**NEONATAL PAIN ASSESSMENT TOOL (PAT)**

**Non-ICU Version**

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<thead>
<tr>
<th>Date:</th>
<th>Time:</th>
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</table>

### 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- **Agitated or withdrawn**: 2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

### Respiration:
- **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:

<table>
<thead>
<tr>
<th>Nurse Action/s Code:</th>
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### Nurse’s Initials:

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<th>Comments:</th>
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**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 e.g. reducing noise, shading baby from light, reducing activity around the baby
- **T**: Tactile soothing e.g. 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

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

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<th>0</th>
<th>1</th>
<th>2</th>
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<tbody>
<tr>
<td>Posture / Tone</td>
<td>Relaxed</td>
<td>Extended</td>
<td>Flexed and/or tense</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Digits widespread</td>
<td>- Fists clenched</td>
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<tr>
<td></td>
<td></td>
<td>- Trunk rigid</td>
<td>- Trunk guarding</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Limbs drawn out</td>
<td>- Limbs drawn to midline</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Shoulders raised off bed</td>
<td>- Head and shoulders resist positioning</td>
</tr>
<tr>
<td>Sleep pattern</td>
<td>Relaxed</td>
<td>Frown</td>
<td>Agitated or withdrawn</td>
</tr>
<tr>
<td></td>
<td>- Asleep</td>
<td>- Shallow furrows</td>
<td>- Wakes with startle</td>
</tr>
<tr>
<td></td>
<td>- Quiet alert</td>
<td>- Eyes lightly closed</td>
<td>- Easily woken</td>
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<tr>
<td></td>
<td>- Drowsy</td>
<td></td>
<td>- Restless</td>
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<td></td>
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<td></td>
<td>- Squirming</td>
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<td></td>
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<td></td>
<td>- No clear sleep/wake transition</td>
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<td>- Eye aversion 'shut out'</td>
</tr>
<tr>
<td>Expression</td>
<td>Relaxed</td>
<td>Frown</td>
<td>Grimace</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Shallow furrows</td>
<td>- Deep furrows</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Eyes lightly closed</td>
<td>- Eyes tightly closed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Pupils dilated</td>
</tr>
<tr>
<td>Colour</td>
<td>Pink, Well perfused</td>
<td>Pale / dusky / flushed</td>
<td>Palmar sweating (term infant)</td>
</tr>
<tr>
<td>Nurse’s perception</td>
<td>No</td>
<td>Yes</td>
<td>No pain perceived by me</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>I think the baby is in pain</td>
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### 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