Mock Scenario
Tonsillectomy

We have developed this scenario to provide an outline of the performance we expect and the criteria that the test of competence will assess.

The Code outlines the professional standards of practice and behaviour which sets out the expected performance and standards that are assessed through the test of competence.

The Code is structured around four themes – prioritise people, practise effectively, preserve safety and promote professionalism and trust. These statements are explained below as the expected performance and criteria. The criteria must be used to promote the standards of proficiency in respect of knowledge, skills and attributes. They have been designed to be applied across all fields of nursing practice, irrespective of the clinical setting and should be applied to the care needs of all patients.

Please note - this is a mock OSCE example for education and training purposes only.

The marking criteria and expected performance only applies to this mock scenario. They provide a guide to the level of performance we expect in relation to nursing care, knowledge and attitude. Other scenarios will have different assessment criteria appropriate to the scenario.

Evidence for the expected performance criteria can be found in the reading list and related publications on the learning platform.

Theme from the Code	Expected Performance and Criteria
Promote professionalism	Behaves in a professional manner respecting others and adopting non-discriminatory behaviour. Demonstrates professionalism through practice. Upholds the patient's dignity and privacy.
Prioritise people	Introduces self to the patient at every contact.
	Actively listens to the patients and provides information and clarity.
	Treats each patient as an individual showing compassion and care during all interactions. Displays compassion, empathy and concern. Takes an interest in the patient.
	Respects and upholds people's human rights. Upholds respect by valuing the patient's opinions and being sensitive to feelings and/or appreciating any differences in culture.
	Checks that patient is comfortable, respecting the patient's dignity and privacy.
Infection prevention and control	Adopts infection control procedures to prevent healthcare-associated Infections at every patient contact.
	Applies appropriate Personal Protective Equipment (PPE) as indicated by the nursing procedure in accordance with the guidelines to prevent healthcare associated infections.
	Disposes of waste correctly and safely.
Care, compassion and communication	Seeks patient's permission/consent to carry out observations/procedures at every patient contact.
	Checks patient identity correctly both verbally, and/or with identification bracelet and the respective documentation at every patient contact.
	Uses a range of verbal and nonverbal communication methods. Displays good verbal communication skills by appropriate language use, some listening skills, paraphrasing, and appropriate use of tone, volume and inflection. Good non-verbal communication including elements relating to position (height and patient distance), eye contact and appropriate touch if necessary.

Practice effectively	Maintains the knowledge and skills needed for safe and effective practice in all areas of clinical practice.
Organisational aspects of care specific to specific skills	Ensures people's physical, social and psychological needs are assessed.
	Completes physiological observations accurately and safely for the required time using the correct technique and equipment.
	Ensures any information or advice given is evidence based including using any healthcare products or services.
Documentation	Documents all nursing procedures accurately and in full, including signature, date and time.
	Writes patient's full name and hospital number clearly so that it can be easily read by others.
	Records the date, month and year of all observations.
	Charts all observations accurately.
	Scores out all errors with a single line. Additions are dated, timed and signed.
	Writes the record in ink.
Preserve safety	Supplies, dispenses or administers medicines within the limits of training, competence, the law, the NMC and other relevant policies, guidance and regulations.
Medicine management	

The Mock OSCE is made up of four stations: assessment, planning, implementation and evaluation. Each station will last approximately fifteen minutes and is scenario based. The instructions and available resources are provided for each station, along with the specific timing.

Scenario

Sam Evans has been admitted to the Surgical Ward for an elective Tonsillectomy today and is accompanied by a carer.

You will be asked to complete the following activities to provide high quality, individualised nursing care for the patient, providing an assessment of her needs using a model of nursing that is based on the activities of living. All four of the stages in the nursing process will be continuous and will link with each other.

Station	**You will be given the following resources**
Assessment – **15 minutes** You will collect, organise and document admission information about the patient.	• Assessment overview and documentation (pages 9-11) • Wong-Baker Faces Pain Rating scale (ticked) (page 24)
Planning – **15 minutes** You will complete the planning template to establish how the care needs of the patient will be met, how these are prioritised and what evidence-based nursing care you'll provide.	• A partially completed nursing care plan for two nursing care and self-care needs (pages 12-15) • A blank National Early Warning score chart 2 (PEWS2) (page 23)
Implementation – 15 minutes You will administer medications while continuously assessing the individual's current health status.	• An overview and Medication Administration Record (MAR) (pages 16-19) • Wong-Baker Faces Pain Rating scale (ticked) (page 24)
Evaluation – 15 minutes You will document the care that has been provided so that this is communicated with other healthcare professionals, provide a record of clinical actions completed, disseminate information and demonstrate the order of events relating to individual care.	• An overview and transfer of care letter for admission to a discharge lounge (pages 20-22) • A blank National Early Warning score chart 2 (NEWS2) (page 23)

On the following page, we have outlined the expected standard of clinical performance and criteria. This marking matrix is there to guide you on the level of knowledge, skills and attitude we expect you to demonstrate at each station.

Assessment Criteria
Introduce self to child and carer
Explain to the child and family the purpose and format of the assessment process and gain consent
Determine the relationship of the adult present to the child
What is the family composition? Who lives at home with the child? Do they have siblings? If so, what are their names and ages.
May establish who has parental responsibility for the child
Establish what the child likes to be called
Be welcoming in a warm, friendly fashion
Maintain good eye contact throughout
Use jargon-free, non-technical terms throughout
Encourage the child and family to ask questions and voice any concerns. Use a mixture of open and closed questions
May ask what the child and family's first language is? If it is not spoken English, do they need an interpreter or 'signer' to be present?
Demonstrate respect for the child's gender, cultural and religious beliefs throughout the assessment
Clarify understanding of issues raised by reflecting back the child's and parent's statements, such as 'What happens when your child eats peanuts?'
May check the height and weight recorded for the child with the child or parent
Find out what the child and family's reason for attending the hospital or clinic is
Ask the child and family to describe the symptoms of the illness or problem in their own words
Has the child been in hospital before? If so, when was this and what was wrong with them?
May check for allergies

What medicines is the child currently taking? (Note the dosage and frequency of all medicines)
Has the child been immunised? (If so, take details of which vaccinations they have received and when. Check this against the current recommended immunisation schedule. Make a note of any vaccinations they have not received and the reason why.)
Accurately complete the admission documentation.

Planning Criteria
Handwriting is clear and legible for problems one and two
Identify two relevant nursing problems / needs
Identify aims for both problems
Set appropriate evaluation date for both problems
Ensure nursing interventions are current / relate to EBP / best practice
Self-care opportunities identified and relevant
Professional terminology used in care planning
Confusing abbreviations avoided
Ensure strike-through errors retain legibility
Print, sign and date

Implementation Criteria
Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels
Introduce self to child and parent

Check that the name and either date of birth or hospital number on the medication chart corresponds with the details on the child's name band and checks this verbally with the child or parent
May identify if the child has any previous experience of taking medication and if so, what the experience was like
Check the child does not have any known allergy or contra-indication to the prescribed medication (if the child does, do not give the medication and inform the responsible prescriber immediately)
Before administering any prescribed drug, look at the person's prescription chart and check the following is correct:
Person
Drug
Calculation of dose
Dose given
Date and time of administration
Route and method of administration
Ensures:
Validity of prescription Signature of prescriber
The prescription is legible
Confirm height and weight of the child with parent or MAR
Identify and administer drugs due for administration correctly and safely
Explain to the child using age and developmentally appropriate language what medication is due and why

Negotiate roles for the administration of the medication with the child and parent/carer
Provide positive reinforcement as appropriate during and following administration of medication
Omit drugs not to be administered and provides verbal rationale (ask candidate reason for non-administration if not verbalised)
Accurately record drug administration and non-administration

Evaluation Criteria
Clearly describe reason for initial admission and diagnosis
Record date of admission
Identify main nursing needs
Record approaches and interventions used
Outline current ability to self-care based on the person's care plan
List areas identified for health education
Documents allergies
Ensure strike-through errors retain legibility
Print, sign and date

Candidate's Name: _____

Scenario
Sam Evans has arrived with a carer at the surgical ward to be admitted for an elective tonsillectomy. You are a children's nurse working in the Surgical ward and have been asked to complete the nursing admission paperwork for Sam Evans.

Assume it is **TODAY** and it is **08:00**.

This documentation is for your use and is **not marked** by the examiners.

Test of Competence NHS Trust

Child Inpatient Admission/Discharge Form and Trust Core Patient Activities of Living Initial Assessment

Hospital Number 0004321
SAM EVANS
MALE
01/01/2015
41 ALMOND CLOSE,
TATTERELL, LL12 TBU

Ward: SURGICAL

Date of admission: TODAY	Time: 07:00
Consultant:	MISS LEGUME
Admitting nurse:	

Patient details:

Name:	SAM EVANS
Address:	1 SWEET STREET, WESTSHIRE
Post code:	WW6 5PQ
Date of birth:	01/01/2015
Height:	104 CM
Weight on admission:	17 KG
Ethnicity:	
Religion:	

Special dietary needs: Yes ☐ No ☐

If yes, please specify:

Language spoken by:

Child: Family:

Permission to put child's name on the board?

Yes ☐ No ☐

Next of Kin details:

Name:

Relationship:

Address:

Post code:

Mobile:

GP details

Name:	DR WILLIAMS
Address:	WESTSHIRE GP SURGERY
Telephone:	01234 57890
Post code:	WW6 6RS

School/Nursery:

Are immunisations up to date?

Yes ☐ No ☐

Recent contact with infectious illnesses:

Yes ☐ No ☐

Allergies (include medicines, latex, food, other):

State reaction experienced:

Regular medications:

Where have you lived in the past 6 months:

Parent resident?

Yes ☐ No ☐

Temporary address (overseas patients):

Post code:

Who does the child live with:

Hospital Number 0145692498
SAM EVANS
MALE
01/01/2015
41 ALMOND CLOSE,
TATTERELL, LL12 TBU

Reason for admission:	**Past medical history:**
Is this a re-admission: Yes ☐ No ☐	
How many previous admissions in the last 12 months:	**Additional professionals:** Health visitor: Telephone number:
Significant social information:	Social worker: Telephone number: Community nurse: Telephone number:
	Is the child in pain? Yes ☐ No ☐ Pain score: Pain tool used:

Candidate's Name: _____

Note to Candidate:

- Document to NMC standards
- Your examiner will retain all documentation at the end of the station

Scenario
Sam Evans arrived with a carer at the paediatric surgical ward this morning for an elective tonsillectomy. Sam has returned from recovery and is back on the paediatric surgical ward for further observation. Sam is accompanied by their carer.

Based on your nursing assessment of Sam Evans, please produce a nursing care plan for **2 relevant aspects of nursing and family-centred care suitable for Sam and their carer for the next 24 hours.**

Complete **all** sections of the care plan.

Assume it is **TODAY** and it is **11:30**.

Patient Details: Name: Sam Evans Hospital No: 0145692498 Address: 41 Almond Close, Tatterell, LL12 TBU Date of Birth: 01/01/2015	
1) Nursing problem / need	
Aim(s) of care:	
Re-evaluation date:	
Care provided by nurse(s)	**Family-centred care activities**

2) Nursing problem / need	
Aim(s) of care:	
Re-evaluation date:	
Care provided by nurse(s)	**Family-centred care activities**
NAME (Print):	
Nurse Signature:	**Date:**

This page is not a required element but for use in case of error.	
Nursing problem / need	
Aim(s) of care:	
Re-evaluation date:	
Care provided by nurse(s)	**Family-centred care activities**

Candidate's Name: _____

Note to Candidate:

- Talk to the person
- Please verbalise what you are doing and why
- Read out the chart and explain what you are
- checking/giving/not giving and why
- Complete all the required drug administration checks
- Complete the documentation and use the correct codes
- The correct codes are on the chart and on the drug trolley
- Check and complete the last page of the chart
- All the medications on the Medication Administration Record do not require second checking.
- You have 15 minutes to complete this station, including the required documentation
- Please proceed to administer and document their 16:00 medications in a safe and professional manner

Scenario
Sam Evans was admitted to the paediatric surgical ward today for an elective tonsillectomy. Sam returned from recovery at 11.30. Sam has returned from recovery and is back on the paediatric surgical ward for further observation. Sam is accompanied by their carer.

Please administer and **document** Sam's 14:00 medications in a safe and professional manner.

Complete **all** sections of the documentation.

Assume it is **TODAY** and it is **14:00**.

Prescription Chart for:	SAM EVANS MALE	**HOSPITAL NUMBER:** **DATE OF BIRTH:** **ADDRESS:**	0145692498 01/01/2015 41 ALMOND CLOSE TATTERELL, LL12 TBU
ADMISSION DATE & TIME:	TODAY 08:00	**WARD:**	SURGICAL WARD

KNOWN ALLERGIES OR SENSITIVITIES		**TYPE OF REACTION**	
PENICILLIN		ANAPHYLAXIS	
Signature:	*Dr V Phillip 3459*	**Date:**	TODAY

INFORMATION FOR PRESCRIBERS:	**INFORMATION FOR NURSES ADMINISTERING MEDICATIONS:**	
USE BLOCK CAPITALS.	RECORD TIME, DATE AND SIGN WHEN MEDICATION IS ADMINISTERED OR OMITTED AND USE THE FOLLOWING CODES IF A MEDICATION IS NOT ADMINISTERED.	
SIGN AND DATE AND INCLUDE BLEEP NUMBER.		
SIGN AND DATE ALLERGIES BOX- IF NONE- WRITE "NONE KNOWN".	**1. PATIENT NOT ON WARD.**	**6. ILLEGIBLE/INCOMPLETE PRESCRIPTION OR WRONGLY PRESCRIBED MEDICATION.**
RECORD DETAILS OF ALLERGY.	**2. OMITTED FOR A CLINICAL REASON**	**7.NIL BY MOUTH**
DIFFERENT DOSES OF THE SAME MEDICATION MUST BE PRESCRIBED ON SEPARATE LINES.	**3. MEDICINE IS NOT AVAILABLE.**	**8. NO IV ACCESS**
CANCEL BY PUTTING LINE ACROSS THE PRESCRIPTION AND SIGN AND DATE.	**4. PATIENT REFUSED MEDICATION.**	**9. OTHER REASON- PLEASE DOCUMENT**
INDICATE START AND FINISH DATE.	**5. NAUSEA OR VOMITING.**	

**** IF MEDICATIONS ARE NOT ADMINISTERED PLEASE DOCUMENT ON THE LAST PAGE OF THE DRUG CHART.***

Does the patient have any documented Allergies?	~~YES~~ **NO**	**Please check the chart before administering medications.**

WARD	**CONSULTANT**	**HEIGHT**	104 cm
PAEDIATRIC SURGICAL WARD	MISS LEGUME	**WEIGHT**	17 kg
ANY Special Dietary requirements?	~~YES~~ **NO**	**If YES please specify**	N/A

Prescription Chart for:	SAM EVANS MALE	HOSPITAL NUMBER: DATE OF BIRTH: ADDRESS:	0145692498 01/01/2015 41 ALMOND CLOSE TATTERELL, LL12 TBU
ADMISSION DATE & TIME:	TODAY 08:00	WARD:	SURGICAL WARD

Does the patient have any documented Allergies?	~~YES~~ NO	Please check the chart before administering medications.

ONCE ONLY AND STAT DOSES:

Date	Time due	Drug name	Dose	Route	Prescribers signature & bleep	Given by	Time given
TODAY	10:00	PARACETAMOL	255 mg	PO	*Dr V Phillip 3459*	D WANG	10:15

PRN (AS REQUIRED MEDICATIONS):

Date	Drug	Dose	Route	Instructions	Prescriber signature & bleep	Given by	Time given
TODAY	PARACETAMOL	255 mg	PO	6 HOURLY PYREXIA	*Dr V Phillip 3459*		
TODAY	IBUPROFEN	150 mg	PO	8 HOURLY PAIN	*Dr V Phillip 3459*		

ANTIMICROBIALS:

1. DRUG	PHENOXYMETHYLPENICILLIN					Date and signature of nurse administering medications. Code for non-administration.	
DATE	DOSE	FREQUENCY	ROUTE	DURATION	TIME	TODAY	
TODAY	125 mg	4 TIMES A DAY	PO	5 DAYS	08:00	D MISTRY	
Start date	TODAY				14:00		
Finish date	+4 DAYS				20:00		
Prescriber signature & bleep	*Dr V Phillip 3459*				00:00		

REGULAR MEDICATIONS:

1. DRUG	MOVICOL					Date and signature of nurse administering medications. Code for non-administration.	
DATE	DOSE	FREQUENCY	ROUTE	DURATION	TIME	TODAY	
TODAY	1 SACHET	ONCE A DAY	PO	5 DAYS	08:00	D MISTRY	
Start date	TODAY						
Finish date	+4 DAYS						
Prescriber signature & bleep	*Dr V Phillip 3459*						

Prescription Chart for:	SAM EVANS MALE	HOSPITAL NUMBER: DATE OF BIRTH: ADDRESS:	0145692498 01/01/2015 41 ALMOND CLOSE TATTERELL, LL12 TBU
ADMISSION DATE & TIME:	TODAY 08:00	WARD:	SURGICAL WARD

Does the patient have any documented Allergies?	~~YES~~ NO	Please check the chart before administering medications.

2. DRUG						Date and signature of nurse administering medications. Code for non-administration.	
DATE	DOSE	FREQUENCY	ROUTE	DURATION	TIME		
Start date							
Finish date							
Prescriber signature & bleep							

3. DRUG						Date and signature of nurse administering medications. Code for non-administration.	
DATE	DOSE	FREQUENCY	ROUTE	DURATION	TIME		
Start date							
Finish date							
Prescriber signature & bleep							

DRUGS NOT ADMINISTERED:				
DATE	TIME	DRUG	REASON	NAME AND SIGNATURE

Candidate's Name: _____

Note to Candidate:

- This document must be completed in **BLUE** pen
- At this station you should have access to your Assessment, Planning and Implementation documentation. If not, please ask the examiner for it
- Please note; there is a total of 3 pages to this document
- Document to NMC standards
- The examiner will retain all documentation at the end of the station

Scenario
Sam Evans was admitted to the paediatric surgical ward today for an elective tonsillectomy. Sam returned from recovery and is now on the paediatric surgical ward for further observation. Sam is accompanied by their carer. Sam has received prescribed medications and is ready to be discharged.

Complete a transfer of care letter to ensure that the receiving health visitor has a full and accurate picture of Sam's history and needs.

Complete **all** sections of the documentation.

Assume it is **TODAY** and it is **16:30**.

Transfer of Care Letter

Patient Details: Name: Sam Evans Hospital No: 0145692498 Address: 41 Almond Close, Tatterell, LL12 TBU Date of Birth: 01/01/2015
Clearly describe reason for admission.
Date of admission:
Identify the main child/patient needs addressed during Sam's stay.
Outline the nursing approaches and interventions provided to meet the identified needs.

Outline Sam and their family's current ability to self-care based on the child's care plan.
Document Sam's allergies and associated reactions.
List risks identified for Sam and their family's health education.
Date and time of transfer:
NAME (Print):
Nurse Signature: **Date:**

NAME: SAM EVANS   HOSPITAL NO: 0145692498

Date:	
Time:	0800
Location	Ward
Prescribed frequency of observations:	15 min

Parameter	Scale	Example	Right label
Respiratory Rate	70, 60, 50, 40, 30, 20, 10, 0	• (plotted 30–40)	RR
	actual	35	actual
SpO2	94+ / 92 - 93 / less than 92	• (92 - 93)	SpO2
	actual	92	actual
Oxygen	air		O2
	l/min	4L	l/min
	Mode of Delivery eg facemask, nasal cannulae	FM	Mode of Delivery
Heart Rate	170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40	• (140–150)	HR
	actual	146	actual
Blood Pressure (Plot systolic and diastolic but score SYSTOLIC only) BP cuff size:	170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60	↕ (100 to 60)	BP
	actual	100/60	actual
Capillary return (central in seconds)	less than 2 secs / 2 - 4 secs / more than 4 secs	• (less than 2 secs)	CRT
Conscious level (if V / P / U complete GCS chart)	Alert / Asleep / Verbal / Pain / Unresponsive	• (Alert)	AVPU (if V / P / U complete GCS chart)
Temperature °C	40, 39, 38, 37, 36, 35, 34	• (36–37)	Temp °C
	actual	36.8	actual
Staff or Carer Concerns (Staff = S, Carer = C, None = N)		C	(Staff = S, Carer = C, None = N)
PEWS		6	PEWS
Initials		ABC	Initials
Time of medical review if score elevated		08.15	Time of medical review if score elevated
Pain Score		0	Pain Score
Blood Glucose		4.6	Blood Glucose

Score key: 0 | 1 | 3

5-11 YEARS

NHS SCOTLAND

PAEDIATRIC EARLY WARNING SCORE (PEWS) 5 – 11 YEARS

(To be used from 5 years until day before 12th birthday)

Name	SAM EVANS
DOB	01/01/2015
Hospital No.	0145692498
	Affix Patient ID label
Ward	SURG
Consultant	MISS LEGUME
Chart Number	
Date	TODAY

PEWS is a tool to aid recognition of sick and deteriorating children. PEWS should be calculated every time observations are recorded.

How to calculate score:

- Record observations at intervals as prescribed
- Record observations in black pen with a dot
- Score as per the colour key

0 | 1 | 3

- Add total points scored
- Record total score in PEWS box at bottom of chart
- Action should be taken as below

PEWS	Level of escalation	Action to be taken
Regardless of PEWS always escalate if concerned about a patient's condition		
0	0	4 HOURLY
1-2	1	1 HOURLY
3-4 or any in red zone	2	CONTINUOUS AND CALL PAEDIATRIC RETRIEVAL TEAM
5 or more	3	CONTINUOUS AND CALL PAEDIATRIC RETRIEVAL TEAM
Bradycardia, cardiac or respiratory arrest		CALL PAEDIATRIC EMERGENCY TEAM - 2222

Concerns include, but are not restricted to;

- **gut feeling**
- **looks unwell**
- **apnoea**
- **airway threat**
- **increased work of breathing,**
- **significant ↑ in O² requirement**
- **Poor perfusion / blue / mottled / cool peripheries**
- **seizures**
- **confusion / irritability / altered behaviour**
- **hypoglycaemia**
- **high pain score despite appropriate analgesia**

If observations are as expected for patient's clinical condition, please note below accepted parameters for future calls

Acceptable parameters	RR	O² saturation	HR	BP	Temperature °C
Upper acceptable					
Normal range					
Lower acceptable					
Doctor's signature	Date & Time				

PAEDIATRIC SEPSIS 6
Recognition: Suspected or proven infection + 2 of:

- Core temperature < 36°C >38°C
- Inappropriate Tachycardia
- Altered mental state: sleepy / irritable / floppy
- Peripheral perfusion, CRT >2 sec, cool, mottled

Lower threshold in vulnerable groups

Think could this be sepsis? IF NOT then why is this child unwell?

If YES respond with Paediatric Sepsis 6 within 1 hour:

- Give high flow oxygen
- IV or IO access and blood cultures, glucose, lactate
- Give IV or IO antibiotics
- Consider fluid resuscitation
- Consider inotropic support early
- Involve senior clinicians/ specialists EARLY

Neurological Observations

				Time	
COMA SCALES	Eyes Open	Spontaneously	4		Eyes closed by swelling – C
		To Speech	3		
		To Pain	2		
		None	1		
	Best Verbal Response	Alert, Coos and babbles, words to usual ability	5		Endotracheal tube or tracheostomy – T
		Irritable cries, less than normal ability	4		
		Cries in response to pain	3		
		Moans to pain	2		
		No response	1		
	Best Motor Response	Moves purposefully and spontaneously	6		Usually record the best arm response
		Withdraw to touch	5		
		Withdraws in response to pain	4		
		Flexion to pain	3		
		Extension to pain	2		
		None	1		
		Score			
Pupils	Right	Size			Reacts + No reaction - Eye closed c
		Reaction			
	Left	Size			
		Reaction			
LIMB MOVEMENT	ARMS	Normal power			Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness			
		Severe weakness			
		Spastic flexion			
		Extension			
		No response			
	LEGS	Normal power			
		Mild weakness			
		Severe weakness			
		Extension			
		No response			

Pupil Scale (m.m.) 8 7 6 5 4 3 2 1

Assessment of Acute Pain in Children

	No Pain	Mild Pain	Moderate Pain	Severe Pain
Faces Scale Score				
Ladder Score	0	1-3	4-6	7-10
Behaviour	* Normal activity * No ↓movement * Happy	* Rubbing affected area * Decreased movement * Neutral expression * Able to play/talk normally	* Protective of affected area * ↓movement/quiet * Complaining of pain * Consolable crying * Grimaces when affected part moved/touched	* No movement or defensive of affected part * Looking frightened * Very quiet * Restless/unsettled * Complaining of lots of pain * Inconsolable crying

Developed by Healthcare Improvement Scotland

Assessment of Acute Pain in Children

	No Pain	Mild Pain	Moderate Pain	Severe Pain
Faces Scale Score				
Ladder Score	0	1-3	4-6	7-10
Behaviour	* Normal activity * No ↓movement * Happy	* Rubbing affected area * Decreased movement * Neutral expression * Able to play/talk normally	* Protective of affected area * ↓movement/quiet * Complaining of pain * Consolable crying * Grimaces when affected part moved/touched	* No movement or defensive of affected part * Looking frightened * Very quiet * Restless/unsettled * Complaining of lots of pain * Inconsolable crying