I. PURPOSE
All patients will receive the best level of pain control that can safely be provided in order to prevent unrelieved pain.

II. POLICY
Pain is recognized as a sixth vital sign. This policy provides guidelines to caregivers in how to assess, treat, and assist in managing a patient’s pain.

III. DEFINITIONS
A. “Pain is whatever the experiencing person says it is, existing whenever s/he says it does” (McCaffery, 1968). Self-report is the preferred indicator of pain, and behavioral/physiological indicators are used only when the patient is unable to self-report, (i.e., vented patient newborn, infant, child- not sure if this adult only).
B. Maple Grove uses a self rating scale 0-10 to evaluate pain. 0 indicates no pain, 10 indicates worst pain imaginable.
C. Newborns, infants and children exhibit physiological and behavioral responses that are similar to, but can be more intense than, adult responses (Merenstein).
D. Unrelieved, non-ischemic pain is defined as:
   1. a pain scale intensity rating of equal to or greater than 4 or,
   2. causes the patient distress or,
   3. is unacceptable to the patient or,
   4. limits the patient’s physical, cognitive or psychological function.
E. Cardiac pain needs to be assessed and treated immediately.
F. Pain relief is the alleviation of pain or a reduction in pain to a level of comfort that is acceptable to the patient and is demonstrated by a decrease in the patient’s pain scale rating and an improvement in physical, cognitive, behavioral, and/or psychosocial functioning.
G. Opioid naive individual is defined as an individual who has NOT been utilizing an opioid on a regular basis (e.g., four times per day) for an extended period of time (e.g., one month).
H. Opioid tolerant individual is defined as an individual who has received an opioid on a regular basis for an extended period of time.
I. Multi-model approach to pain management. This is defined as using pharmacological (opioid and non-opioid) interventions and non-pharmacological interventions together to provide comfort.
IV. PROCEDURE: PAIN MANAGEMENT – ALL PATIENTS

A. Assess for presence of pain for all patients:
   1. On initial assessment.
   2. At regular intervals, with a minimum of t.i.d. (every 8 hour shift) and prn.
      a. With each new report/rating of pain; before, during and after any known
         pain-producing event.
      b. With unrelieved pain.
      c. Re-assess pain intensity after each pain management intervention
         (pharmacological and non-pharmacological) once a sufficient time has
         elapsed for the treatment to reach peak effect (within 2 hours of
         intervention - general guidelines: 30 minutes for IV, 60 minutes for
         PO/IM, and 15-60 minutes for non-pharmacological).
   3. Assess patient's ability to use a pain rating scale and the patient's personal goal
      for pain relief.
   4. For newborn/infants/children - use age appropriate pain scale.
   5. Pain rating scales used include: Numeric (0-10; 0 indicating no pain and 10
      indicating worse possible pain), verbal, behavioral, faces, FLACC, and N-Pass
      (see attached-need to attach if using).
   6. Utilize the acronym "APP" (assume pain present) for patients who are unable to
      self-report and/or are unable to demonstrate pain related behaviors. Examples of
      patients this might affect include: the unresponsive patient, the sedated,
      chemically paralyzed patient, potentially hospice patients and patients with brain
      insults.
   7. With initial assessment of pain and new onset of pain, assess factors utilizing
      WILDA (W = in the patients own words, I = intensity (pain rating scale), L =
      location, D = description, A = alleviating and aggravating factors), functional
      status and quality of life.
   8. Monitor for common side effects which may include oversedation, respiratory
      depression, nausea/vomiting, pruritus and acute confusion.

B. Principles of Intervention/Patient Education
   1. Provide patients/family with verbal and written information about pain
      management.
   2. Teach patients/families to use a pain rating scale that is age, condition, and
      language appropriate for reporting pain intensity and that the goal of pain
      management is prevention.
   3. Teach patient/family pharmacologic and non-pharmacologic interventions.
   4. Develop an individualized pain management plan which includes the patient’s
      goal for pain management, patient preferences for treatment, age, type of pain,
      risk for cognitive impairment, history of chemical dependency, chronic pain and
      cultural beliefs and practices.
   5. The physician should be notified of pain that remains at a 4 or greater or higher
      than the patient's comfort level.
   6. A guide to pharmacologic interventions with acute pain. See diagram below.
7. Choose IV or PO routes instead of IM for administering pain medications.
8. Prevent, anticipate, and institute aggressive treatment for pain before, during, and after all painful diagnostic and/or therapeutic procedures.
9. Pain management resources include Pharmacy, MD's, CNS.
10. Anticipate and manage opioid-induced side effects. For patients on PCA or epidural utilize pre-printed orders for side effect management. For other patients, on opioid therapy, utilize a stool softener/laxative combination (e.g., Senokot-S) to prevent constipation, antiemetic [e.g., Ondansetron (Zofran)] for nausea/vomiting and an antihistamine [e.g., diphenhydramine (Benadryl)] for itching.
11. Offer non-pharmacologic interventions. During painful procedures for infants, encourage breastfeeding, holding, or offering 24% sucrose as appropriate.
   a. Physical Agents: Heat/cold Applications, massage, exercise, TENS, immobilization, or re-positioning
   b. Cognitive-Behavioral: Guided Imagery, relaxation techniques, music/sound therapy, preparatory information, slow rhythmic breathing, diversional activities (children)
   c. Developmental Care for neonates/infants - Non-nutritive sucking, Repositioning with boundaries, nesting, swaddling, and positioning aides, Holding and rocking as appropriate, skin-to-skin contact, decreased noise, light and tactile stimulation
   d. Distraction/Relaxation: for pediatrics—age appropriate distraction (toy, game or movie). Age appropriate relaxation techniques (parental touch, soothing speech, breathing techniques, guided imagery).

C. Communicate the pain management plan on patient transfer to other nursing units or services, as well as to other care facilities on patient discharge.
D. Provide discharge instructions regarding pain management including how to take medications and what to report to the physician.

V. PROCEDURE: PAIN MANAGEMENT – NEONATE/PEDIATRIC
A. Definitions
   1. Newborns and pediatrics (0-17 years of age)
   2. Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage and effects of the environment. Infants/children who are premature, ill, drug exposed or require surgery have the potential for pain.
3. Unrelieved pain is defined as:
   a. N-PASS score of 4 or greater than which continues one hour after intervention.
   b. FLACC score of 4 or greater than which continues one hour after intervention.
   c. As defined in definitions on page one.
   d. FACES scale of 4 or greater.

4. Pain relief is the alleviation of pain or a reduction of pain, decreased pain responses and increased comfort and organized behaviors.

B. Standards of Care of Pain Management – Infants/Pediatric/Principles for Assessment
   1. Assess for pain on admission including onset, physiological and behavioral indicators, and aggravating factors, taking into account maternal factors and age of patient.
   2. Pain scores should be directly reported by the patient using Numeric, Verbal or Faces scale. If the patient is unable to self-report FLACC, N-PASS or behavioral indicators are used (e.g., N-PASS; FLACC for 0-7 years of age)
   3. Routinely assess for pain at regular intervals completing it with vital signs and physical assessments every shift (minimum of t.i.d., approximately every 8 hours) or as directed by physician. Reassess after each pain management intervention, within two hours (general guidelines are 30 minutes for IV interventions and 60 minutes for PO/IM and non-pharmacological interventions).

C. Principles of Intervention
   1. All infants must be provided with non-pharmacological interventions to help relieve pain as stated in the Protocol for Developmental Care:
      a. Involve parents
      b. Decrease noise and light.
      c. Cover isolette
      d. Speak softly to infant
      e. Support with boundaries, nesting, positioning aides to promote a balance of flexion and extension postures
      f. Handle infant slowly and smoothly
      g. Work around sleep/wake patterns and try not to interrupt sleep. Cluster care.
      h. Promote self-regulatory behavior - holding, grasping, sucking
   2. Infants undergoing a procedure, with potential for pain, can benefit from Sucrose 24% as a pain management comfort measure. Examples of procedures; heel stick, venipuncture, tape removal & dressing changes, suctioning, eye exam, strenuous OT/ PT, circumcision, immunizations, and urinary catheterization.
      a. Gather 24% sucrose solution and oral syringe or pacifier.
      b. Administer the dose by dipping pacifier in solution or give by syringe into side of mouth. The sucrose is absorbed via oral mucosa.
      c. Sucrose and non-nutritive sucking induces endogenous opioids providing analgesia for approximately two minutes.
      d. Administer dose within a 2 minutes of pending procedure for efficacy. (Maximum dose is 2ml= 8 doses in 24 hours.)
      e. Giving sucrose may decrease cry duration, heart rate, facial grimacing and lower ratings on neonatal pain scales.
      f. Monitor pain throughout procedure (N-PASS), continue dosing through procedure to maintain comfort, not to exceed maximum dose.
g. Provide other non-pharmacologic comfort measures in addition. Sucrose is less effective in older infants 6-18 months of age.

h. Sucrose is contraindicated in infants with the following:
   i. absent bowel sounds
   ii. GI surgery in previous 5 days, active persistent pulmonary hypertension
   iii. presence of necrotizing enterocolitis, or at risk for, feeding intolerance
   iv. asphyxiated infants
   v. hyper-/ hypo- glycemia
   vi. corrected gestational age less than 28 weeks
   vii. poor perfusion
   viii. receiving dopamine or dobutamine

3. Pediatric patients
   a. Assess using age appropriate pain scale.
      a. FLACC - 2 months to 7 years
      b. FACES - As young as 3 years
      c. Numeric - As young as 5 years
      d. Behavioral - Over 7 years but unable to use other scale
   b. Form trusting relationship with parent and involve them in assessing pain.
   c. Use age appropriate techniques to prepare the patient for pain.
   d. Offer non-pharmacologic strategies
      a. Age appropriate distraction (toy, game, talk, movie or other interest).
      b. Age appropriate relaxation techniques (parental touch, soothing speech, breathing techniques, guided imagery).

VI. CROSS REFERENCE


VII. ATTACHMENTS

Attachment A – Faces Pain Scale and Behavior Pain Scale
Attachment B – NPASS
Attachment C – FLACC Scale
Attachment D – Numeric Pain Scale
**Attachment A – Faces Pain Scale and Behavior Pain Scale**

**Faces Pain Scale**
Describe how bad your pain is on a pain scale to help your physician and nurse know if the treatment is working or if a change is needed. Rate your pain on a scale of 0 to 10. (0 = no pain; 10 = worst possible pain)

<table>
<thead>
<tr>
<th>Faces</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worst Possible Pain</td>
<td>10</td>
</tr>
<tr>
<td>Very Severe Pain</td>
<td>9</td>
</tr>
<tr>
<td>Severe Pain</td>
<td>8</td>
</tr>
<tr>
<td>Moderate Pain</td>
<td>7</td>
</tr>
<tr>
<td>Mild Pain</td>
<td>6</td>
</tr>
<tr>
<td>No Pain</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

**Behavior Pain Scale**
Directions: Use these five categories of behavior descriptions to determine whether patient has pain, but cannot communicate this verbally.

**Breathing: Normal**
- Occasional labored breathing.
- Short period of hyperventilation.
- Noisy labored breathing.
- Long period of hyperventilation.
- Cheyne-Stokes respirations.

**Vocalization: None**
- Occasional moan or groan.
- Low level speech with a negative or disapproving quality.
- Repeated troubled calling out.
- Loud moaning or groaning.
- Crying.
- Sighs, grunts, gasps.
- “Ouch, that hurts.”
- Cussing during movement.
- Exclamation of protest “Stop!”

**Facial Expression: Smiling or inexpressive**
- Sad
- Frightened
- Frown
- Clenched teeth.
- Tightened lips.
- Distorted expressions.

**Body Language: Relaxed**
- Tense.
- Distressed pacing.
- Fidgeting.
- Rubbing affected area.
- Rigid.
- Fists clenched or clutching or holding onto siderails.
- Knees pulled up.
- Pulling or pushing away.
- Striking out.
- Rocking.
- Constant hand motions.

**Consolability: No need to console.**
- Distracted or reassured by voice or touch.
- Unable to console, distract or reassure.
Attachment B - N-PASS

<table>
<thead>
<tr>
<th>Assessment Criteria</th>
<th>Sedation</th>
<th>Normal</th>
<th>Pain / Agitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crying Irritability</td>
<td>-2</td>
<td>-1</td>
<td>0</td>
</tr>
<tr>
<td>Crying</td>
<td>No cry with painful stimuli</td>
<td>Moans or cries minimally with painful stimuli</td>
<td>Appropriate crying</td>
</tr>
<tr>
<td>Irritability</td>
<td>Not irritable</td>
<td>Irritable or crying at intervals</td>
<td>Consolable</td>
</tr>
<tr>
<td></td>
<td>High-pitched or silent-continuous cry</td>
<td>Inconsolable</td>
<td></td>
</tr>
<tr>
<td>Behavior State</td>
<td>No arousal to any stimuli</td>
<td>Aroused minimally to stimuli</td>
<td>Appropriate for gestational age</td>
</tr>
<tr>
<td></td>
<td>No spontaneous movement</td>
<td>Little spontaneous movement</td>
<td>Restless, squirming</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Awakens frequently</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Arching, kicking</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Constantly awake or arouses minimally / no movement (not sedated)</td>
</tr>
<tr>
<td>Facial Expression</td>
<td>Mouth is lax</td>
<td>Minimal expression with stimuli</td>
<td>Relaxed</td>
</tr>
<tr>
<td></td>
<td>No expression</td>
<td></td>
<td>Any pain expression intermittent</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Any pain expression continual</td>
</tr>
<tr>
<td>Extremities Tone</td>
<td>No grasp reflex</td>
<td>Weak grasp reflex</td>
<td>Relaxed hands and feet</td>
</tr>
<tr>
<td></td>
<td>Flaccid tone</td>
<td>↓ muscle tone</td>
<td>Normal tone</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Intermittent clenched toes, fists or finger splay</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Body is not tense</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Continual clenched toes, fists or finger splay</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Body is tense</td>
</tr>
<tr>
<td>Vital Signs HR, RR, BP SaO2</td>
<td>No variability with stimuli</td>
<td>&lt; 10% variability from baseline with stimuli</td>
<td>Within baseline or normal for gestational age</td>
</tr>
<tr>
<td></td>
<td>Hypoventilation or apnea</td>
<td></td>
<td>↑ 10-20% from baseline</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SaO2 76-85% with stimulation - quick ↑</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>↑ &gt; 20% from baseline</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SaO2 ≤ 75% with stimulation - slow ↑</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Out of sync with vent</td>
</tr>
</tbody>
</table>

© Hummel & Puchalski (Rev. 8/14/01)
Pat Hummel, MA, RNC, NNP, PNP & Mary Puchalski, MS, RNC
Adapted from Loyola University Health System, Loyola University Chicago, 2000

+ 3 if < 28 weeks gestation/corrected age
+ 2 if 28-31 weeks gestation/corrected age
+ 1 if 32-35 weeks gestation/corrected age
Assessment of Sedation

- Sedation is scored in addition to pain for each behavioral and physiological criteria to assess the infant's response to stimuli
- Sedation does not need to be assessed/scored with every pain assessment/score
- Sedation is scored from 0 → -2 for each behavioral and physiological criteria, then summed and noted as a negative score (0 → -10)
  - A score of 0 is given if the infant's response to stimuli is normal for their gestational age
- Desired levels of sedation vary according to the situation
  - "Deep sedation" → score of -10 to -5 as goal
  - "Light sedation" → score of -5 to 2 as goal
- Deep sedation is not recommended unless an infant is receiving ventilatory support, related to the high potential for apnea and hyperventilation
- A negative score without the administration of opioids/sedatives may indicate:
  - The premature infant's response to prolonged or persistent pain/stress
  - Neurologic depression, sepsis, or other pathology

Assessment of Pain/Agitation

- Pain is scored from 0 → +2 for each behavioral and physiological criteria, then summed
- Points are added to the premature infant's pain score based on their gestational age to compensate for their limited ability to behaviorally or physiologically communicate pain
- Total pain score is documented as a positive number (0 → +10)
- Treatment/interventions are indicated for scores > 3
- Interventions for known pain/painful stimuli are indicated before the score reaches 3
- The goal of pain treatment/intervention is a score < 3
- More frequent pain assessment indications:
  - Indwelling tubes or lines which may cause pain, especially with movement (e.g., chest tubes) → at least every 2-4 hours
  - Receiving analgesics and/or sedatives → at least every 2-4 hours
  - 30-60 minutes after an analgesic is given for pain

Pavulon/Paralysis

- It is impossible to behaviorally evaluate a paralyzed infant for pain
- Increases in heart rate and blood pressure may be the only indicator of a need for more analgesia
- Analgesics should be administered continuously by drip or around-the-clock dosing
  - Higher, more frequent doses may be required if the infant is post-op, has a chest tube, or other pathology (such as NEC) that would normally cause pain
  - Opioid doses should be increased by 10% every 3-5 days as tolerance will occur without symptoms of inadequate pain relief
Scoring Criteria

Crying/Irritability
-2 → No response to painful stimuli, e.g.:
  - No cries with needle sticks
  - No reaction to ETT or naso suctioning
  - No response to care giving
-1 → Moans, sighs or cries (audible or silent) minimally to painful stimuli, e.g. needle sticks, ET T or nares suctioning, care giving
0 → Not irritable-appropriate crying
  - Cries briefly with normal stimuli
  - Easily consoled
  - Normal for gestational age
+1 → Infant is irritable/crying at intervals-but can be consoled
  - if intubated-interruption silent cry
+2 → Any of the following:
  - Cry is high-pitched
  - Infant cries incoherently
  - If intubated-silent continuous cry

Behavior/State
-2 → Does not arouse or react to any stimuli:
  - Eyes continually shut or open
  - No spontaneous movement
-1 → Little spontaneous movement, arouses briefly and/or minimally to any stimuli:
  - Opens eyes briefly
  - Reacts to suctioning
  - Withdraws to pain
0 → Behavior and state are gestational age appropriate
+1 → Any of the following:
  - Restless, squirming
  - Awakens frequently/easily with minimal or no stimulation
+2 → Any of the following:
  - Kicking
  - Arching
  - Constantly awake
  - No movement or minimal arousal with stimulation (inappropriate for gestational age or clinical situation, i.e. post-operative)

Facial Expression
-2 → Any of the following:
  - Mouth is lax
  - Drooling
  - No facial expression at rest or with stimuli
-1 → Minimal facial expression with stimuli
0 → Face is relaxed at rest but not lax-normal expression with stimuli
+1 → Any pain face expression observed intermittently
+2 → Any pain face expression in continual
  
Extremities/Tone
-2 → Any of the following:
  - No palmar or plantar grasp can be elicited
  - Flaccid tone
-1 → Any of the following:
  - Weak palmar or plantar grasp can be elicited
  - Decreased tone
0 → Relaxed hands and feet-normal palmar or sole grasp elicited-appropriate tone for gestational age
+1 → Intermittent (< 30 seconds duration) observation of toes and/or hands as clenched or fingers splayed
  - Body is not tense
+2 → Any of the following:
  - Frequent (≥ 30 seconds duration) observation of toes and/or hands as clenched or fingers splayed
  - Body is tense/stiff

Vital Signs: HR, BP, BR & O₂ Saturations
-2 → Any of the following:
  - No variability in vital signs with stimuli
  - Hypoventilation
  - Apnea
  - Ventilated infant-no spontaneous respiratory effort
-1 → Vital signs show little variability with stimuli-less than 10% from baseline
0 → Vital signs and/or oxygen saturations are within normal limits with normal variability-or normal for gestational age
+1 → Any of the following:
  - HR, BP and/or RR are 10-20% above baseline
  - With care/stimuli infant desaturates minimally to moderately (SaO₂ 75-85%) and recovers quickly (within 2 minutes)
+2 → Any of the following:
  - HR, BP and/or RR are > 20% above baseline
  - With care/stimuli infant desaturates severely (SaO₂ < 75%) and recovers slowly (> 2 minutes)
  - Infant is out of synchrony with the ventilator-fighting the ventilator
**Attachment C – FLACC Scale**

<table>
<thead>
<tr>
<th>FLACC SCALE</th>
<th>FACE</th>
<th>LEGS</th>
<th>ACTIVITY</th>
<th>CRY</th>
<th>CONSOLABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>No particular expression or smile</td>
<td>Normal position Or relaxes</td>
<td>Lying quietly Normal position Moves easily</td>
<td>No cry (Awake or Asleep)</td>
<td>Content Relaxed</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Occasional grimace or frown, withdrawn, disinterested</td>
<td>Uneasy, Restless, Tense</td>
<td>Squirming Shifting back/forth Tense</td>
<td>Moans or whimpers Occasional Complaint</td>
<td>Reassured by occasional touching, hugging, or &quot;talking to&quot; Distractable</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Frequent to constant frown, clenched jaw, quivering chin</td>
<td>Kicking Or Legs drawn up</td>
<td>Arched Rigid Or Jerking</td>
<td>Crying Steadily Screams or Sobs Frequent Complaints</td>
<td>Difficult to console or comfort</td>
</tr>
</tbody>
</table>

The FLACC is a behavior pain assessment for use in non-verbal patients unable to provide reports of pain.

**Instructions:**
1. Rate patient in each of the five measurement categories
2. Add together
3. Document total pain score
Attachment D - Numeric Pain Scale

- **Description**
  - Our numeric scale is vertical because many people find a vertical scale more intuitive.

- **Scoring**
  - Maple Grove protocol states that treatment/interventions should be initiated for pain intensity rated higher than 4, or outside the patient’s stated comfort goal.
  - Patients with chronic conditions or high pain tolerance may score their pain in 1-3 range and it is their target comfort range.

- **Target Population**
  - This scale is not appropriate for patients who have diminished mental capacity, or children.
  - The scale is not recommended for deaf patients by itself. The scale should be put into context using American Sign Language, or written English.

- **Strengths and Limitations**
  - Strengths: Most commonly used pain scale in healthcare
  - Limitations: Patients may have difficulty with the concept of 10 representing “the worst pain you can imagine.”
  - Instead, before assessing pain, ask your patient to describe the worst pain they have previously experienced and refer to their prior pain experience as a “10”.
  - Using their prior pain as a reference, ask the patient to compare their current pain to it.
  - Keep in mind that their current pain may become the new “10”.

<table>
<thead>
<tr>
<th>Numeric Pain Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>10- Worst Pain</strong></td>
</tr>
<tr>
<td>9</td>
</tr>
<tr>
<td>8</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td><strong>4- pain outside of comfort goal without treatment/ intervention</strong></td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td><strong>0- No Pain</strong></td>
</tr>
</tbody>
</table>