

<p>Location</p> <p>Intensity</p> <p> Patient rates pain 0-10 or use scales below</p> <p> Pain at present</p> <p> Worst pain gets</p> <p> Best pain gets</p> <p> Acceptable level of pain</p>	<p>Quality (Use patient's own words)</p> <p>Onset, Duration, variations, rhythms</p> <p>Manner patient expresses pain</p> <p>What relieves pain?</p> <p>What causes or increase pain?</p> <p>Effects of pain?</p>
<p>If new pain medication ordered, did you begin Bowel protocol?</p>	

CHECKLIST OF NONVERBAL PAIN INDICATORS (CNPI) FOR COGNITIVELY IMPAIRED ADULTS

Use "0" if the behavior was not observed and "1" if the behavior occurred even briefly during activity or rest.

Once you total the score, base the number on the numeric pain scale 0 - 10. If the score totals from 10 - 12 this is considered excruciating pain. (Feldt, 2000).	WITH MOVEMENT	REST
<p>VOCAL COMPLAINTS: NONVERBAL</p> <p>Expression of pain, not in words, moans, groans, cries, gasps, sighs.</p>		
<p>FACIAL GRIMACES/WINCES</p> <p>Furrowed brow, narrowed eyes, tightened lips, dropped jaw, clenched teeth, distorted expression.</p>		
<p>BRACING</p> <p>Clutching or holding on to siderails, bed tray table, or affected area during movement.</p>		
<p>RESTLESSNESS</p> <p>Constant or intermittent shifting of position, rocking, intermittent or constant hand motions, inability to keep still.</p>		
<p>RUBBING</p> <p>Massaging affected area. In addition, record verbal complaints.</p>		
<p>VOCAL COMPLAINTS: VERBAL</p> <p>Words expressing discomfort or pain - "ouch", "that hurts," cursing during movement, or exclamations of protest - "stop," "that's enough."</p>		
<p>Subtotal scores</p>		
<p>Total score</p>		

Pediatric patients or non-responsive patients can be assessed using the University of Michigan Behavioral Pain Assessment Scale (FLACC Scale) as follows:

FLACC SCALE

Rate patient in each of the five measurement categories, add together, and document total pain score (0 - 10).

	0	1	2
FACE	No particular expression or smile.	Occasional grimace or frown, withdrawn.	Frequent to constant frown.
LEGS	Normal position or relaxed.	Uneasy, restless, tense.	Kicking or legs drawn upward.
ACTIVITY	Lying quietly, normal position, moves easily.	Squirming, shifting back and forth, tense.	Arched, rigid or jerking.
CRY	No cry (awake or asleep).	Moans, whimpers, occasional complaint.	Crying steadily, screams or sobs, complaining.
CONSOLABILITY	Content and relaxed.	Reassured by occasional touching, hugging, or "talking."	Difficult to console or comfort.

0 - 10 Escala Numérica de la
Intensidad de Dolor
(Spanish)

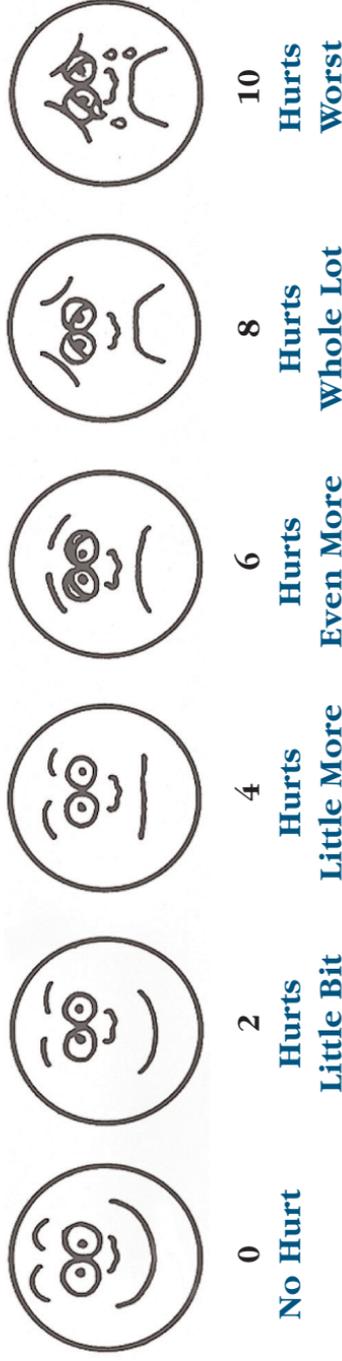


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0 - 10 Meziré Ki Valé Doulé Ou
Genyen Ak Niméwo Sw-a-yo
(Creole)

VISUAL PAIN SCALE



Ningún Dolor

Dolor moderado

Dolor peor posible

Pa gen doulé di tou

Y on doulé ki
pa tro fo

Y on doulé
pi fó anpil