Assessing Children's Pain

r-FLACC (revised FLACC) Pain Rating Scale for children with developmental disability.

Starship Child Health

	0	1	2
Face	No expression or smile	Occasional grimace or frown, withdrawn, disinterested; appears sad or worried	Frequent to constant frown, clenched jaw, quivering chin; ***distressed looking face; expression of fright or panic*** *Individualised behaviour described by family:*
Legs	Normal position or relaxed; usual muscle tone and motion to arms and legs	Uneasy, restless, tense; occasional tremors	Kicking, or legs drawn up; ***marked increase in spasticity; constant tremors or jerking*** *Individualised behaviour described by family:*
Activity	Lying quietly, normal position, moves easily; regular rhythmic breaths (respiration)	Squirming, shifting back and forth, tense or guarded movements; mildly agitated (head back and forth, aggression); shallow, splinting breaths (respirations); occasional sighs	Arches, rigid, or jerking; ***severe agitation; head banging; shivering (not rigors); breath holding, gasping, or sharp intake of breaths; severe splinting*** *Individualised behaviour described by family:*
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint; occasional verbal outburst or grunt	Crying steadily, screams or sobs, frequent complaints; ***repeated outbursts; constant grunting*** *Individualised behaviour described by family:*
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or "talking to"; Can be distracted	Difficult to console or comfort; ***pushing away caregiver; resisting care or comfort measures*** *Individualised behaviour described by family:*

The revised FLACC (Face, Legs, Activity, Cry, Consolability) is a behavioural pain assessment scale for use with children unable to self-report their level of pain due to developmental disabilities. Rate the child in each of the five measurement categories, add together, and document total pain score (0 – 10).

Children who are awake: Observe for at least 1-2 minutes. Observe legs and body uncovered. Reposition patient or observe activity, assess body for tenseness and tone. Initiate consoling interventions if needed.

Children who are asleep: Observe for at least 2 minutes or longer. Observe legs and body uncovered. If possible, reposition the patient. Touch the body and assess for tenseness and tone.

The revised FLACC can be used for all non-verbal children. The additional descriptors (in italics) are descriptors validated in children with cognitive impairment. The nurse can review with parents/caregivers the descriptors within each category. Ask the parents/caregivers if there are additional behaviours that are better indicators of their child experiencing pain. Add these behaviours to the tool in the appropriate category.

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