Updated: Nov 2020

Revised-FLACC

(Revised descriptors for children with disabilities shown in [brackets]

Categories	0	1	2
Face	**No particular expression or smile**	**Occasional grimace or frown, withdrawn, disinterested** *[appears sad or worried]*	**Constant grimace or frown** **Frequent to constant quivering chin, clenched jaw** *[Distressed-looking face: Expression of fright or panic]*
INDIVIDUAL BEHAVIOURS			
Legs	**Normal position or relaxed**	**Uneasy, restless, tense** *[Occasional tremors]*	**Kicking, or legs drawn up** *[Marked increase in spasticity, constant tremors or jerking]*
INDIVIDUAL BEHAVIOURS			
Activity	**Lying quietly, normal position moves easily**	**Squirming, shifting back & forth tense.** *[Mildly agitated (e.g.. head back and forth, aggression); shallow, splinting, respirations, intermittent sighs]*	**Arched, rigid or jerking** [Severe agitation head banging; Shivering (not rigors); Breath holding, gasping or sharp intake of breath; Severe splinting]
INDIVIDUAL BEHAVIOURS			
Cry	**No cry, (awake or asleep)**	**Moans or whimpers; occasional complaint** [Occasional verbal outbursts or grunts]	**Crying steadily, screams or sobs, frequent complaints** *[Repeated outbursts, constant grunting]*
INDIVIDUAL BEHAVIOURS			
Consolability	**Content, relaxed**	**Reassured by occasional touching hugging or being talked to, distractible**	**Difficulty to console or comfort** *[Pushing away caregiver, resisting care or comfort measures]*
INDIVIDUAL BEHAVIOURS			

Updated: Nov 2020

Introduction:

FLACC has been validated for children **from the age of 2 months**.

FLACC Revised (FLACC with additional behavioral descriptors) has been validated for children with **cognitive impairment**.

Instructions for using FLACC Revised:

Individualize the tool: The nurse should review the descriptors within each category with the child's parents/caregivers. Ask them if there are any additional behaviors that are better indicators of pain in their child. Add these behaviors to the tool in the appropriate category.

Scoring: Each of the five categories [(F) Face, (L) Leg, (A) Activity, (C) Cry and (C) Consolability] is scored from 0-2, which results in a total score between 0-10.

Patients who are awake: Observe for at least 1-3 minutes. Observe legs and body uncovered. Reposition patient. Observe activity, assess body for tenseness and tone. Initiate consoling interventions if needed.

Patients who are asleep: Observe for at least 5 minutes. Observe body and legs uncovered. If possible, reposition the patient. Touch the patient to assess for tenseness and tone.

- *Merkel S, Voepol-Lewis T, Shayevitz J et al. The FLACC: a behavioral scale for scoring post-operative pain in young children. Pediatric Nursing, 1997; 23:293-297.*
- *Malviya S, Voepol-Lewis T, Burke C et al. The revised FLACC observational pain tool: improved reliability and validity for pain assessment in children with cognitive impairment. Pediatric Anesthesia 2006; 16:258-265.*
- *Royal College of Nursing (2009) Clinical Practice Guidelines for the Recognition and assessment of Acute Pain in Children. London. Royal College of Nursing.*