PAIN SCALE - BEHAVIORAL-PHYSIOLOGICAL SCALE FOR NONVERBAL OR PREVERBAL PATIENTS

Score	Assessment Guideline
0	No Signs of Irritability or Pain Exhibited
+	Signs of Irritability • Intermittent vocalizations, soft or brief cry but *able* to suck or feed • Increased activity of extremities, restless, purposeless movements but trunk is relaxed • Frowning, furrowed brow, eyes open • Mildly increased tone of extremities • Increased arousability, more awake than usual • Unexplained mild changes in respiratory pattern, HR and BP
++	Signs of Pain • Loud cry, sustained attempts to cry • Refuses to feed, eat and/or pacifier does not relieve crying • Thrashing of limbs of infants • Marked brow bulge in infants, grimace, eyes closed tightly • Decreased activity, fatigue, social withdrawal • Tense muscles, guarding, posturing • Flushed face, diaphoresis • Change in sleep or awake pattern • Attempts to withdraw limb from pain or tries to touch hurt area • Unexplained duskiness/decreased oxygen saturations • Unexplained changes in RR, HR and BP

Developed at Fountain Valley Regional Hospital and Medical Center, CA by F Box RN, MJ Wainwright RN and L Thompson RN, rev 3/97

This tool should be used as a guideline for healthcare providers attempting to assess irritability and pain in nonverbal or preverbal patients.

Instructions for use of Assessment Guideline: *Evaluate all patients at regular intervals.*

Score 0 Patients are identified as those who do not exhibit one or more of the behaviors listed in the (+) or (++) boxes.

Score + Patients demonstrate one or more of the behaviors listed in the (+) box. Use age-appropriate comforting measures. *Re-evaluate.*

Score ++ Patients demonstrate one or more of the behaviors listed in the (++) box. Consider trial of pain medication. *Re-evaluate.*

There is no reliable tool yet developed that accurately measures pain in patients that are unable to verbalize their pain. It is possible that the patient may be experiencing pain and **not** show any of the behaviors listed above. Whenever pain is suspect, pain medication may be indicated.

References:

Broome, M (1990) Differentiating Between Pain and Agitation in Premature Neonates. Journal of Perinatal and Neonatal Nursing (pp 53-60).

Halsinski, MF (1992) Assessment and Management of Pain in Children. In MF Halsinski Nursing Care of the Critically Ill Child (pp 80-83), St. Louis: Mosby.

Herr, K (2006) Pain Assessment in the Nonverbal Patient: Position Statement with Clinical Practice Recommendations, American Society for Pain Management Nursing, pp. 44-52.

Watson, J (et al) (1992) Clinical Judgment in Assessing Children's Pain. In J Watson (Ed) Pain Management: A Nursing Perspective (pp 243-246), St. Louis: Mosby.

PAIN SCALE - BEHAVIORAL-PHYSIOLOGICAL SCALE FOR NONVERBAL OR PREVERBAL PATIENTS (continued)

GUIDELINES FOR NURSING INTERVENTIONS

- **When to use this scale:**
  - When patients are not able to give any form of self-report of pain for whatever reason; e.g., pharmacological/physiological paralysis, developmental level, persistent vegetative state, severe mental retardation.

- **+ Assess:**

  If there is at least one sign in the (+) category indicating irritability, **consider causative factors**: is there a physiologic cause contributing to the change; e.g., vital signs such as hypovolemia, hyperthermia, hypothermia, hypoxia? If physiologic causes are ruled out, try to identify source of irritability; e.g., position, sensory overload, sensory deprivation, wet diaper, etc.

  - **Intervene:**
    - Use age-appropriate comfort measures to reduce irritability such as:
      - Swaddling
      - Decreased light and noise
      - Decreased handling: increased rest periods between procedures
      - Rhythmic activities: stroking, patting
      - Vestibular stimulation: upright positioning
  - **Evaluate:**
    - Reassess for increased level of comfort and no other interventions are required for irritability; document which measures were effective.

- **++ Assess:**

  If there is at least one sign in the (++) category indicating pain, **consider causative factors;** again, look at oxygen requirements, volume needs, thermoregulatory needs, etc. If physiologic causes are ruled out, try to identify source of pain; e.g., infiltrated IV, chest tube position, surgical incision, etc.

  - **Intervene:**
    - Remove identifiable source of pain, if possible. Collaborate with physician to give trial of pain medication as indicated. Use age-appropriate measures, such as:
      - Swaddling or containment during procedure
      - Pacifier during and after procedure
      - Tactile stimulation
      - Rocking or holding
      - Alternative distraction: music (never during a painful procedure, but after), light conversation
      - Imagery
  - **Evaluate:**
    - Reassess infant/child's level of comfort within 30 minutes. If level of comfort has increased, document which measures were effective. If level of comfort has not improved or has worsened, reassess for a possible new source of pain or ineffective pain medication. Collaborate with physician and document.
  - **Expected Outcome:**
    - A decrease in (++) behaviors to a (0 or +) level of signs might indicate increased comfort.

