FLACC Behavioural Pain Assessment Scale

SKIN AND WOUND CARE

Applies to:	Clinical staff assessing pain in children.
Purpose:	To assess pain in children aged 2 months or greater and for those who are non-verbal or may not accurately self-report.

Tip: Pain assessment is the fifth vital sign, thus, should be assessed every time vitals are taken.

Instructions:

- Observe the patient/client for at least 5 minutes.
- Ensure the body and legs are uncovered.
- Reposition the patient/client and reassess.
- Touch the body and assess for tenseness and tone.

Each category is scored on the 0-2 scale, which results in a total score of 0-10.

- **0** = Relaxed and comfortable.
- **1-3** = Mild discomfort.
- **4-6** = Moderate pain.
- **7-10** = Severe discomfort/pain.

Treatment and interventions are indicated for scores greater than 3 (should be individualized for each patient), and the goal is to decrease the score to less than or equal to 3.

Categories	Scoring		
	0	1	2
Face	• No particular expression or smile. • Relaxed, expression • Makes eye contact. • Shows interest in surroundings.	• Occasional grimace or frown. • Withdrawn, disinterested. • Any pain expression, intermittent. • Worried facial expression with eyebrows lowered. • Mouth pursed. • Eyes partially closed.	• Frequent-to-constant frown, clenched jaw, quivering chin. • Any pain expression, continual. • Deep furrows in forehead, deep lines around nose and lips. • Closed eyes. • Open mouth.
Legs	• Normal position or relaxed. • Normal tone. • Normal motion.	• Uneasy, restless, tense, rigid. • Intermittent clenched toes, fists or finger splay. • Body is not tense.	• Kicking or legs drawn up/pulled tight. • Tremors. • Continual clenched toes, fists, or finger splay. • Body is tense.
Activity	• Lying quietly, normal position, moves easily and freely.	• Squirming, shifting back and forth, tense.	• Fixed position.

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	• Appropriate for gestational age. • Normal activity or restrictions.	• Restless, awakens frequently. • Appears hesitant to move. • Demonstrates guarding.	• Arched, rigid, or jerking, kicking, rocking. • Constantly awake. • Arouses minimally/no movement (not sedated). • Side-to-side head movement. • Rubbing of body part.
Cry	• No crying (awake or asleep). • No moaning. • Appropriate crying.	• Occasional moans, cries, sighs, or whimpers. • Irritable or crying at intervals, consolable.	• Crying steadily, grunts, screams or sobs; frequent complaints or continuous.
Consolability	• Content, relaxed. • Calm. • Does not require consoling.	• Reassured by/responds to occasional touching, hugging, or being talked to, distractible in 30 seconds to 1 minute.	• Difficult to console or comfort. • Requires constant comforting. • Inconsolable.
Vital signs	• Within baseline or normal for gestational age.	• Increase 10-20% from baseline.	• Increase >20% from baseline.