**Table 1. Adult Nonverbal Pain Scale University of Rochester Medical Center**

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| Categories | 0 | 1 | 2 |
|---|---|---|---|
| Face | No particular expression or smile. | Occasional grimace, tearing, frowning, wrinkled forehead. | Frequent grimace, tearing, frowning, wrinkled forehead. |
| Activity (movement) | Lying quietly, normal position. | Seeking attention through movement or slow, cautious movement. | Restless, excessive activity and/or withdrawal reflexes. |
| Guarding | Lying quietly, no positioning of hands over areas of body. | Splinting areas of the body, tense. | Rigid, stiff. |
| Physiology (vital signs) | Stable vital signs | Change in any of the following:<br>* SBP > 20 mm Hg.<br>* HR > 20/minute. | Change in any of the following:<br>* SBP > 30 mm Hg.<br>* HR > 25/minute. |
| Respiratory | Baseline RR/$SpO_2$ Compliant with ventilator | RR > 10 above baseline, or 5% ↓$SpO_2$ mild asynchrony with ventilator | RR > 20 above baseline, or 10% ↓$SpO_2$ severe asynchrony with ventilator |

Abbreviations: HR, heart rate; RR, respiratory rate; SBP, systolic blood pressure; SpO2, pulse oximetry. Instructions: Each of the 5 categories is scored from 0-2, which results in a total score between 0 and 10. Document total score by adding numbers from each of the 5 categories. Scores of 0-2 indicate no pain, 3-6 moderate pain, and 7-10 severe pain. Document assessment every 4 hours on nursing flowsheet and complete assessment before and after intervention to maximize patient comfort. Sepsis, hypovolemia, hypoxia need to be excluded before interventions.



***Source***: Odhner M, Wegman D, Freeland N, Ingersoll G. Evaluation of a newly developed non-verbal pain scale (NVPS) for assessment of pain in sedated critically ill patients.