

REVIEW ARTICLE

Pediatric Pain Scale

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ABSTRACT

Pain scales are a vital asset in identifying pain levels, intensity and duration, especially for the paediatric population, as they might not be able to properly verbalise their pain, and hence targeted pain management won't happen. Various paediatric pain scales for paediatrics are FLACC, Wong's Baker Faces Pain Scale, Comfort Scale, and Poker Chip Tool, & for newborns – NIPS, CRIES can be followed. Pain scale also helps us to identify pain characteristics like throbbing pain, stabbing pain, etc. Pain scales will provide the pain level data on admission & during the course of the patient's stay, & by doing assessment & re-assessment using the pain scale, we will come to know the effectiveness of the treatment.

Hence knowledge, skills & usage of the paediatric pain scale is the need of the hour, and hence nurses need to be trained & equipped to follow the pain scale in their paediatric patients for providing prompt care in pain management.

KEYWORDS

• Paediatric Pain Scale • Pain Assessment • Pain Levels

INTRODUCTION

Pain is one of the symptoms that drives the patient to the hospital to get rid of it. Pain is an important aspect of patient nursing care, and it is the responsibility of the nurse to help the patient get relief from pain. It is also considered a 5th vital sign. Pain experience can lead to variations in vital signs like tachycardia, tachypnoea, etc. Pain can be mild, moderate, or severe & it can be relieved by pharmacological & non-pharmacological measures.

So pain identification becomes important, but at times pain assessment becomes a tough task because if:

- Patient is in severe pain & not in a situation to verbalise.
- Patient is unconscious.
- The patient is paediatric and does not possess the intellectual capacity to verbalise his or her pain.
- Nurses lack the skill to assess for pain and the ability to understand behavioural

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cues for pain, especially when working with children.

So in order to correctly and properly identify pain in the above scenarios, pain scales are helpful & resourceful.

As nurses are in the near vicinity of the patient, it becomes a helpful, resourceful, and important tool for easy understanding of the patient pain levels.

Paediatric Pain Scale:

The pain scale is an instrument that will aid in identifying the pain. The pain scale helps to measure the intensity of pain and its impact on a patient's well-being. A pain scale helps in better understanding one's pain levels.

Pain will have a significant impact on a child's health and well-being and can have long-term consequences if pain is not treated.

Certain paediatric pain scales that can be used to identify paediatric population pain are:

For New-borns:

- NIPS
- CRIES

For Paediatric Population:

- FLACC
- Wong's Baker Facial Pain scale
- Numeric Pain scale
- Comfort Scale
- Poker Chip Scale

Points under consideration when assessing for paediatric pain:

A child, in response to pain, usually cries, and sometimes it becomes difficult to understand whether the child is crying because of pain or anxiety or hunger.

So when assessing the pain keep in mind the various factors like children:

- Stage of Development
- Certain environmental factors
- Cognitive impairment in child
- Severe diseases in child

Pain Levels:

- Relaxed and comfortable
- 1-3 - Mild discomfort

- 4-7 - Moderate pain
- 8-10 - Severe discomfort pain

FLACC Scale

FLACC Scale assesses pain in children from 1 month to 5 years.

FLACC is a behavioural pain assessment tool that is used to evaluate pain in children who are unable to verbalise their own pain.

FLACC has 5 categories: face, leg, activity, cry, and consolability.

Categories	Scoring		
	0	1	2
Face	No particular expression or smile	Occasional grimace or frown withdrawn, disinterested	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and fourth, tense	Arched, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to; distractible	Difficult to console or comfort

- Scoring to be done between 0 and 2.
- Which results in a total score between 0 and 10.
- A 10 indicates the highest level of pain.

In patients who are awake:

- Observe for 1 to 5 minutes or longer.
- Observe legs and body uncovered.
- Reposition the patient or observe activity.
- Assess body for tenderness and tone.
- Initiate consoling interventions if needed.

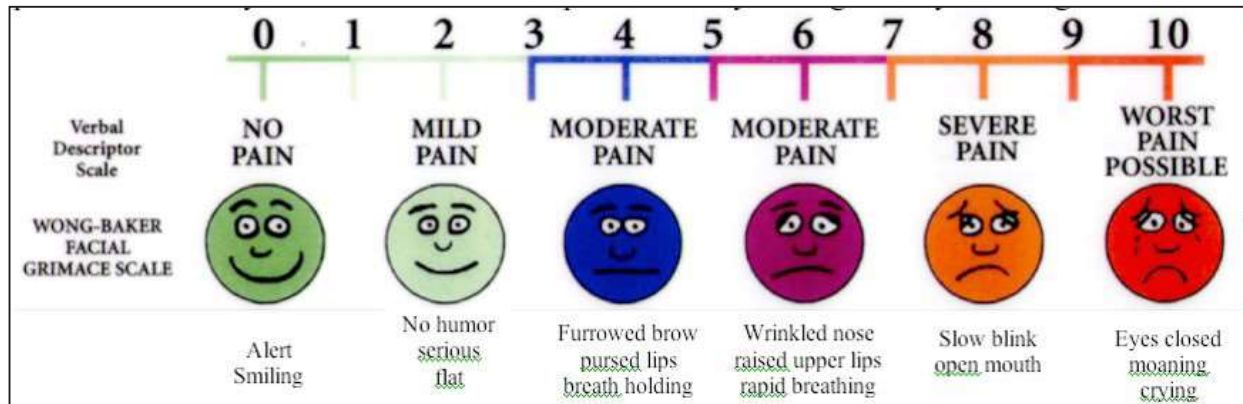
In patients who are asleep:

- Observe for 5 minutes or longer.
- Observe body and legs uncovered.

- If possible, reposition the patient.
- Touch the body and assess for tenderness and tone.

Wong-Baker Faces Pain Rating Scale

A scale that uses six cartoon faces to indicate increasing levels of distress, from no pain (0) to worst pain (10).



Ranges from 0 for a smiling face to 10 for a tearful face, indicating “worst pain”.

Each face is scored 0, 2, 4, 6, 8, and 10.

- Face 0 is ‘no hurt.’
- More than 0 up to 2 is ‘hurts a little bit.’
- More than 2 up to 4 is ‘hurts a little more.’
- More than 4 up to 6 is ‘hurts even more.’
- More than 6 up to 8 is ‘hurts a whole lot.’
- More than 8 up to 10 is ‘hurts worse’ (although you don’t have to be crying to feel this bad).

How to assess pain using Wong’s Baker Pain Scale:

- Ask children to choose a face that best describes their own pain and record the appropriate number.
- For patients with chronic pain, nurses must have knowledge of the patient’s baseline level of pain to use this scale most effectively.

FACES-R (Faces Pain Scale Revised)

Used for children age from 4–18 years, this scale shows faces with numbers that correspond to different levels of pain.

This scale is intended to measure how children feel inside, not how their face looks.

COMFORT scale

The comfort scale aids in measuring distress in unconscious and ventilated children and adolescents.

This scale is used for unconscious children on ventilators to help determine their distress levels.

The comfort scale has eight indicators:

- Alertness
- Calmness / agitation
- Respiratory response
- Physical movement
- Blood pressure
- Heart rate
- Muscle tone
- Facial tension.

Each indicator is scored between 1 and 5.

Scoring is based upon the behaviour exhibited by the child.

The total score can range between 8 and 40.

Interpretation of Scores:

The COMFORT scale is useful for monitoring and adjusting sedation and pain management strategies in patients who are unable to verbally communicate.

- **8-10:** May indicate over-sedation.
- **11-23:** May indicate moderate sedation.
- **24-30:** May indicate little sedation.
- **17-26:** Generally indicates adequate sedation and pain control.

	1	2	3	4	5
Alertness Lightly	Deeply asleep	Asleep	Drowsy	Fully awake and alert	Hyper-alert
Calmness or agitation	Calm	Slightly anxious	Anxious	Very anxious	Panicky
Respiratory response	No movement	Occasional, slight movement	Slight movement often	Vigorous movement limited to extremities	Vigorous movement including torso and head
Blood Pressure	Less than baseline	Consistently at baseline	Occasional increases of 15% or more (10-3 episodes during observation period)	Multiple increase of 15% or more (>3 episodes)	Sustained increase > 15%
Muscle Tone	Muscles totally relaxed; no muscle tone	Reduced muscle tone	Normal muscle tone	Increase muscle tone and flexion of fingers and toes	Extreme muscle rigidity and flexion of fingers and toes
Facial tension	Facial muscles totally relaxed	Facial muscle tone normal; no facial muscle tension evident	Tension evident in some facial muscles	Tension evident throughout facial muscles	Facial muscles contorted and grimacing

Poker Chip Tool

A simple clinical tool that can be used to identify the presence or absence of pain and to estimate pain intensity in young children.

The Poker Chip Tool (PCT) is a self-report pain scale that uses poker chips to help children indicate how much pain they are experiencing. It is also known as the Pieces of Hurt tool.

How it works

- The child is given four red poker chips or one white chip and four red chips.
- The child chooses how many red chips represent their pain level.
- One chip represents a little bit of pain, two chips represent a little more pain, and so on.
- Four chips represent the most pain a child can experience.

When it's used

- The PCT is often used with children aged 3–5 years.
- It's been used to compare the validity of other pain scales.

PAIN SCORE TOOL FOR NEONATES:

This can be used to monitor a neonate before, during, and after a painful procedure such as venipuncture.

Various New-born scales are:

- **NIPS:** Neonatal Infant Pain Scale
- **CRIES:** C-Crying, R-Requires increased oxygen administration, I-Increased vital

signs, E-Expression, S-Sleeplessness.

Minimum score – 0, Maximum score – 10

A combination of NIPS & CRIES pain can be used to assess new-born pain.

Parameters which are to be assessed as part of the combined NIPS & CRIES scale are:

- Breathing Pattern
- Arousal
- Cry
- Facial Expression
- Increase in Vital Signs
- Extremity Movement

Scoring is to be done from 0 to 2, whereas

- 0 score indicates No Pain,
- 1 score indicates mild pain &
- 2 scores indicate Moderate to severe pain

Other parameters to check:

In addition to asking patients to rate their pain verbally, the patient should be asked about:-

- The location of pain
- Pain character
- Frequency of Pain
- Duration of Pain

Pain Characteristics:

Various pain characteristics to be seen are:

- Sharp Pain
- Aching Pain
- Burning Pain

- Throbbing Pain
- Stabbing Pain

Behavioural cues for pain:

The following signs may be an indication of a child suffering from pain:

- Crying
- Making sad, crying or grimace-like facial expressions
- Changes in behaviour
- Fussy Behaviour
- Not feeding well

Pain Classification:

Pain sensation in paediatrics is classified as:

1. Based on its duration:

- Acute pain (short-term)
- Chronic pain (long-term)
- Recurrent pain (intermittent episodes)

2. Based on physiological:

- Nociceptive pain (due to tissue damage)
- Neuropathic pain (damage to nerves)
- Nociplastic pain (altered pain processing without clear tissue damage)

3. Based on duration:

- **Acute pain:** Has a sudden onset & is for a short time due to a cut or injury.

Common complaints seen in acute pain are headache, abdominal pain, earache, sore throat, toothache, muscle aches, pain related to immunisation, and pain following surgery.

Abdominal pain is often one of the most frequent acute pain complaints in children.

- **Chronic pain:** Pain here is persistent & lasting for weeks or months. Due to certain underlying chronic conditions.

Common complaints seen in chronic pain are headaches, recurrent abdominal pain and general musculoskeletal pain, including limb pain and back pain.

Recurrentpain: It is characterised by intermittent pain episodes that come and go.

Based on physiological mechanism:

Nociceptivepain: It is the most common type. It arises from activation of pain receptors in

response to tissue damage (e.g., muscle strain, burns).

Nociceptive pain is further subdivided into

- **Somatic nociceptive pain:** Pain arising from skin, muscle, and bone.
- **Visceral nociceptive pain:** Pain arising from internal organs.

Neuropathicpain: Pain is due to the damage to nerves. Pain characteristics associated with neuropathic pain are often described as burning or tingling.

Nociplasticpain: Pain arising from altered pain processing by the brain without clear tissue damage.

Pain without any known cause is also common in children.

Pain Assessment & Re-assessment:

- Pain assessment is to be done at the time of admission.

This gives us baseline data regarding pain & aids us to know the pain levels at the time of admission and guides us further in the pain management process.

Pain reassessment to be done:

- Every shift
- When are there any changes in the patient's condition?
- When there are changes in the treatment plan.
- Self-reporting of pain by the child or evidence of behavioural cues indicative of the presence of pain.
- To Tow the effectiveness of treatment modalities until the patient achieves consistent pain relief or pain control.
- If the patient score is more than mild levels, then monitoring is done every 30 minutes after each intervention taken until the intensity rating is in the mild range.

LIMITATIONS

- A falsely low score may be seen in an infant who is too ill to respond.
- A falsely low score may be seen in an infant who is receiving a paralyzing

agent.

- Inexperienced Nurse may find it difficult to assess the pain using pain scale.

DISCUSSION

Educational teaching programmes, self-instructional modules, video-assisted teaching, etc., are to be carried out for the nurses to improve the knowledge. Skills & practices of using the paediatric pain scale.

In-service training programmes to be targeted towards proper utilisation & following of pain scales.

Pocket-sized cut-outs of pain scales to be distributed among paediatric nurses, which will serve as ready material for reference when needed.

Pain scales can be modified too based on hospital policy & other pain symptoms.

CONCLUSION

Paediatric nurses need to be very skilful and knowledgeable & must have practice using pain scales in evaluating the pain levels of children, including the child who cannot verbalise.

Paediatric nurses must also understand the behavioural cues for pain which a child may exhibit due to pain, including fussy behaviour, crying, etc.

Paediatric nurses, while evaluating the pain levels, must also put stress towards identifying the pain character, pain intensity, duration,

and location, as it aids in identifying all the dimensions of pain. And on that basis, pain management techniques like pharmacological or non-pharmacological techniques can be adopted.

Hence Proper utilisation of pain scales allows for proper & detailed pain assessment, especially in vulnerable populations like paediatrics.

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