

SELECTION OF ASSESSMENT TOOL

Recommendation by Ministry of Health (MOH)

AGE	SCALE
ADULT	MOH PAIN SCALE
PAEDIATRIC:	
< 1 month	NIPS (Neonatal Infant Pain Scale)
1 month - 4 years	FLACC SCALE
4 - 7 years	FACES SCALE
> 7 years	MOH PAIN SCALE
Language barrier/Cognitively Impaired Patient	FLACC SCALE
Patient ventilated & sedated	CPOT/ BPS
Pain Assessment In Advanced Dementia	PAINAD



CLINICAL TECHNIQUE FOR MEASUREMENT OF PAIN

SELF REPORTING BY THE PATIENT

- ✓ Gold standard
- ✓ Best method

OBSERVER ASSESSMENT

- ✓ Observation of behavior and vital signs
- ✓ Functional assessment



Category	Scoring		
	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw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 sleep)	Moans or whimpers; occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console

MOH PAIN SCALE



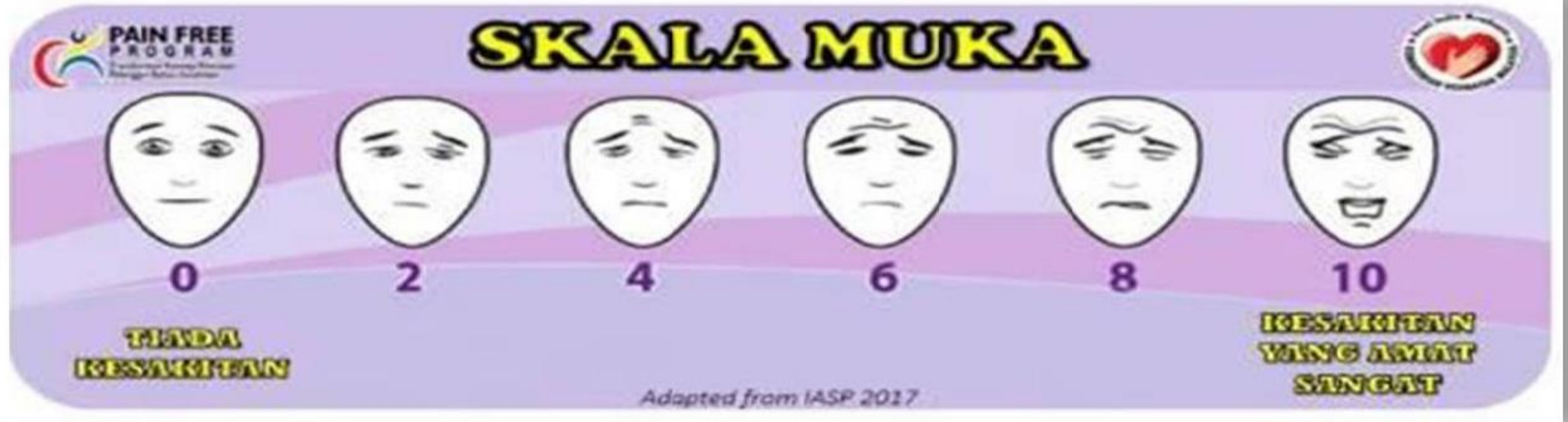
On a scale of '0' to '10' (show the pain scale)

If "0" = No pain, and "10": worst pain you can imagine

What is your pain score now?

Patient is asked to show the severity of pain, which is recorded as a number (0 to 10)

IASP FACES SCALE



- ✓ Self reported tool
- ✓ Aged 4 – 7 years old
- ✓ Numbers must not be mentioned

2. BEHAVIORAL PAIN SCALE (BPS)

ITEM	DESCRIPTION	SCORE
Facial expression	Relaxed	1
	Partially tightened (e.g. brow lowering)	2
	Fully tightened (e.g. eyelid closing)	3
	Grimacing	4
Upper limb movements	No movement	1
	Partially bend	2
	Fully bend with finger flexion	3
	Permanently retracted	4
Compliance with mechanical ventilation	Tolerating movement	1
	Coughing but tolerating ventilation for the most of the time	2
	Fighting ventilator	3
	Unable to control ventilation	4

- Total score varies from 3 to 12
- Scores ≤ 3 no pain.
- Scores 4-5 mild pain.
- Scores 6-11 an unacceptable amount of pain.*
- Scores ≥ 12 maximum pain.*
- Target score < 5 .
- Validated in English, French and Mandarin.

3. MULTIDIMENSIONAL ASSESSMENT

PAINAD:

Pain Assessment In Advanced Dementia

- simple, valid and sensitive tool for detecting pain in people with advanced dementia and non-communicative patients
- useful to assess whether pain management strategies have been successful

*Total scores range from 0 to 10 (based on a scale of 0 to 2 for 5 items)

Obtained scores are NOT TO BE USED to infer absolute pain intensity i.e. a score of 10 on the PAINAD is not necessarily equal to an NPS rate of 10 (severe pain). Instead, compare the total score to the previous score received. An increased score suggests increase in pain, while a lower a score suggests pain is decreased.

ITEM	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 of 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*				



BEHAVIOURAL MEASURES

NEONATES UP TO 1 MONTH: NIPS

Neonatal/Infant Pain Scale (NIPS) ⁴ A score greater than 3 indicates pain		Score
Facial expression		
0 - Relaxed muscles	Restful face, neutral expression	
1 - Grimace	Tight facial muscles, furrowed brow, jaw, chin (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 movements).	
Breathing Patterns		
0 - Relaxed	Usual pattern for this infant	
1 - Change in breathing	In drawing, irregular, faster than usual, gagging and breath holding.	

Neonatal/Infant Pain Scale (NIPS) ⁴ A score greater than 3 indicates pain		Score
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 movements of arms.	
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	

FLACC SCALE (1 MONTH-4 YEARS)

CATEGORY	SCORE		
	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn down
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 sob, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to distractable	Inconsolable

- ✓ Observational tools
- ✓ Look at behavioural changes
- ✓ Observe for 2-5 minutes

