There are many short and long-term consequences of inadequately treated acute pain. These include hyperglycaemia, insulin resistance, increased risk of infection, decreased patient comfort and satisfaction, and the development of chronic pain (Reardon et al. 2015).

Uncontrolled pain can lead to increased anxiety, fear, sleeplessness and muscle tension, which further exacerbate pain. It can delay the recovery process by hindering mobilization and deep breathing, which increases the risk of a patient developing a deep vein thrombosis, chest infection or pressure damage. (Schug et al. 2015).

In the long term, poorly controlled acute pain may lead to the development of chronic pain (Shipton, 2014). The consequence of which can lead to an inability to perform normal activities of daily living and a decreased quality of life leading to an increased propensity to anxiety and depression (Gan, 2017; Sinatra, 2010). All of which have an associated individual and societal economic cost.

1.2 Scope

FNHC care for individuals from pre-birth to the end of life. This policy is applicable to all nursing staff involved in this care.

1.3 Role and Responsibilities

1.3.1 The Chief Executive (CEO)

The CEO has overall responsibility for effective management of risk within the organisation. As Accountable officer, the CEO is responsible for the effectiveness of the organisation's systems of internal controls.

1.3.2 Director of Governance and Care

The Director of Governance and Care is responsible for ensuring that there:

- is an up to date pain assessment policy in place
- are systems in place to monitor the use and effectiveness of this policy

1.3.3 Operational Leads

Operational leads have responsibilities for ensuring that the required structures and resources are in place to enable effective pain assessment.

1.3.4 Team Leaders

Team Leaders have responsibility to ensure that all staff are aware of this policy and to encourage and monitor compliance with it. They are responsible for identifying learning needs of the teams.

1.3.5 All Staff

All staff with face to face contact with patients have a responsibility to adhere to this policy within their own level of competency. If/when a scenario is encountered outside their normal remit staff should inform the relevant member of their team for further assessment/management and/or onward referral. All staff must identify and address any learning needs they may have in relation to it.

2 POLICY

During all face to face patient contact, regardless of the care speciality, staff will provide effective pain assessment to inform subsequent pain management. This will be undertaken without discrimination of age, gender, culture or cognitive ability.

2.1 Education, Training and Competence

The policy can be used in conjunction with the key [RCN Pain Knowledge and Skills Framework document \(RCN 2015\)](#). Staff must ensure their knowledge and skills, pertinent to their job role and sphere of practice, are up to date. If necessary, Team Leads should be approached highlighting areas for development so training may be implemented.

3 PROCEDURE

3.1 Documenting Pain Assessment

Self-report is identified as the gold standard for pain assessment (Schofield, 2018; NPC, 2001, Kang and Dimitris, 2018). Many patients with moderate to severe cognitive impairment are able to report pain reliably when prompted (Manz et al., 1998).

Pain assessment is not just about a completion of a scale but needs to explore a patient's pain experience (Schofield, 2018). Utilise a validated pain assessment tool in discussion with the patient and/or family member/carer. Robust documentation of pain assessment improves its management (Sturesson et al, 2016). Record the following:

- Location of pain
- Intensity
- Medication used
- Non-pharmacological methods employed in pain management,
- Impact on daily lives (activities of daily living)
- What level of pain is acceptable
- Psychological impact

Table 1. Pain Assessment Tool Application

	Children < 3 years	Children > 3 years	Adults (including those with moderate to severe cognitive impairment)	Children with moderate to severe cognitive impairment	Advanced dementia
Abbey pain scale					√ Except in advanced cancer pain
Numerical pain rating scale		√	√		
Pain in Advanced Dementia (PAINAD)					√
S-LANSS Pain Score			√		
The Wong-Baker 'Faces' Pain Scale	√	√	√		
The FLACC Scale	√	√ validated for use up to 7 years		√	

3.2 Pain assessment at the end of life

3.2.1 Adult Services

Saunders conceptualised “total pain” in evaluating and managing pain in the dying. The concept of total pain encompasses four components, notably the physical noxious stimuli, emotional discomfort, interpersonal conflicts, and the non-acceptance of one’s own death. To alleviate the discomfort of the dying, all four of these attributes of pain need to be addressed (Ong et al 2005).

Anxiety and depression frequently accompany pain, and addressing this is pivotal to alleviating “total pain.” Failure to address pre-existing anxiety can lead to significant distress at the end of life.

Organic causes of anxiety include:

- a feeling of impending doom in patients with respiratory diseases causing hypoxia and dyspnoea
- cardiac diseases
- electrolyte imbalances
- dehydration
- infection leading to sepsis
- Medications like nebulisation treatments, corticosteroids, anti-emetics

The concept of total pain should guide the discussion, and the history should also focus on the physical and mental well-being. Physical examination includes a head-to-toe assessment for factors that may contribute to pain. Physical signs of pain include facial grimacing, restlessness, tachypnoea as well as tachycardia. (Sinha et al 2023). Utilising a tool that encompasses all these aspects will ensure a holistic approach to pain management at the end of life. See appendix 1 for symptom and care chart for use in last days of life (GSF red).

NICE (2015) recommend to consider non-pharmacological management of pain in a person in the last days of life.

- Be aware that not all people in the last days of life experience pain. If pain is identified, manage it promptly and effectively, and treat any reversible causes of pain, such as urinary retention. See appendix 2 for WHO analgesic ladder.
- Assess the dying person’s level of pain and assess for all possible causes when making prescribing decisions for managing pain.
- Follow the principles of pain management used at other times when caring for people in the last days of life, for example, matching the medicine to the severity of pain and, when possible, using the dying person’s preferences for how it is given.
- For a person who is unable to effectively explain that they are in pain, for example someone with dementia or learning disabilities, use a validated behavioural pain assessment to inform their pain management.

3.2.2 Community Children’s Nurses Team (CCNT)

The CCNT follow the Symptom Management Plan which is updated daily by the Southampton General Hospital Palliative Care Team.

3.3 Pain Assessment Tools

3.3.1 Numerical Pain Rating Scale (NPRS)

The NPRS-11 is an 11-point scale for self-report of pain. It is a quick and easy to use tool that has been validated for numerous pain types e.g. acute, cancer and chronic (NPC, 2001). The tool may be used with most adults and children > 10 years old, and has also been shown to be reliable for mild to moderately cognitively impaired adults, in whom self-report often remains the gold standard (Schofield, 2018).

3.3.2 Pain in Advanced Dementia (PAINAD)

UK National Guidelines (Schofield, 2018) recommend for older people with severe cognitive impairment the use of the following tools; Pain in Advanced Dementia (PAINAD) or Doloplus-2. See appendix 3 for PAINAD tool. This requires observation of the older adult for 3-5 minutes during activity/with movement (such as bathing, turning, transferring).

3.3.3 Abbey Pain Scale

The Abbey Pain Scale (Appendix 4) is a valid tool for assessing pain in stroke patients but not for advanced cancer patients suffering from poor performance status, delirium, drowsiness or unconsciousness (Tegenborg et al., 2023).

As an observational behavioural pain assessment tool it is also appropriate for people with end or late stage dementia using six categories of appraisal to establish the probability the person, unable to articulate, is experiencing pain. It is likely to require the support of family / carers who know the patient for accurate assessment.

3.3.4 The Wong-Baker ‘Faces’ Pain Scale

The Wong-Baker ‘Faces’ pain scale (Appendix 5) is renowned to be the preferred, reliable and valid tool in assessing pain in children aged 3 and above (Walker, Polaner, and Berde, 2019). It ensures that children can be helped to clearly communicate their pain experience to then facilitate that they receive appropriate analgesia (Wong-Baker Foundation, 2016).

The tool is not to be used by anyone other than the patient – it is a self-assessment tool that must be clearly explained before use. It is important to state that to identify their pain with face 10 the patient doesn’t have to be actually crying.

3.3.5 The Revised FLACC (r-FLACC) Scale

The FLACC pain scale is an acronym which identifies 5 standard categories of potential pain behaviour in young children:

- **F**acial expression

- Leg movement
- Activity
- Cry
- Consolability

It has been recognised as a valid and reliable pain assessment tool to assist in quantifying pain in children aged 2 months to 7 years who are unable to verbalise (Voepel-Lewis *et al*, 2010).

The r-FLACC (Appendix 6) is a revision of the original tool which includes additional descriptors and opportunity to individualise the pain behaviour descriptors in collaboration with parents / carers. It has been validated for effective pain assessment of nonverbal children with developmental delays, cognitive impairments and intellectual disabilities as well as young children not able to verbalise pain (Malviya 2006 and Hansen, 2022).

3.3.6 Leeds Assessment of Neuropathic Symptoms and Signs (LANSS)

The LANSS was developed to provide a simple clinical tool that can be used to identify pain of predominantly neuropathic origin, thus distinguishing between neuropathic pain and nociceptive pain. By identifying neuropathic pain mechanisms, more individualised treatment can follow. The LANSS was developed in 2001, and a self-report version, the S-LANSS was developed in 2005 (see appendix 6).

Bennet *et al* (2005) reported validity of a LANSS self- assessment tool. This is in a clinical environment. This policy recommends this tool is used by patients with support of carers and / nursing staff as self-assessment use in the community has not yet been validated. It is not suitable for use for assessment of pain in patients with pressure ulcers (Rutherford *et al*, 2016).

4 MONITORING COMPLIANCE

Team Leaders have responsibility to monitor competent compliance of pain assessment in relation to this policy within an individual's sphere of practice.

Compliance will be monitored through audit. A tool has been developed on the Assure system.

5 CONSULTATION PROCESS

Name	Title	Date
Clare Stewart	Operational / Clinical Lead Out of Hospital Services	15.2.2024
Claire White	Director of Governance and Care	15.2.2024
Elsbeth Snowie	Head of Quality and Safety	15.2.2024
Michelle Cumming	Operational Lead for Child and Family Services	15.2.2024
Tia Hall	Operational Lead for Adult services	15.2.2024
Gill John	Team Lead for CCNT services	15.2.2024
Michelle Margetts	Team Lead for District Nursing service	15.2.2024
Joanna Champion	Team Lead for District Nursing service	15.2.2024
Angela Stewart	Team Lead for District Nursing service	15.2.2024
Louise Hamilton	Team Lead for RRRT	15.2.2024
Charmaine Dwyer & Judy le Marquand	Jersey Hospice Care	15.2.2024

6 EQUALITY IMPACT STATEMENT

Family Nursing & Home Care is committed to ensuring that, as far as is reasonably practicable, the way services are provided to the public and the way staff are treated reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This policy document forms part of a commitment to create a positive culture of respect for all individuals including staff, patients, their families and carers as well as community partners. The intention is to identify, remove or minimise discriminatory practice in the areas of race, disability, gender, sexual orientation, age and 'religion, belief, faith and spirituality' as well as to promote positive practice and value the diversity of all individuals and communities.

The Family Nursing & Home Care values underpin everything done in the name of the organisation. They are manifest in the behaviours employees display. The organisation is committed to promoting a culture founded on these values.

Always:

- Putting patients first
- Keeping people safe
- Have courage and commitment to do the right thing
- Be accountable, take responsibility and own your actions
- Listen actively
- Check for understanding when you communicate
- Be respectful and treat people with dignity
- Work as a team

This policy should be read and implemented with the Organisational Values in mind at all times. See overleaf/below for the Equality Impact Assessment for this policy.

6.1 EQUALITY IMPACT SCREENING TOOL

Stage 1 - Screening			
Title of Procedural Document: Pain assessment Policy			
Date of Assessment	24.1.2024	Responsible Department	Family Nursing and Home Care
Completed by	Ann Morgan	Job Title	Practice Development CNS
Does the policy/function affect one group less or more favourably than another on the basis of:			
	Yes/No	Comments	
Age	No		
Disability <i>(Learning disability; physical disability; sensory impairment and/or mental health problems e.g. dementia)</i>	No		
Ethnic Origin <i>(including hard to reach groups)</i>	No		
Gender reassignment	No		
Pregnancy or Maternity	No		
Race	No		
Sex	No		
Religion and Belief	No		
Sexual Orientation	No		
If the answer to all of the above questions is NO, the Equality Impact Assessment is complete. If YES, a full impact assessment is required: go on to stage 2.			
Stage 2 – Full Impact Assessment			
What is the impact	Level of Impact	Mitigating Actions <i>(what needs to be done to minimise / remove the impact)</i>	Responsible Officer
Monitoring of Actions			
The monitoring of actions to mitigate any impact will be undertaken at the appropriate level			

7 IMPLEMENTATION PLAN

Action	Responsible Person	Planned timeline
Email to all staff	Secretary/Administration Assistant (Quality and Governance Team)	Within 2 weeks following ratification
Policy to be placed on organisation's Procedural Document Library	Secretary/Administration Assistant (Quality and Governance Team)	Within 2 weeks following ratification
Staff to sign up to documents if relevant via Virtual College	Secretary/Administration Assistant (Quality and Governance Team)	Within 1 month following ratification
EMIS pain assessment templates to be updated to reflect those in the policy	Practice Development CNS / Data Analyst	Within 1 month following ratification
Template care plans to be updated	Team Leaders supported by Practice Development CNS	Within 1 month following ratification

8 GLOSSARY

Acute Pain	Pain of recent onset and probable limited duration (Ready et al, 1992).
Allodynia	Feeling pain from something that does not usually cause pain, such as a light touch or pressure to the skin (NHS, 2022).
Breakthrough cancer pain	A transient exacerbation of pain that occurs either spontaneously, or in relation to a specific predictable or unpredictable trigger, despite relatively stable and adequately controlled background pain (Davies et al, 2009).
Chronic Pain	Persistent or recurrent pain lasting longer than 12 weeks (Treede et al. 2019). It is often associated with major changes in personality, lifestyle and functional ability (Orenius et al. 2013).
Hyperalgesia	Feeling more pain than usual to something that is painful (NHS 2022).
Neuropathic Pain	Pain caused by a lesion or disease of the somatosensory system. The somatosensory system allows for the perception of touch, pressure, pain, temperature, position, movement and vibration (Colloca et al, 2017). This can consist of motor, sensory or autonomic dysfunction (Steeds, 2016).
Nociceptive pain	Often referred to as acute pain, it is caused by stimulation of peripheral nerve fibers (nociceptors) that act only to protect the body from a stimuli approaching or has the ability to cause harm. Most common type of wound pain, generally localized to wound and surrounding tissue, includes cuts lacerations and burns. Generally decreases over time in line with progressive wound healing. Usually relieved by analgesia / local anaesthetics such as paracetamol and anti-inflammatory drugs. (NHS 2015).
Pain	The International Association for the Study of Pain (IASP) (2020) revised the definition of pain as follows: "An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage," and is expanded upon by the addition of six key notes and the etymology of the word pain for further valuable context: <ul style="list-style-type: none"> • Pain is always a personal experience that is influenced to varying degrees by biological, psychological, and social factors. • Pain and nociception are different phenomena. • Pain cannot be inferred solely from activity in sensory neurons.

	<ul style="list-style-type: none"> • Through their life experiences, individuals learn the concept of pain. • A person's report of an experience as pain should be respected. • Although pain usually serves an adaptive role, it may have adverse effects on function and social and psychological well-being. <p>Verbal description is only one of several behaviours to express pain; inability to communicate does not negate the possibility that a human or a nonhuman animal experiences pain. As pain is subjective, another favoured definition for use in clinical practice, proposed originally by McCaffery, (1968) is, 'Pain is whatever the experiencing person says it is, existing whenever the experiencing person says it does.'</p>
Somatic Pain	May be described as sharp, hot or stinging; is generally well localized; and is associated with local and surrounding tenderness (Schug et al. 2015).
Total pain	Saunders (1978) described "total pain" and suggested that pain can be understood as having physical, psychological, social, emotional, and spiritual factors . The combination of these result in a "total pain" experience that is individualised and specific to each patient's particular situation.
Visceral Pain	May be described as dull, cramping or colicky; is often poorly localized; and may be associated with tenderness locally or in the area of referred pain, or with symptoms such as nausea, sweating and cardiovascular changes (Schug et al. 2015).

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[IASP Announces Revised Definition of Pain - International Association for the Study of Pain \(IASP\) \(iasp-pain.org\)](https://www.iasp-pain.org/Advocacy/Content.aspx?ItemNumber=1821)

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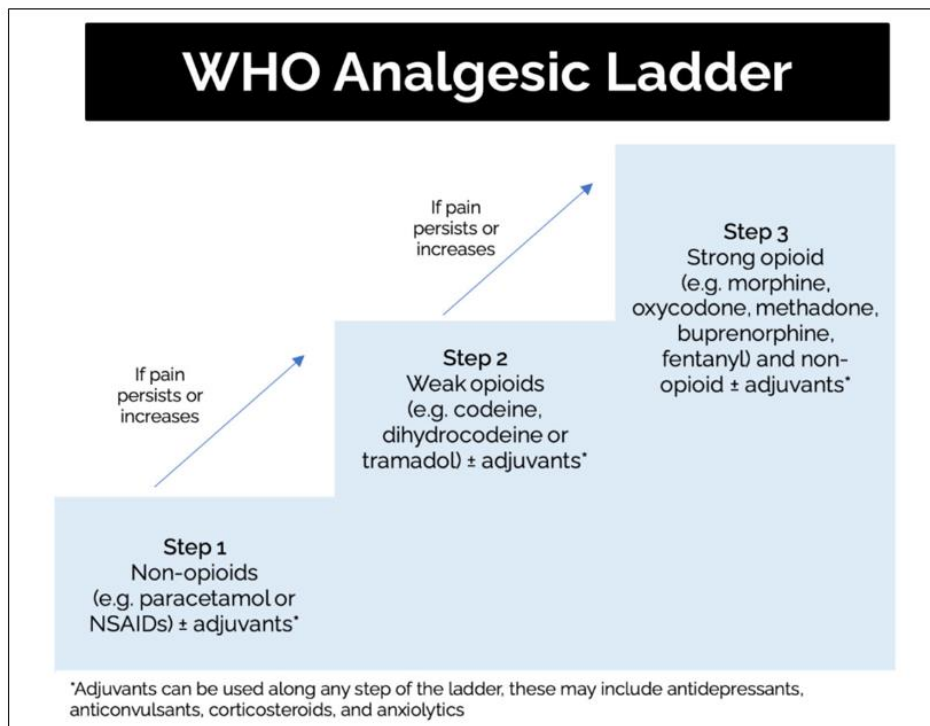
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SYMPTOM AND CARE CHART													
DATE COMMENCED:							FREQUENCY:						
KEY	Y: Yes		N: No		N/A: Not Applicable		D: Declined		C: Catheter				
Alert	Confused		Voice		Pain		Unconscious		Sleeping				
	DATE												
	TIME												
PERSONAL CARE													
Level of consciousness A C V P U S													
Mouth care													
Eye care													
Passed urine													
Bowels open													
Personal hygiene													
Taking diet													
Taking fluids													
SKIN													
Is pressure prevention equipment functioning correctly?													
Are sheets/bedding smooth?													
Check positioning of invasive devices (Tick)													
SKIN INSPECTION													
Is there any evidence of pressure damage?													
Buttocks													
Elbows													
Sacrum													
Trochanters (hips)													
Spine and shoulders													
Heels													
Occipital area (back of head)													
Toes													
Other (describe):													
Repositioning: From and To	F	T	F	T	F	T	F	T	F	T	F	T	
L: Left, R: Right, B: Back, P: Prone, SU: Sitting Up, C: Chair, M: Mobilising													
Initial													
Role/Designation													

10.2 Appendix 2. World Health Organisation (WHO) Analgesic Ladder

Taken from Prescribing Analgesia and the WHO Analgesic Ladder (Ubhi, 2023).



The WHO analgesic ladder has **five key principles**:

1. **Oral administration** of analgesics should be used whenever possible
2. Analgesics should be given at **regular intervals** with the duration and dose of medication supporting the patient's level of pain
3. Analgesics should be prescribed according to the pain intensity **characterised by the patient** (this should be free from judgement from the clinician)
4. Dosing of pain medication should be adapted to the individual, starting at the **lowest** dose and duration possible but titrating accordingly to response
5. **Consistent** administration of analgesics is vital for effective pain management

Opioid Toxicity is covered in the [Palliative Care \(Adult\): Symptom Management Guidelines for information](#)

10.3 Appendix 3. Pain Assessment in Advanced Dementia (PAINAD) Scale

Warden et al (2003)

Pain Assessment in Advanced Dementia (PAINAD) Scale Tool								
Patient details:								
Items	Date & time	Date & time	Date & time	Date & time	Date & time	Date & time	Date & time	Date & time
Five-item observational tool (see the description of each item below).								
Breathing independent of vocalisation								
<ul style="list-style-type: none"> ➤ Normal 0 ➤ Occasional laboured breathing / Short period of hyperventilation 1 ➤ Noisy laboured breathing/ Long period of hyperventilation / Cheyne-Stokes respirations 2 								
Negative vocalisation								
<ul style="list-style-type: none"> ➤ None 0 ➤ Occasional moan or groan / Low level speech with a negative or disapproving quality. 1 ➤ Repeated trouble calling out / Loud moaning or groaning / Crying 2 								
Facial expression								
<ul style="list-style-type: none"> ➤ Smiling or inexpressive 0 ➤ Sad. Frightened / Frown 1 ➤ Facial grimacing 2 								
Body language								
<ul style="list-style-type: none"> ➤ Relaxed Tense 0 ➤ Distressed pacing / Fidgeting 1 ➤ Rigid / Fists clenched 2 								
Consolability								
<ul style="list-style-type: none"> ➤ No need to console 0 ➤ Distracted or reassured by voice or touch 1 ➤ Unable to console, distract or reassure 2 								
Total Score								
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").								
Signature of person completing score								
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").								

Breathing	<ol style="list-style-type: none"> 1. Normal breathing is characterized by effortless, quiet, rhythmic (smooth) respirations. 2. Occasional laboured 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 laboured 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 apnoea (cessation of breathing).
Negative vocalization	<ol style="list-style-type: none"> 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 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	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 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. The person might be hitching a chair across the room. 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. 6. Knees pulled up is characterized by flexing the legs and drawing the knees up toward the chest. An overall troubled appearance (exclude any contractures). 7. 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. 8. Striking out is characterized by hitting, kicking, grabbing, punching, biting, or other form of personal assault.
Consolability	<ol style="list-style-type: none"> 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 behaviour when the person is spoken to or touched. The behaviour stops during the period of interaction with no indication that the person is at all distressed. <p>Unable to console, distract or reassure is characterized by the inability to sooth the person or stop a behaviour with words or actions. No amount of comforting, verbal or physical, will alleviate the behaviour.</p>

10.4 Appendix 4. Abbey Pain Scale

Adapted from: Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L; Parker, D; and Lowcay, B. Funded by the JH and JD Gunn Medical Research Foundation 1.

Abbey Pain Scale Assessment Tool								
Patient details:								
	Date & time	Date & time	Date & time	Date & time	Date & time	Date & time	Date & time	Date & time
Vocalisation Whimpering, crying, and groaning. Absent 0 Mild 1, moderate 2, Severe 3								
Facial expression Looking tense, frowning, grimacing, looking frightened Absent 0 Mild 1, moderate 2 Severe 3								
Change in body language Fidgeting, rocking, guarding part of body, withdrawn Absent 0 Mild 1, moderate 2 Severe 3								
Behavioural change Increased confusion, refusing to eat, alteration in usual patterns Absent 0 Mild 1, moderate 2 Severe 3								
Physiological Changes Temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor Absent 0 Mild 1, moderate 2, Severe 3								
Physical Changes Skin tears, pressure areas, arthritis, contractures, previous injuries Absent 0 Mild 1, moderate 2 Severe 3								
Total Score								
Signature of person completing score								
	0-2 No Pain		3-7 Mild Pain		8-13 Moderate Pain		14+ Severe Pain	

10.5 Appendix 5. The Wong-Baker 'Faces' Pain Scale



Instructions

Explain to the child that each face is for a person who feels happy because he has no pain (hurt) or sad because he has some or a lot of pain.

Face 0 is very happy because he doesn't hurt at all (NRS 0)

Face 1 hurts just a little bit (NRS 1-2)

Face 2 hurts a little more (NRS 3-4)

Face 3 hurts even more (NRS 5-6)

Face 4 hurts a whole lot more (NRS 7-8)

Face 5 hurts as much as you can imagine, although you do not have to be crying to feel this bad (NRS 9-10)

Ask the child to choose the face that best describes how he/she is feeling.

10.6 Appendix 6. Revised FLACC Scale for the assessment of pain in infants or non-verbal children.

Used with permission from Great Ormond Street Hospital.

<p style="text-align: center;">Revised FLACC Scale</p> <p style="text-align: center;">Great Ormond Street Hospital for Children NHS Foundation Trust</p>		Scoring		
		0	1	2
Name:	Hosp No:			
DOB:	NHS no:			
Categories				
Face	No particular expression or smile	Occasional grimace/frown; withdrawn or disinterested; appears sad or worried	Consistent grimace or frown; frequent/constant quivering chin, clenched jaw; distressed-looking face; expression of fright or panic	
Individual Behaviours				
Legs	Normal position or relaxed; usual tone and motion to limbs	Uneasy, restless, tense; occasional tremors	Kicking, or legs drawn up; marked increase in spasticity, constant tremors or jerking	
Individual Behaviours				
Activity	Lying quietly, normal position, moves easily; Regular, rhythmic respirations	Squirming, shifting back and forth; tense or guarded movements; mildly agitated (eg. head back and forth, aggression); shallow, splinting respirations, intermittent sighs	Arched, rigid, or jerking; severe agitation, head banging, shivering (not rigors); breath-holding, gasping or sharp intake of breaths; severe splinting	
Individual Behaviours				
Cry	No cry/verbalisation	Moans or whimpers; occasional complaint; occasional verbal outburst or grunt	Crying steadily, screams or sobs, frequent complaints; repeated outbursts, constant grunting	
Individual Behaviours				
Consolability	Content and relaxed	Reassured by occasional touching, hugging, or being talked to; distractible	Difficult to console or comfort; pushing away caregiver, resisting care or comfort measures	
Individual Behaviours				

(Adapted from Malviya et al, 2006)

Revised FLACC – Instructions for Use

- Individualise the tool:** The nurse should review the descriptors within each category with the child's parents or carers. Ask them if there are additional behaviours that are better indicators of pain in their child. Add these behaviors to the tool in the appropriate category.
- Each of the five categories (F) Face; (L) Legs; (A) Activity; (C) Cry; (C) Consolability is scored from 0-2, which results in a total score between zero and ten.
- Patients who are awake:** Observe for at least 1-3 minutes. Observe legs and body uncovered. Reposition patient or observe activity, assess body for tenseness and tone. Initiate consoling interventions if needed.
- Patients who are asleep:** Observe for at least 5 minutes. Observe body and legs uncovered. If possible reposition the patient. Touch the body and assess for tenseness and tone.

Version No: 1.1	Version date: 08/04/2020	Document development lead: Jude Middleton	H:\Pain Assessment Tools\Revised FLACC Paperwork.doc
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10.7 Appendix 7 Leeds Assessment of Neuropathic Symptoms and Signs (S-LANSS)

Patient Name:		URN:
Date:		
The S-LANSS Pain Score		
1.	In the area where you have pain, do you also have "pins and needles", tingling or prickling sensations? <input type="checkbox"/> No – I don't get these sensations <input type="checkbox"/> Yes – I get these sensations	0
		5
2.	Does the painful area change colour (perhaps look mottled or more red) when the pain particularly bad? <input type="checkbox"/> No – The pain does not affect the colour of my skin <input type="checkbox"/> Yes – I have noticed the pain makes my skin look different to normal	0
		5
3.	Does your pain make the affected skin abnormally sensitive to touch? Getting unpleasant sensations or pain when lightly stroking the skin might describe this. <input type="checkbox"/> No – The pain does not make my skin abnormally sensitive to touch. <input type="checkbox"/> Yes – My skin in that area is particularly sensitive to touch.	0
		3
4.	Does your pain come on suddenly and in bursts for no apparent reason when you are completely still? Words like "electric shocks", jumping and bursting might describe this. <input type="checkbox"/> No – My pain doesn't really feel like this. <input type="checkbox"/> Yes – I get these sensations often.	0
		2
5.	In the area where you have pain, does your skin feel unusually hot like a burning pain? <input type="checkbox"/> No – I don't have burning pain <input type="checkbox"/> Yes – I get burning pain often	0
		1
6.	Gently rub the painful area with your index finger and then rub a non-painful area (for example, an area of skin further away or on the opposite side from the painful area). How does this rubbing feel in the painful area? <input type="checkbox"/> No – The painful area feels no different from the non-painful area <input type="checkbox"/> Yes – I feel discomfort, like pins and needles, tingling or burning in the painful area that is different from the non-painful area.	0
		5
7.	Gently press on the painful area with your finger tip and then gently press in the same way onto a non-painful area (the same non-painful area that you chose in the last question). How does this feel in the painful area? <input type="checkbox"/> No – The painful area does not feel different from the non-painful area. <input type="checkbox"/> Yes – I feel numbness or tenderness in the painful area that is different from the non-painful area.	0
		3
Total Score:		
Signed:		Date:
Scoring 12 or more suggests pain of predominantly neuropathic origin		

Source: Bennett, M et al J Pain, Vol 6, No 3 March, 2005 pp 149–158 The S-LANSS Score for Identifying Pain of Predominantly Neuropathic Origin: Validation for Use in Clinical and Postal Research