UCLA Health System

Pain Assessment Tool for Non - Cognizant Adults

Assessment Criteria	0	1	2
Facial Expression	**No particular expression** **(relaxed, calm)**	**Any intermittent pain Expression** (e.g., occasional grimace, frown, eyebrows lowered, eyes partially closed , or mouth pursed)	**Frequent to continuous pain expression** (e.g., grimacing, frown, clenched jaw, quivering chin, deep furrows on forehead, eyes closed)
Body Language/ Extremities	**Normal position or relaxed**	**Intermittent flexion/extension** (e.g., uneasy, restless, tense, increased tone, rigidity, fidgeting, guarding)	**Frequent to continuous flexion/extension** (e.g. hypertonicity, kicking, legs drawn up, extension of extremities, fists clenched, tremor, exaggerated guarding)
Compliance with Ventilation **OR** **Verbal Response**	**Tolerating movement** OR **None**	**Coughing but tolerating ventilation for most of the time** OR **Occasional complaints** (e.g. moans or whimpers, occasional cries, sighs, groans)	**Fighting or unable to control ventilation** OR **Frequent complaints** (e.g. crying steadily, screams, sobs, moans, grunts)
Vital Signs (HR, BP, RR)	**Within normal baseline**	HR, BP, and/or RR are **10%- 20% above** baseline.	HR, BP, and/or RR are **>20% above baseline**
Physiologic Signs	**Warm, dry skin**	Dilated pupils, perspiring, flushing	Diaphoretic, pallor

0 = No Pain **1-3 = Mild Pain** **4-7 = Moderate Pain** **8-10 = Severe Pain**

References

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Payen, J.F., Bru, O., Bosson, J.L., Lagrasta, L., Novel, E., Deschaux, I., Lavagne, P., & Jacquot, C. (2001) Assessing pain in critically ill sedated patients by using a behavioral pain scale. Critical Care Medicine, 29, 2258-2263.

N-PASS (Neonatal Pain, Agitation, & Sedation Scale) - By Pat Hummel, MA, RNC, NNP, PNP & Mary Puchalski, MS, RNC. Loyola University Health System, Loyola University Chicago, 2000
(This tool is currently undergoing testing for validity and reliability)

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