

As possible, please point a number word or face that shows how much you are hurting on ONE of the scales below

### Numeric Pain Scale

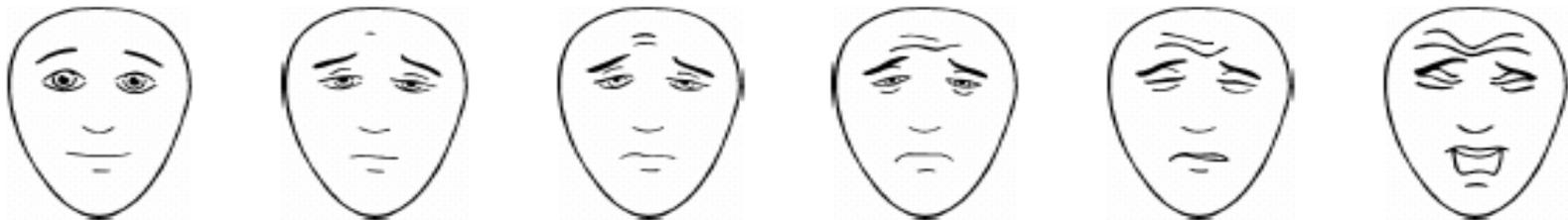


### Verbal Descriptor Pain Scale

No Pain	Mild	Moderate	Severe	Extreme	Worst Pain
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### Revised Faces Pain Scale

These faces show how much something can hurt. The left-most face (point to it) shows no pain. With each face to the right of it (point) showing more and more pain, with the far right one (point to it) showing very much pain. **Point to the face that shows how much you hurt right now.**



## Critical Care Pain Observation Tool\*

Indicator	Description	Score												
<b>Facial Expressions</b>	0 = Relaxed: neutral facial expression 1 = Tense: Frowning, brow-lowering, orbit tightening, &/or levator contraction 2 = Grimace: All of facial criteria above plus eyelids tightly closed													
<b>Body Movements</b>	0 = Absence of movements: (does not necessarily mean no pain) 1 = Protection/guard, withdraws: Slow, cautious movements, rubs pain site 2 = Restlessness/thrashing: Pulls tube, attempt to sit, climb out of bed, thrash, strikes out													
<b>Muscle Tension</b> Evaluate w/ passive flexion /extension of arms	0 = Relaxed: No resistance to passive arm movement 1 = Tense, rigid: Resists to passive arm movement 2 = Very tense, rigid: Strong resistance to passive movement													
<b>Ventilation compliance</b>  <b>-or-</b> <b>Vocalization</b> (if extubated)	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center; border-bottom: 1px solid black;"><u>Ventilated Patient</u></td> <td style="text-align: center; border-bottom: 1px solid black;">or</td> <td style="text-align: center; border-bottom: 1px solid black;"><u>Extubated, “vocal” Patient</u></td> </tr> <tr> <td>0 = Tolerating ventilator, no alarms</td> <td></td> <td>0 = Quiet/normal tone</td> </tr> <tr> <td>1 = Intermittent alarms, stop spontaneously, coughing</td> <td></td> <td>1 = Sigh, moaning</td> </tr> <tr> <td>2 = Fight ventilator/asynchrony, frequent alarms</td> <td></td> <td>2 = Crying out, sobbing</td> </tr> </table>	<u>Ventilated Patient</u>	or	<u>Extubated, “vocal” Patient</u>	0 = Tolerating ventilator, no alarms		0 = Quiet/normal tone	1 = Intermittent alarms, stop spontaneously, coughing		1 = Sigh, moaning	2 = Fight ventilator/asynchrony, frequent alarms		2 = Crying out, sobbing	
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<b>Pain with Movement</b> Evidence of pain (e.g. above behavior or individualized response) while providing usual care (e.g. turning).	0 = No sign of pain while providing care 1 = Resists movement / guards against certain movements 2 = Pain behaviors (e.g. grimace, withdraws, vocalization, sudden HR or BP spike) with movement associated with routine care or provided treatments													
<b>TOTAL:</b>														

**Instructions for use:** Observe the patient’s face and body movement at rest and rate those aspects accordingly. Observe for vocalizations (if extubated) or compliance with ventilator and score per the appropriate scale. Passively move the patient’s arms and rate the level of resistance on a 0-2 scale. Observe for facial or bodily indicators of pain while providing usual care (e.g. turning) and rate per the scale provided. Add up the scores for each measure to determine a total score. Scores of >1 at rest indicate the presence of pain. Scores >2 with movement (turning) indicate pain. Higher scores generally provided more support of the presence of severe pain, but the relationship is not linear (a 4 is not twice as intense as a “2”) and a low score (e.g. “2”) can indicate the presence of severe pain.

\*Scoring modified to standardize to the MGH policy of ranking pain on a 0-10 scale