

FUNDAMENTALS • ASSESSMENT • NGN 2026

Pain Scales & Pain Management

The 5th vital sign — pain assessment, pediatric & nonverbal pain tools, pharmacologic management, and priority nursing care across the lifespan.

■ SCALES: 9 TOOLS ■ AGES: NEONATE → GERIATRIC ■ NGN CLINICAL JUDGMENT

SOURCE TRANSPARENCY NOTICE

This topic was not present in your uploaded personal notes. Content is compiled from standard NCLEX references: *Saunders Comprehensive Review for the NCLEX-RN (Silvestri)*, *ATI RN Fundamentals & Pharmacology*, *Lippincott Manual of Nursing Practice*, the American Society for Pain Management Nursing (ASPMN)

position statements,
American Academy of Pediatrics (AAP)

guidelines on pediatric pain,
The Joint Commission

pain assessment standards, and validated scale documentation (Wong-Baker FACES Foundation; Merkel et al. for FLACC; Krechel & Bildner for CRIES; Lawrence et al. for NIPS).

01 Definition & Overview

- ▶ **Pain** = whatever the experiencing person says it is, existing whenever they say it does (McCaffery's classic definition — pain is *subjective*).
- ▶ Often called the **"5th vital sign"** — must be assessed at every encounter using an age- and ability-appropriate tool.
- ▶ Untreated pain → delayed healing, immobility complications (atelectasis, DVT, ileus), chronic pain syndromes, depression, & in neonates → altered brain development.
- ▶ **NCLEX core principle:** believe the patient. Vital signs and behavior are *supporting* data — not the primary determinant of pain in alert patients.

02 Pathophysiology — The Nociceptive Pathway

STEP 1

Transduction

Tissue injury → release of chemicals (prostaglandins, bradykinin, substance P, histamine) → stimulate nociceptors. *NSAIDs & acetaminophen work here.*

STEP 2

Transmission

Pain impulse travels along A-delta (fast/sharp) & C fibers (slow/dull) → spinal cord → ascends spinothalamic tract. *Local anesthetics block here.*

STEP 3

Perception

Thalamus relays to cerebral cortex & limbic system → conscious awareness of pain + emotional response. *Opioids, distraction, imagery work here.*

STEP 4

Modulation

Descending pathways release endorphins, serotonin, norepinephrine → inhibit pain signals. *SNRIs & TCAs enhance this pathway.*

Pain Classification

CATEGORY	TYPE	ORIGIN / QUALITY	EXAMPLE
Nociceptive	Somatic	Skin, muscle, bone — sharp, localized, aching	Fracture, incision
	Visceral	Organs — deep, cramping, poorly localized, may refer	Appendicitis, MI
Neuropathic		Nerve damage — burning, shooting, tingling, electric	Diabetic neuropathy, post-herpetic, phantom limb
Acute		< 3–6 months, identifiable cause, resolves with healing	Post-op, kidney stone
Chronic		> 3–6 months, often no objective signs, fatigue/depression common	Fibromyalgia, low back pain

03 Which Scale, Which Patient? — Quick Picker

Selecting the correct tool is itself a high-yield NCLEX skill. Match the scale to **developmental age + ability to self-report**.

0-6 MO NEONATE / YOUNG INFANT Cannot self-report. Observe physiologic + behavioral cues. NIPS • CRIES	2 MO - 7 YR INFANT / TODDLER / PRESCHOOL Pre-verbal or limited self-report. Observe 5 behaviors. FLACC	3 YR + PRESCHOOL / SCHOOL-AGE Can point to a picture matching how they feel. WONG-BAKER FACES	7 YR - ADULT SCHOOL-AGE & OLDER Concrete number reasoning developed; can self-rate. NRS 0-10 • VAS
NONVERBAL CRITICALLY ILL / INTUBATED ADULT Sedated, ventilated, unable to communicate. CPOT • BPS	DEMENTIA ADVANCED COGNITIVE IMPAIRMENT Cannot reliably self-report due to cognition. PAINAD		

04 The Scales — In Detail

Numeric Rating Scale (NRS)

AGES 7+ · ADULT GOLD STANDARD



No Pain Moderate Worst Imaginable

- 0 = no pain · 1–3 mild · 4–6 moderate · 7–10 severe
- Patient verbally states or points to number
- Requires intact cognition + ability to abstract numbers

Visual Analog & Verbal Descriptor

ADULT · ADOLESCENT

- **VAS:** 10-cm line anchored "no pain" ↔ "worst pain." Patient marks point; nurse measures in mm.
- **Verbal Descriptor:** none → mild → moderate → severe → very severe → worst possible.
- Useful when number rating is difficult (literacy, language).

Wong-Baker FACES

AGES 3+ · SELF-REPORT



- Child *points* to the face that best matches their pain
- Explain: "These faces show how much something hurts — pick the one that shows how *you* feel."
- Originally validated for 3+; widely used across pediatrics & some adults

FLACC Scale

2 MO - 7 YR · NONVERBAL

Behavioral observation tool. Each of 5 categories scored 0–2; total 0–10.

	0	1	2
Face	No expression / smile	Occasional grimace	Frequent frown / quivering chin
Legs	Normal / relaxed	Uneasy / restless	Kicking / drawn up
Activity	Lying quietly	Squirming / tense	Arched / rigid / jerking
Cry	No cry (awake or asleep)	Moans / whimpers	Steady cry / screams / sobs
Consolability	Content / relaxed	Reassured by touch / talk	Difficult to console

- 0 relaxed · 1–3 mild · 4–6 moderate · 7–10 severe

CRIS Scale

NIPS — Neonatal Infant Pain Scale

NEONATES 32 WK GA - 6 MO

Five domains, each scored **0–2**; total **0–10**. Designed for post-op neonatal pain.

- Crying — high-pitched / inconsolable
- Requires O₂ for SpO₂ < 95%
- Increased vital signs (HR & BP vs pre-op)
- Expression — grimace
- Sleepless

Score ≥ 4 = treat pain. Reassess after intervention.

PRETERM & TERM · UNDER 1 YR

Six behavioral/physiologic indicators, total **0–7**.

- Facial expression (0–1)
- Cry (0–2)
- Breathing pattern (0–1)
- Arms (0–1)
- Legs (0–1)
- State of arousal (0–1)

> 3 = pain present; intervene.

CPOT — Critical-Care Pain Observation

ADULT · INTUBATED / NONVERBAL ICU

Four indicators, each scored **0–2**; total **0–8**.

- Facial expression
- Body movements
- Muscle tension
- Compliance with ventilator *or* vocalization (if extubated)

> 2 = pain likely; treat & reassess.

PAINAD — Advanced Dementia

ADULTS · COGNITIVE IMPAIRMENT

Five items, each scored **0–2**; total **0–10**.

- Breathing (independent of vocalization)
- Negative vocalization
- Facial expression
- Body language
- Consolability

1–3 mild · **4–6** moderate · **7–10** severe.

05 Priority Nursing Interventions (ABCs + Safety)

A • AIRWAY

Monitor Sedation & Respirations

- ▶ Count RR for full minute before opioid dose
- ▶ Hold opioid if RR < 10–12/min (adult)
- ▶ Watch SpO₂ & capnography for opioid-induced respiratory depression
- ▶ Naloxone at bedside for high-risk patients

B • BREATHING

Assess Before, During, After

- ▶ Baseline pain + VS before intervention
- ▶ Reassess pain: **15–30 min IV · 30 min IM · 60 min PO**
- ▶ Document score, location, quality, intervention, & response

C • CIRCULATION

VS & Pain Together

- ▶ ↑ HR, ↑ BP, ↑ RR in acute pain (sympathetic surge)
- ▶ **Chronic pain may have NORMAL VS** — don't dismiss
- ▶ Neonates: bradycardia + apnea can occur with severe pain

SAFETY

Fall & Constipation Prevention

- ▶ Bed alarm + call light within reach after opioid
- ▶ Start stool softener / bowel regimen with scheduled opioid
- ▶ Assess for urinary retention
- ▶ Reorient prn (delirium risk in elderly)

ASSESSMENT

Use PQRST / OLDCARTS

- ▶ Use age-appropriate validated scale every encounter
- ▶ Trust self-report > behavior > VS
- ▶ Pre-medicate before procedures (dressing change, PT)

NON-PHARM

Always Combine With Drugs

- ▶ Positioning, ice/heat, splinting, TENS
- ▶ Distraction, music, guided imagery
- ▶ Neonates: swaddling, non-nutritive sucking, sucrose 24% pre-procedure, kangaroo care
- ▶ Children: bubbles, pinwheels, comfort positions (parent's lap)

06 Pharmacology — WHO Analgesic Ladder & Drug Comparison

WHO 3-Step Analgesic Ladder

STEP 1 • MILD (1-3)

Non-opioids ± adjuvant

Acetaminophen, NSAIDs (ibuprofen, ketorolac), aspirin. Add adjuvant for neuropathic.

STEP 2 • MOD (4-6)

Mild opioid + non-opioid ± adjuvant

Codeine, hydrocodone, tramadol, oxycodone (low dose). Often combined with acetaminophen.

STEP 3 • SEVERE (7-10)

Strong opioid ± non-opioid ± adjuvant

Morphine, hydromorphone, fentanyl, methadone. PCA pump, epidural, around-the-clock dosing.

Drug Comparison Table

DRUG / CLASS	MECHANISM	KEY SIDE EFFECTS	NURSING CONSIDERATIONS
Acetaminophen (Tylenol)	Central COX inhibition; ↓ prostaglandins in CNS	Hepatotoxicity (overdose)	Max 4 g/24 hr healthy adult; 2-3 g if liver disease/etoh. Antidote: N-acetylcysteine .
NSAIDs (ibuprofen, ketorolac, naproxen)	Peripheral COX-1/2 inhibition → ↓ prostaglandins	GI bleed, renal injury, ↑ BP, platelet dysfunction	Give <i>with food</i> . Avoid in renal disease, peptic ulcer, late pregnancy. Ketorolac max 5 days.
Morphine (opioid agonist)	μ-receptor agonist → CNS pain modulation	Respiratory depression, sedation, constipation, pruritus, hypotension, urinary retention	Hold if RR < 12. Bowel regimen. Avoid in renal failure (active metabolite accumulates). Naloxone antidote.
Hydromorphone (Dilaudid)	μ-receptor agonist; ~5-7× more potent than morphine	Same as morphine; HIGH overdose risk if confused with morphine	NOT equivalent dose to morphine — verify carefully. Safer in renal impairment.
Fentanyl (IV, patch, lozenge)	Synthetic μ-agonist, 100× morphine potency	Respiratory depression, chest wall rigidity (rapid IV)	Patch: <i>not</i> for opioid-naïve. Onset 12-24 hr — don't titrate quickly. Remove old patch.
Codeine / Tramadol	Weak μ-agonist (codeine prodrug); tramadol also inhibits SNRI reuptake	Constipation, drowsiness; tramadol → seizures, serotonin syndrome	Codeine contraindicated < 12 yr & post-tonsillectomy (FDA box warning — ultra-rapid metabolizers).
Meperidine (Demerol)	μ-agonist; metabolite normeperidine	Seizures, neurotoxicity (normeperidine accumulation)	Largely avoided. Never in renal failure or with MAOIs. Max 48 hr use.

DRUG / CLASS	MECHANISM	KEY SIDE EFFECTS	NURSING CONSIDERATIONS
Naloxone (Narcan)	Pure opioid antagonist — competitive μ blockade	Acute withdrawal: pain rebound, tachycardia, HTN, agitation	Titrate slowly to restore RR, not full alertness. Short half-life — may need repeat doses .
Adjuvants (gabapentin, pregabalin, amitriptyline, duloxetine)	Modulate neuropathic pain pathways	Sedation, dizziness, weight gain, dry mouth	First-line for neuropathic pain. Slow titration. Don't stop abruptly.



OPIOID RED FLAGS

- **RR < 8–10/min** or unresponsive → naloxone + call rapid response
- **Sedation scale > 3** (Pasero) — sedation precedes respiratory depression
- **Pinpoint pupils** + somnolence + ↓ RR = opioid overdose triad
- **Never crush extended-release** (oxycontin, MS Contin) — fatal dose dumping

07 NCLEX Test Traps — Wrong vs Right

✗ WRONG ANSWER PATTERNS

- "Patient is smiling and talking — no pain" → ignore self-report
- "VS are normal — pain must be controlled"
- Holding opioid for elevated BP (acute pain ↑ BP — treat the pain)
- Using NRS for a 2-year-old
- Giving codeine to a 6-year-old post-tonsillectomy
- Crushing OxyContin in applesauce for a patient with dysphagia
- Waiting until patient asks for prn before assessing pain
- Reassessing IV opioid pain at 5 min or skipping reassessment

✓ RIGHT ANSWER PATTERNS

- **Believe the patient's self-report** — it's the gold standard
- Assess pain at every encounter using the correct scale
- Reassess **15–30 min after IV, 60 min after PO**
- Premedicate *before* dressing changes / PT / mobilization
- FLACC or CRIES for non-verbal — not NRS
- Use sucrose 24% PO for neonatal procedural pain (heel sticks)
- Start bowel regimen *with* scheduled opioid
- Hold opioid & notify provider for RR < 12, sedation > 3

⚠ TOP CONFUSED CONCEPTS

- **Tolerance vs. Addiction vs. Dependence:** Tolerance = needing more for the same effect (physiologic). Dependence = withdrawal if stopped (physiologic). Addiction = compulsive use despite harm (psychological). The first two are *expected* with long-term opioids; do not equal addiction.
- **Pseudoaddiction:** drug-seeking behavior caused by *under-treatment* of pain — resolves when pain is adequately controlled.
- **Placebo:** never give to "prove" pain isn't real — unethical per ASPMN.
- **PCA pump:** *only the patient* presses the button. PCA-by-proxy (family pressing) is a sentinel event risk.

o8 Patient & Family Education

PAIN REPORTING

- ✓ Report pain early — easier to treat than severe pain
- ✓ Use the same scale consistently
- ✓ Describe quality, location, what helps / worsens it
- ✓ Pain control is your right — speak up

OPIOID SAFETY AT HOME

- ✓ Take exactly as prescribed — don't double dose
- ✓ No alcohol, sedatives, or driving until you know your response
- ✓ Use stool softener / fiber / fluids to prevent constipation
- ✓ Lock up medication; dispose of leftovers at takeback sites
- ✓ Keep naloxone in the home if prescribed

PARENTS OF CHILDREN IN PAIN

- ✓ You know your child best — report behavior changes
- ✓ Stay during procedures if comforting (developmentally appropriate)
- ✓ Use distraction: bubbles, books, videos, favorite toy
- ✓ Don't promise "it won't hurt" — be honest, then comfort
- ✓ Sucrose pacifier & swaddling for infant procedures

NON-PHARM STRATEGIES

- ✓ Heat for muscle tension / chronic pain
- ✓ Ice for acute injury, swelling, inflammation
- ✓ Distraction, music, guided imagery, deep breathing
- ✓ Positioning, splinting incisions when coughing
- ✓ Rest and gentle activity — balance both

WHEN TO CALL PROVIDER

- ✓ Pain rating > previous baseline or unrelieved by medication
- ✓ New severe constipation or no BM in 3 days
- ✓ Excessive drowsiness, slow breathing, confusion
- ✓ Allergic reaction (rash, hives, swelling)
- ✓ Signs of infection at the source of pain

END-OF-LIFE / CHRONIC PAIN

- ✓ Around-the-clock dosing prevents pain spikes
- ✓ Breakthrough pain meds are normal & expected
- ✓ Addiction risk is extremely low in dying patients
- ✓ Fear of "double effect" should not withhold comfort

09

Memory Boosters & Mnemonics

PQRST

PAIN ASSESSMENT

- P** — Provokes / Palliates
- Q** — Quality (sharp, dull, burning)
- R** — Region / Radiation
- S** — Severity (0–10)
- T** — Timing (onset, duration)

OLDCARTS

COMPREHENSIVE SYMPTOM ASSESSMENT

- O** — Onset
- L** — Location
- D** — Duration
- C** — Character
- A** — Aggravating factors
- R** — Relieving factors
- T** — Timing
- S** — Severity

FLACC

PEDIATRIC BEHAVIORAL SCALE

- F** — Face
- L** — Legs
- A** — Activity
- C** — Cry
- C** — Consolability

CRIES

NEONATAL POST-OP PAIN

- C** — Crying
- R** — Requires O₂
- I** — Increased VS
- E** — Expression
- S** — Sleepless

ABCDE

PAIN MANAGEMENT (AHCPR)

- A** — Ask about pain regularly
- B** — Believe patient & family
- C** — Choose options appropriate to patient
- D** — Deliver in timely, logical manner
- E** — Empower & enable patient

WILDA

QUICK PAIN SCREEN

- W** — Words to describe pain
- I** — Intensity (0–10)
- L** — Location
- D** — Duration
- A** — Aggravating / Alleviating

⚡ QUICK PATTERN RECOGNITION

- "Faces" = 3+ years · "FLACC" = nonverbal/young · "CRIES" = newborn
- 2 + 7 = 10 → FLACC works from age 2 months to 7 years, max score 10
- Reassess: IV = 15–30 min · PO = Plus an hour (60 min)
- "Sedation precedes respiratory depression" — watch sedation level closely with opioids
- "Pain is the 5th vital sign" — assess every encounter, document every time

10 NGN Clinical Judgment Scenario (NCJMM)

NEXT GEN NCLEX • 6-STEP CLINICAL JUDGMENT MEASUREMENT MODEL

Case: A 14-month-old post-op day 1 from cleft palate repair is brought to the unit. The child has an IV of D5½NS at 30 mL/hr, ibuprofen scheduled q6h, and morphine 0.05 mg/kg IV q4h prn for pain. The child weighs 10 kg. Currently the child is lying rigidly in the crib with knees drawn up, whimpering, and pulls away when the mother tries to comfort her. HR 162, RR 38, SpO₂ 96%, T 37.2°C. Last morphine dose was 4 hours ago. The mother says, "She always cries when she's hungry — maybe she's just hungry."

1 Recognize Cues

Relevant cues: rigid posture, drawn-up legs, whimpering, inconsolable, HR 162 (elevated for age — normal 90–150), RR 38 (slightly elevated), 4 hr since last analgesic, post-op day 1 from painful surgery, mother attributing behavior to hunger.

FLACC components present: Face (likely grimace), Legs (drawn up = 2), Activity (rigid = 2), Cry (whimper = 1), Consolability (difficult = 2).

2 Analyze Cues

Child is at **2 months – 7 years +** nonverbal → **FLACC is the correct scale** (NRS & Wong-Baker inappropriate at 14 months). Behaviors are classic pain cues, not hunger (hunger = rooting, crying that *stops* with comforting). HR & RR elevations align with sympathetic pain response. FLACC estimate ≈ **8–10** = severe pain. Mother is misinterpreting cues — teaching opportunity.

3 Prioritize Hypotheses

#1 Acute post-operative pain (severe) — most likely & most urgent. Differential: hunger (low probability — feeding may be NPO post-op), urinary retention, position discomfort, anxiety/separation. **Acute pain must be addressed first** because untreated pain delays healing, disrupts feeding/sleep, and is humane priority.

4 Generate Solutions

(a) Score formal FLACC & document. (b) Administer ordered morphine 0.05 mg/kg = **0.5 mg IV** (since 4 hr have passed). (c) Verify ibuprofen is on schedule for multimodal coverage. (d) Non-pharm: swaddle, dim lights, allow mother to hold if surgical site permits, offer pacifier (per cleft palate protocol — usually elbow restraints, no pacifier — check orders). (e) Educate mother on infant pain cues vs hunger cues.

5 Take Action

- Score FLACC = 9.
- Confirm IV patency, verify dose with second RN per pediatric high-alert policy.
- Administer morphine 0.5 mg IV slow push.
- Place child in side-lying position per cleft palate post-op protocol (NOT prone).
- Have mother present, dim lights, swaddle.
- Document score, intervention, time.
- Sedation & respiratory monitoring per opioid protocol.

6 Evaluate Outcomes

Reassess at 15–30 minutes (IV onset). Expected: FLACC ≤ 3, HR & RR trending toward age norms, child resting calmly, consolable. **If pain not improved** → notify provider; consider dose adjustment / scheduled dosing. **Monitor for adverse**

effects: RR < 20 (concerning for 14-month-old), excessive sedation, SpO₂ drop, urinary retention. Document teaching to mother on pain cues. Continue multimodal: scheduled ibuprofen + prn morphine + comfort measures.

NGN NCLEX 2026 · Pain Scales & Management · Diane's Visual Study Library

SOURCES: ASPMN · AAP · The Joint Commission · Saunders Comprehensive Review · ATI RN · Lippincott Manual · Wong-Baker FACES Foundation