Name:

Hosp #:

DOB:

(Affix patient label)

NEONATAL PAIN ASSESSMENT TOOL (PAT) Non-ICU Version

Great Ormond Street Hospital for Children NHS Foundation Trust

Date:																
Time:																
Posture/tone:	**Relaxed 0 Extended 1 Flexed &/or tense 2**															
Sleep pattern:	**Relaxed 0 Agitated or withdrawn 2**															
Expression:	**Relaxed 0 Frown 1 Grimace 2**															
Colour:	**Pink, well perfused 0 Pale/dusky/flushed 2**															
Cry:	**No 0 Yes 2**															
Respirations:	**Normal 0 Tachypnoea 1 Apnoea 2**															
Heart rate:	**Normal 0 Tachycardia 1 Fluctuating 2**															
O2 Saturations:	**Normal 0 Desaturates +/- handling 2**															
Blood pressure:	**Normal 0 Hypo/hypertension 2**															
Nurse perception:	**No 0 Yes 2**															
Total Score /20:																
Nursing Comfort Measures Code:																
Nurse Action/s Code:																
Nurse's Initials:																
Comments:																

Nursing Comfort Measures (NCM) Codes:

R Gently repositioning the infant to make more comfortable
W Wrapping / containment of the infant to provide support for limbs
E Decreasing environmental stressors eg. reducing noise, shading baby from light, reducing activity around the baby
T Tactile soothing eg. stroking the baby gently, supporting the limbs, gently placing your hand on the baby's head
V Talking softly to the baby/ soft appropriate music
N Nappy change
D Using a pacifier/dummy to provide non-nutritive sucking
K Kangaroo care by parent
B Breastfeeding

Nurse Action Codes:

N No action taken
B NCA bolus analgesia given
P Oral/IV Paracetamol given
M Oral morphine given
S Sucrose
I Increased NCA background analgesia infusion
D Decreased NCA background analgesia infusion
PB Pre-procedure NCA bolus analgesia
PP Pre-procedure score
AP After-procedure score

Adapted from: Hodgkinson K., Bear M., Thorn J., Van Blaricum S. (1994) Measuring pain in neonates: Evaluating an instrument and developing a common language. The Australian Journal of Advanced Nursing; 12(1): 17-22

Instructions for completing assessment:

- Nurse should stand where the infants body and face can be seen clearly
- Observation should last for a full two minutes without interruption
- Review the parameter descriptors table and assign a score for each parameter that best describes the infant's behaviour or state (Note that not every descriptor in each box below needs to be present)

Explanation of PAT scoring terms

	0	1	2
Posture / Tone	**Relaxed**	**Extended** - Digits widespread - Trunk rigid - Limbs drawn out - Shoulders raised off bed	**Flexed and/or tense** - Fists clenched - Trunk guarding - Limbs drawn to midline - Head and shoulders resist positioning
Sleep pattern	**Relaxed** -Asleep -Quiet alert -Drowsy		**Agitated or withdrawn** - Wakes with startle - Easily woken - Restless - Squirming - No clear sleep/wake transition - Eye aversion 'shut out'
Expression	**Relaxed**	**Frown** - Shallow furrows - Eyes lightly closed	**Grimace** - Deep furrows - Eyes tightly closed - Pupils dilated
Colour	**Pink, Well perfused**		**Pale / dusky / flushed** - Palmar sweating (term infant)
Cry	**No**		**Yes** - When disturbed - Doesn't settle after handling - Loud - Whimpering - Whining
Respirations	**Normal***	**Tachypnoea* At rest**	**Apnoea** - At rest or with handling
Heart rate	**Normal** *	**Tachycardia* At rest**	**Fluctuating** - Spontaneous or at rest
Oxygen saturation	**Normal** *		**Desaturation*** - with or without handling
Blood pressure	**Normal** *		**Hypo/hypertension* at rest**
Nurse's perception	**No pain perceived by me**		**I think the baby is in pain**

*Refer to PEWS chart or Nervecentre for normal ranges for heart rate, blood pressure, respiratory rate and oxygen saturations.

When to assess:

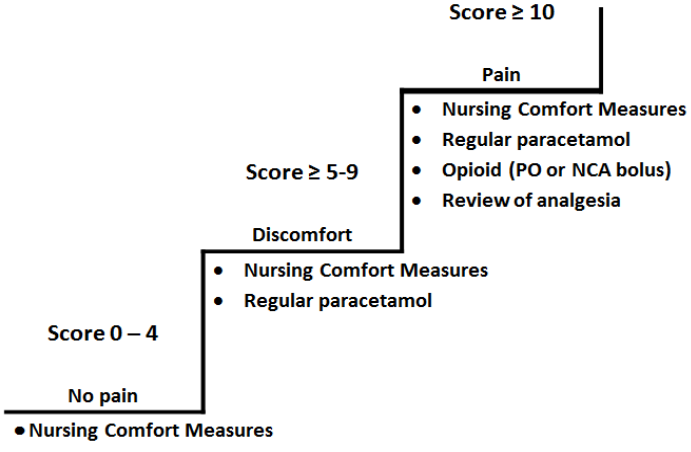
- Minimum 4 hourly
- On admission
- Any changes in physiology or behaviour
- Pre and post painful procedures
- Post-operatively: hourly for the first 6 hours
- Hourly if on NCA or Epidural
- Then adjust frequency according to score generated

The score the neonate generates will influence the frequency of assessment:

- Score 0-4: 4 hourly assessment
- Score 5-9: 2 hourly assessment
- Scores ≥10: hourly assessment until score is less than 10
  Repeat assessment 30 minutes after any pharmacological intervention

Clinical Management

- Scores 0-4: Nursing comfort measures (NCM), continue with current management or consider weaning analgesia
- Scores ≥ 5-9: NCM, paracetamol
- Scores ≥ 10: NCM, paracetamol, opioid (PO or NCA bolus), review of analgesia



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