MassGeneral Hospital for Children

r-FLACC Scale
Face, Legs, Activity, Cry, Consolability

	0	1	2
FACE Individualized behavior: _____	No particular expression or smile	Occasional grimace or frown, withdrawn or disinterested; appears sad or worried	Consistent grimace or frown; frequent/constant quivering chin; clenched jaw; distressed-looking face; expression of fright or panic
LEGS Individualized behavior: _____	Normal position or relaxed; usual tone & motion to limbs	Uneasy, restless, tense; occasional tremors	Kicking, or legs drawn up; marked increase in spasticity, constant tremors or jerking
ACITIVTY Individualized behavior: _____	Lying quietly, normal position, moves easily, regular & rhythmic respirations	Squirming, shifting back/forth, tense or guarded movements, mildly agitated, shallow splinting respirations, intermittent sighs	Arched, rigid or jerking, severe agitation, head banging, shivering, breath holding, gasping or sharp intake of breaths, severe splinting
CRY Individualized behavior: _____	No cry/verbalization	Moans or whimpers, occasional complaint, occasional verbal outburst or grunt	Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting
CONSOLABILITY Individualized behavior: _____	Content or relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort, pushing away caregiver, resisting care or comfort measures

Instructions for Use:

1. Rate patient in each category
2. Add the scores together
3. Document the total pain score

Interpreting the Score

0 Relaxed & comfortable
1 – 3 = Mild discomfort
4 – 6 = Moderate pain
7 –10 = Severe pain or discomfort or both

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How to use the revised FLACC (r-FLACC) scale

In patients who are awake: observe for 1-5 minutes or longer. Observe legs and body uncovered. Reposition patient or observe activity. Assess body for tenseness and tone. Initiate consoling interventions if needed.

In patients who are asleep: observe for 5 minutes or longer. Observe body and legs uncovered. If possible, reposition the patient. Touch the body and assess the tenseness and tone.

In patients with cognitive impairment, obtain parent input on individualized behaviors for each category prior to assessment. Examples of behaviors may include agitation, verbal outbursts, tremors, shivering, hypertonicity or increased spasticity, breath holding, and gasping, and are italicized below.

Face

- **Score 0** if the patient has a relaxed face, makes eye contact, shows interest in surrounding
- **Score 1** if the patient has a worried facial expression, with eyebrows lowered, eyes partially closed, cheeks raised, mouth pursed
- **Score 2** if the patient has deep furrows in the forehead, closed eyes an open mouth, deep lines around nose and lips; *distressed-looking face; expression of fright or panic*

Legs

- **Score 0** if the muscle tone and the motion in the limbs are normal
- **Score 1** if patient has increased tone, rigidity, or tension; if there is intermittent flexion or extension of limbs; *occasional tremors*
- **Score 2** if the patient has hypertonicity, the legs are pulled tight, there is exaggerated flexion or extension of the limbs, tremors; *marked increase in spasticity, constant tremors or jerking*

Activity

- **Score 0** if the patient moves easily and freely, normal activity or restrictions; r*egular, rhythmic respirations*
- **Score 1** if the patient shifts positions, appears hesitant to move, demonstrates guarding, a tense torso, pressure on a body part; *tense or guarded movements; mildly agitated (e.g. head back and forth, aggression); shallow, splinting respirations, intermittent sighs*
- **Score 2** if the patient is fixed in a position, rocking; demonstrates side-to-side head movement or rubbing of a body part; *severe agitation; head banging; shivering (not rigors); breath holding, gasping or sharp intake of breaths, severe splinting*

Cry

- Score 0 if the patient has no cry or moan, awake or asleep
- **Score 1** if the patient has occasional moans, cries, whimpers, sighs; *occasional verbal outburst or grunt*
- **Score 2** if the patient has frequent or continuous moans, cries, grunts; *repeated outbursts, constant grunting*

Consolability

- **Score 0** if the patient is calm and does not require consoling
- **Score 1** if the patient responds to comfort by touching or talking in <30 seconds to 1 minute
- **Score 2** if the patient requires constant comforting or is inconsolable; *pushing away caregiver, resisting care or comfort measures*

Each category is scored on the 0-2 scale, which results in a total possible score of 0-10. 0 = Relaxed and Comfortable, 1-3 = Mild discomfort, 4-6 = Moderate pain, 7-10 = Severe pain or discomfort or both

Revised March 11, 2009