

FLACC SCALE

Category	Score		
	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
Cry	No cry(awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasionally touching, hugging or being talked to, distractible	Difficult to console

How to use FLACC

In patients who are awake: observe for 1-5 minutes or longer. Observe the legs and body uncovered. Reposition patient or observe activity. Assess body for tenseness and tone. Initiate consoling interventions if needed.

In patients who are asleep: Observe for 5 minutes or longer. Observe body and legs uncovered. If possible, reposition the patient. Touch the body and assess for tenseness and tone.

SKALA FLACC

Kategori	Pemarkahan		
	0	1	2
Wajah	Tiada ekspresi tertentu di wajah atau dalam keadaan tersenyum	Kadang-kadang muka berkerut, murung, tidak bermaya atau tidak bersemangat	Rahang terkancing, dagu bergetar (pada kadar kerap hingga berterusan)
Kaki	Kedudukan biasa ayau selesa	Keadaan tidak selesa, resah atau tegang	Menendang-nendang ataupun membengkokkan kaki
Activiti	Berbaring tenang, berkedudukan biasa, bergerak dengan selesa	Berguling, bergerak depan dan belakang, tegang	Meringkuk, kaku atau mengelupur
Tangisan	Tidak menangis (sama ada semasa tidur atau terjaga)	Merengek dan kadang-kadang mengeluh	Menangis berterusan, berteriak dan teresak-esak, sering mengeluh
Keboleh-pujukan	Tenang	Masih dapat dipujuk dengan sesekali sentuhan, pelukan atau kata-kata, masih boleh dialih perhatian	Sukar dipujuk

Cara penggunaan skala FLACC:

Bagi pesakit yang sedar : Pemerhatian hendaklah dilaksanakan selama 1 -5 minit atau selebihnya. Perhatikan kaki dan badan tanpa ditutup. Posisikan pesakit semula dan perhatikan sebarang pergerakan atau aktiviti gerakan badan. Nilai ketegangan badan dan cuba mengurangkan ketidakselesaan sekiranya perlu.

Bagi pesakit yang tidak sedar: Pemerhatian hendaklah dilaksanakan selama lebih daripada 5 minit. Perhatikan kaki dan badan tanpa ditutup. Posisikan pesakit semula sekiranya boleh . Nilai ketegangan badan dengan mengerakkan atau menyentuh bahagian badan tersebut.

REVISED FLACC SCALE

ASSESSMENTS		SCORES		
	0	1	2	
FACE	No particular expression or smile	Occasional grimace or frown, withdrawn or disinterested; appears sad or worried	Consistent grimace or frown; frequent/constant quivering chin; clenched jaw; distressed-looking face; expression of fright or panic	
Individualised behaviour :				
LEGS	Normal position or relaxed; usual tone & motion to limbs	Uneasy, restless, tense; occasional tremors	Kicking, or legs drawn up; marked increase in spasticity, constant tremors or jerking	
Individualised behaviour :				
ACTIVITY	Lying quietly, normal position, moves easily, regular & rhythmic respirations	Squirming, shifting back/forth, tense or guarded movements, mildly agitated, shallow splinting respirations, intermittent sighs	Arched, rigid or jerking, severe agitation, head banging, shivering, breath holding, gasping or sharp intake of breaths, severe splinting	
Individualised behaviour :				
CRY	No cry/verbalization	Moans or whimpers, occasional complaint, occasional verbal outburst or grunt	Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting	
Individualised behaviour :				
CONSOLABILITY	Content or relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort, pushing away caregiver, resisting care or comfort measures	
Individualised behaviour :				

**Individualised pain behaviours unique to each child with severe neurological impairment as identified by carers or staff can be inserted into the most appropriate category in the left column and its severity graded accordingly to encompass pain behaviours not covered by the existing table.*