VA/DoD Postoperative Pain Management Clinical Practice Guideline
REFERENCE CARD

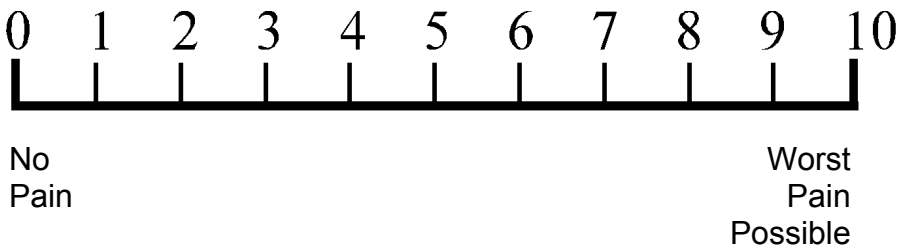
WILDCATS Pain Assessment Card for English Speaking Patients

Words to describe Pain . . Tell me about your pain

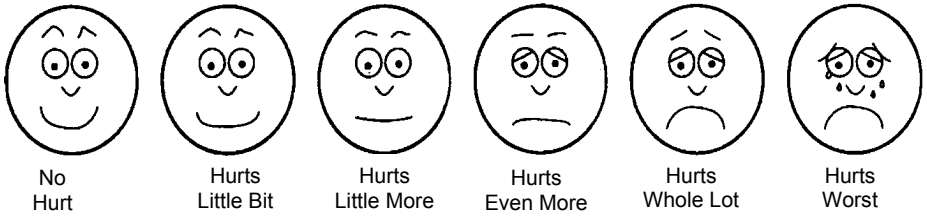
ACHING	**ELECTRICAL**	**SHOOTING**
AGONIZING	**GNAWING**	**SPLITTING**
ANNOYING	**KNIFE-LIKE**	**SQUEEZING**
BLOATED	**MISERABLE**	**STABBING**
BURNING	**NAGGING**	**STINGING**
CRAMPY	**NUMB**	**TENDER**
DEEP	**PRESSURE**	**THROBBING**
DISTENDED	**RADIATING**	**TINGLING**
DULL	**SHARP**	**TIRING**
		UNBEARABLE

Intensity . . .If 0 is no pain and 10 is the worst pain possible, what is your pain now?

Pain Intensity Rating Scale



Wong-Baker Faces Pain Scale



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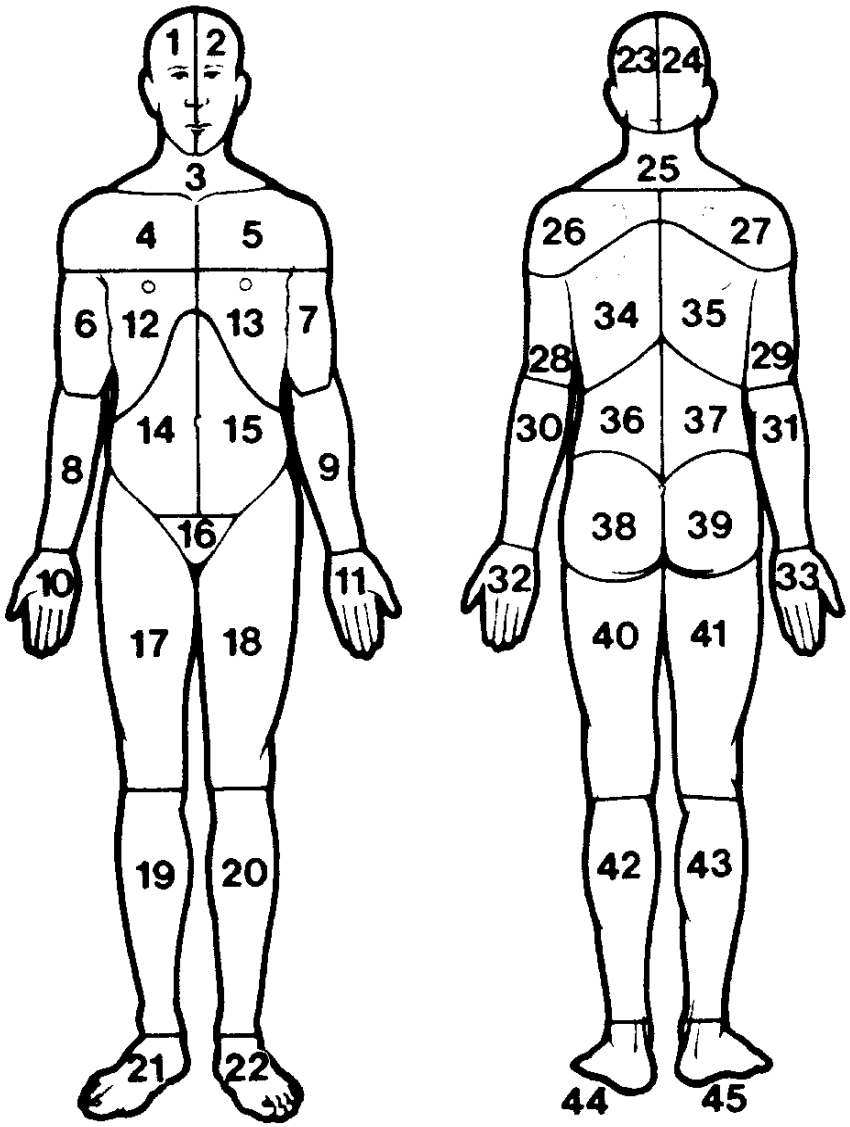
Location . . .Where is your pain...point to where the pain is located using the chart below

Does your pain travel to another location? Point to the area.



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Ask the Patient . . .

Duration . . .

When did the pain start?
Month / _____ Day / _____ Hour / _____

How long does the pain last? / _____
Seconds/ _____ Minutes/ _____
Hours/ _____ Days/ _____

Does the pain come and go?

Comfort Goal . . .

If 0 is no pain and 10 is the worst pain possible, at what pain level do you want to be?
At what pain level do you expect to be treated?

Aggravating/Alleviating Factors . . .

What makes the pain better?
What makes the pain worse?

Treatments . . .

What treatments have you used in the past and how did they work?

Symptoms/Side Effects . . .

How does pain affect: sleep, appetite, energy, activity, relationships, and mood?
Are you having any other symptoms: nausea/vomiting, constipation, itching, sleepiness, confusion, weakness, problems urinating?

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VA/DoD Postoperative Pain Management Clinical Practice Guideline
REFERENCE CARD

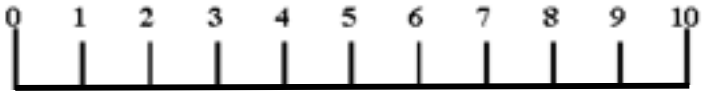
WILDCATS Pain Assessment Card for Spanish Speaking Patients

Words to describe Pain . . Tell me about your pain
Cuénteme sobre su dolor

ACHING	**DOLORIDO**
AGONIZING	**AGONIZANTE**
ANNOYING	**MOLESTO**
BLOATED	**AVENTADO**
BURNING	**ARDIENTE**
CRAMPY	**ENTUMECEDOR**
DEEP	**INTENSO**
DISTENDED	**DISTENDIDO**
DULL	**SORDO**
ELECTRICAL	**ELÉCTRICO**
GNAWING	**ROEDOR**
KNIFE-LIKE	**AGUDO**
MISERABLE	**DESAGRADABLE**
NAGGING	**CONTINUO**
NUMB	**ADORMECIDO**
PRESSURE	**PRESIÓN**
RADIATING	**PROPAGANTE**
SHARP	**AGUDO**
SHOOTING	**PUNZADA**
SPLITTING	**ESPANTOSO**
SQUEEZING	**COMPRIMIDO**
STABBING	**PUNZANTE**
STINGING	**PICANTE**
TENDER	**SENSIBLE**
THROBBING	**PALPITANTE**
TINGLING	**PICAZÓN**
TIRING	**FATIGOSO**
UNBEARABLE	**INTOLERABLE**

Intensity . . .If 0 is no pain and 10 is the worst pain possible, what is your pain now?
Si 0 significa ningún dolor y 10 es el dolor peor posible, ¿cuál es su dolor ahora?

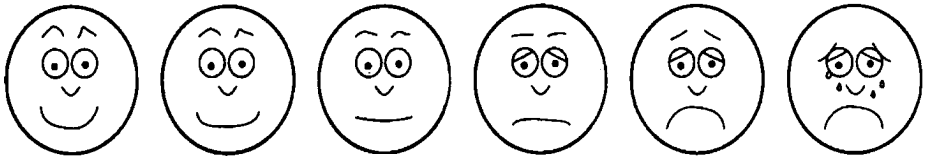
Pain Intensity Rating Scale



No pain
ningún dolor

Worst possible pain
peor dolor posible

Wong-Baker Faces Pain Scale



No Hurt **No duele**	Hurts Little Bit **Duele un poco**	Hurts Little More **Duele un poco más**	Hurts Even More **Duele aún más**	Hurts Whole Lot **Duele bastante**	Hurts Worst **Duele peor**

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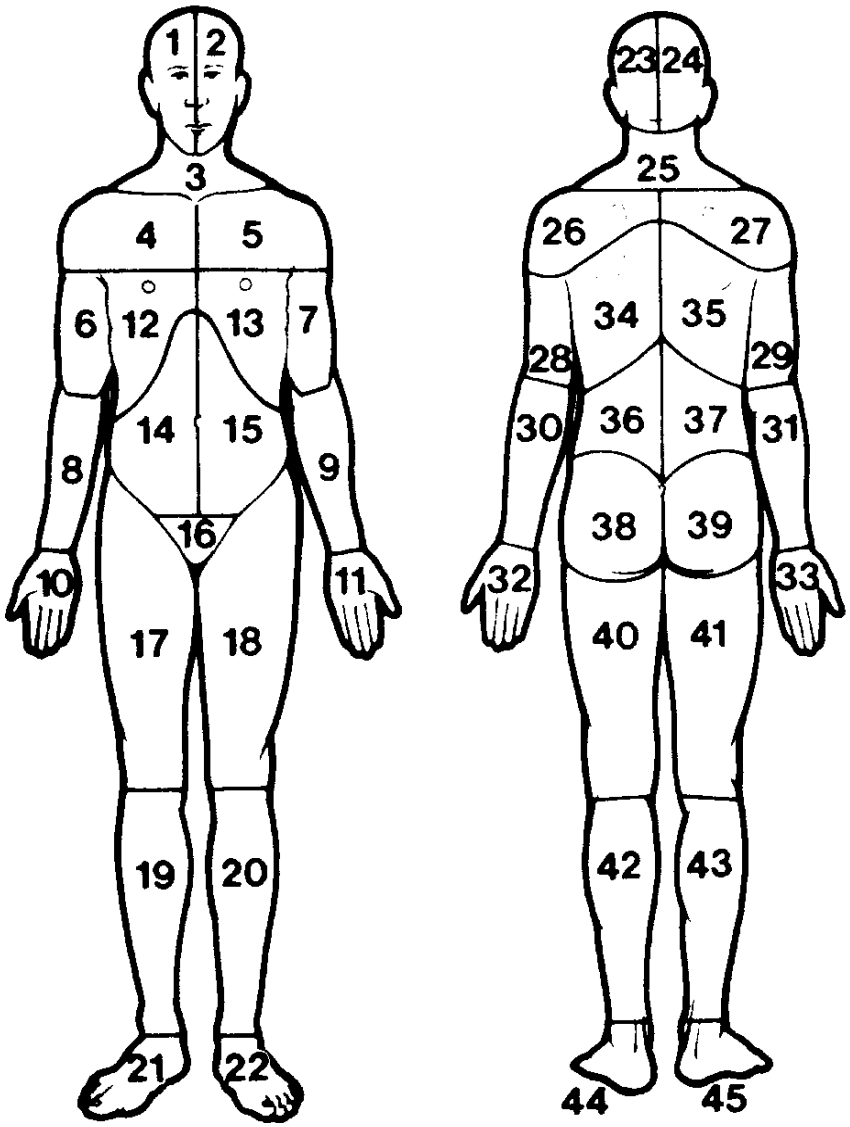
Location . . .Where is your pain...point to where the pain is located using the chart below. **¿Dónde le duele? … señale donde se encuentra el dolor usando la gráfica más abajo.**
Does your pain travel to another location? Point to the area.**¿Se extiende su dolor a otro lugar? Señale el área.**



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Ask the Patient . . .

Duration . . .

When did the pain start**? ¿Cuándo comenzó el dolor?**
Month / **Mes** Day / **Día** Hour / **Hora**

How long does the pain last? **¿Cuánto tiempo dura el dolor?**
Seconds/**Segundos** Minutes/**Minutos**
Hours/**Horas** Days/**Días**

Does the pain come and go**?/¿Va y viene el dolor?**
YES/ **SÍ** NO/**NO**

Comfort Goal . . .

If 0 is no pain and 10 is the worst pain possible, at what pain level do you want to be?
¿Si 0 significa ningún dolor y 10 es el peor dolor, a qué nivel de dolor desea estar?
At what pain level do you expect to be treated? **¿A qué nivel de dolor espera ser tratado?**

(If a translator is available have the patient answer the following questions)

Aggravating/Alleviating Factors . . .

What makes the pain better?
What makes the pain worse?

Treatments . . .

What treatments have you used in the past and how did they work?

Symptoms/Side Effects . . .

How does pain affect: sleep, appetite, energy, activity, relationships, and mood?
Are you having any other symptoms: nausea/vomiting, constipation, itching, sleepiness/confusion, weakness, problems urinating?

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VA/DoD Postoperative Pain Management Clinical Practice Guideline
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WILDCATS Pain Assessment Card for Tagalog Speaking Patients

Words to describe Pain . . Tell me about your pain.
Sabihin mo kung ano ang sakit na nararamdaman mo.

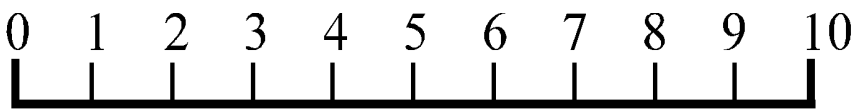
ACHING ..... **pananakit**
AGONIZING ..... **paghihirap**
ANNOYING ..... **pagkayamot**
BLOATED ..... **kinakabagan**
BURNING..... **napapaso**
CRAMPY ..... **pamamanhid**
DEEP ..... **nanunuot**
DISTENDED ..... **pagkabundat**
DULL ..... **pagkabagut**

ELECTRICAL ..... **kinukuryente**
GNAWING ..... **nginangatngat**
KNIFE-LIKE ..... **hinihiwa**
MISERABLE ..... **kaabaaba**
NAGGING ..... **pagkayamot**
NUMB ..... **pagkamanhid**
PRESSURE ..... **madiin**
RADIATING ..... **gumagapang**
SHARP..... **matindi**

SHOOTING ..... **pumuputok**
SPLITTING..... **pinapaghiwalay**
SQUEEZING ..... **pinipiga**
STABBING ..... **tinutusok**
STINGING..... **namimiltik**
TENDER ..... **maselan**
THROBBING ..... **pumipintig**
TINGLING ..... **nangunguliting**
TIRING ..... **nakakapagod**
UNBEARABLE ..... **hindi kayang tiisin**

Intensity . . .If 0 is no pain and 10 is the worst pain possible, what is your pain now?
Kung 0 ay walang sakit at 10 ay matinding sakit, gaano katindi ang nararamdaman mong sakit?

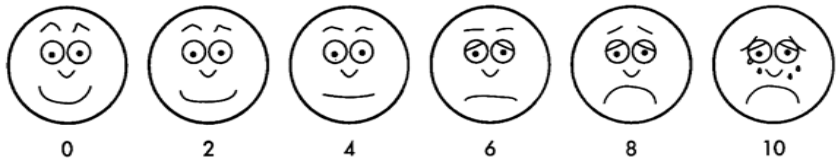
Pain Intensity Rating Scale



No pain
walang sakit

Worst possible pain
pinakamatinding sakit

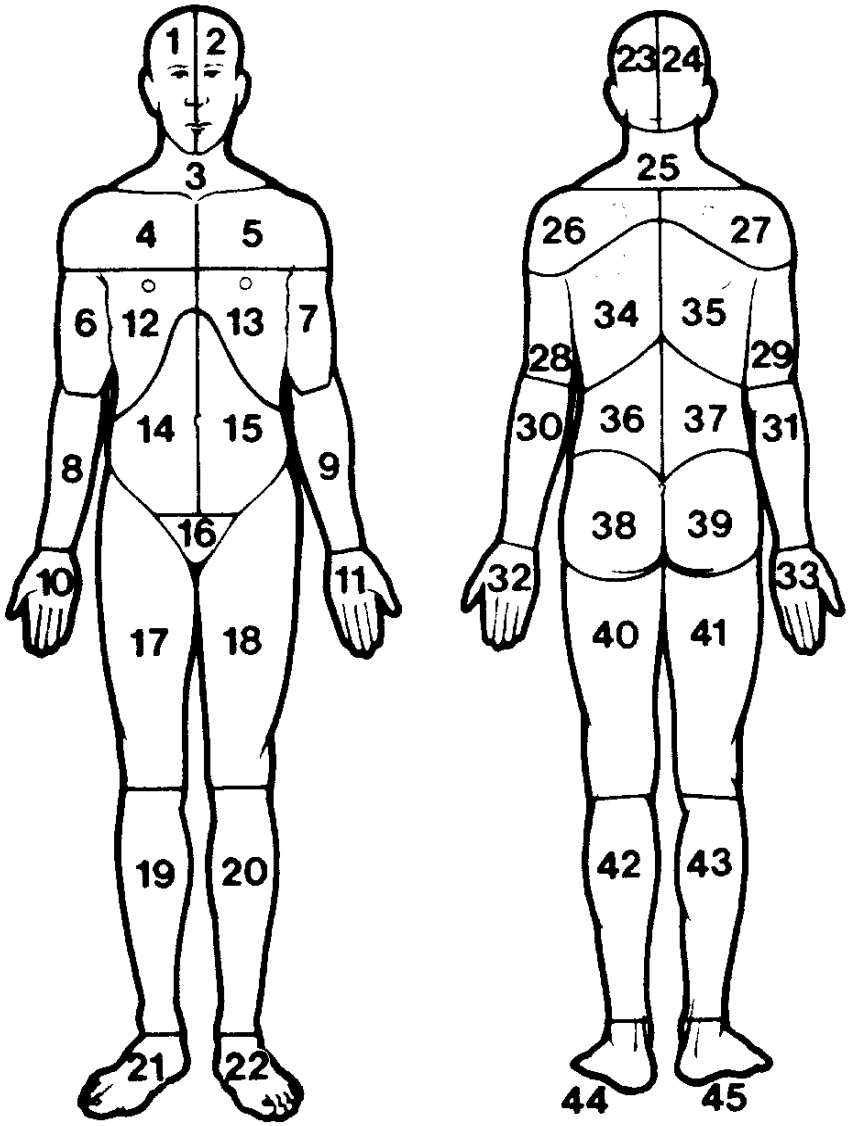
Wong-Baker Faces Pain Scale



0	2	4	6	8	10
No Hurt **walang sakit**	Hurts Little Bit **may konting sa**	Hurts Little More **masakit**	Hurts Even More **lalong masakit**	Hurts Whole Lot **matindi ang sakit**	Hurts Worst **pinakamatindin**

From Wong, DL, Hockenberry-Eaton, M, Wilson, D, Winkelstein, ML, & Schwartz, P. 2001. Wong's Essentials of Pediatric Nursing, 6ed, St. Louis, Mosby, P. 1301. Copyrighted by Mosby-Year Book, Inc.

Location . . .Where is your pain...point to where the pain is located using the chart below. **Nasaan ang sumasakit…ituro kung saan nanggagaling ang sakit sa larawang nasa ibaba.**
Does your pain travel to another location? Point to the area./ **Ang nararamdaman mong masakit ba ay lumilipat sa ibang parte ng iyong katawan? Ituro kung saan.**



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Ask the Patient . . .

Duration . . .

When did the pain start? **Kailan nagsimula ang sakit?**
Month / **Buwan** Day / **Araw** Hour / **Oras**

How long does the pain last? ?
Gaano tumatagal ang sakit ?
Seconds / **segundo** Minutes / **minuto**
Hours / **oras** Days / **araw**

Does the pain come and go?/
Ang sakit ba ay nawawala at bumabalik?

Comfort Goal . . .

If 0 is no pain and 10 is the worst pain possible, where do you want your pain to be?
Kung 0 ay walang sakit at 10 ay matinding sakit, hanggang saang tindi ng sakit ang gusto mo?

At what pain level do you expect to be treated?
Hanggang saang antas ng sakit ang gusto mong malunasan?

(If a translator is available have the patient answer the following questions)

Aggravating/Alleviating Factors . . .

What makes the pain better?
What makes the pain worse?

Treatments . . .

What treatments have you used in the past and how did they work?

Symptoms/Side Effects . . .

How does pain affect: sleep, appetite, energy, activity, relationships, and mood?
Are you having any other symptoms: nausea/vomiting, constipation, itching, sleepiness, confusion, weakness, problems urinating?

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DoD: http://www.cs.amedd.army.mil/qmo
VA: http://www.oqp.med.va.gov/cpg/cpg.htm

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REFERENCE CARD

WILDCATS Pain Assessment Card for Korean Speaking Patients

Words to describe Pain . . Tell me about your pain.
어떻게 아픈지 이야기 하십시오.

ACHING ..... 아픔
AGONIZING ..... 괴로움
ANNOYING ..... 성가심
BLOATED ..... 부푼
BURNING..... 뜨거운
CRAMPY..... 경련이 나는
DEEP ..... 깊숙한
DISTENDED ..... 넓어진
DULL ..... 무지근한

ELECTRICAL..... 강렬한
GNAWING ..... 에는 듯한
KNIFE-LIKE ..... 칼같은
MISERABLE ..... 쓰라린
NAGGING ..... 집요한
NUMB ..... 마비된
PRESSURE ..... 압박감
RADIATING ..... 뻗치는
SHARP..... 날카로운

SHOOTING .....욱신욱신한
SPLITTING.....뻐개지는 듯한
SQUEEZING .....짓누르는
STABBING .....찌르는 듯한
STINGING .....따끔따끔한
TENDER.....예민한
THROBBING .....두근거림
TINGLING.....쑤심
TIRING .....지치게 하는
UNBEARABLE .....참을 수 없는

Intensity . . .If 0 is no pain and 10 is the worst pain possible, what is your pain now?
전혀 없는 상를 **0** 가장 심한 상태를 **10** 이라고 하면, 현재 통증은 몇 번 입니까**?**

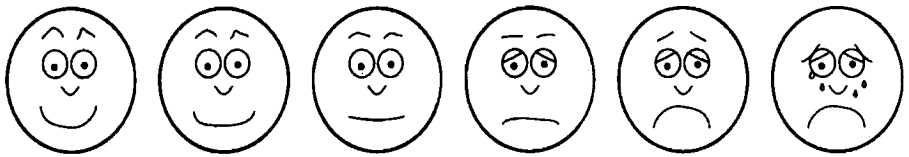
Pain Intensity Rating Scale

0 1 2 3 4 5 6 7 8 9 10

No pain
전혀 아프지 않음

Worst possible pain
가장 심하게

Wong-Baker Faces Pain Scale

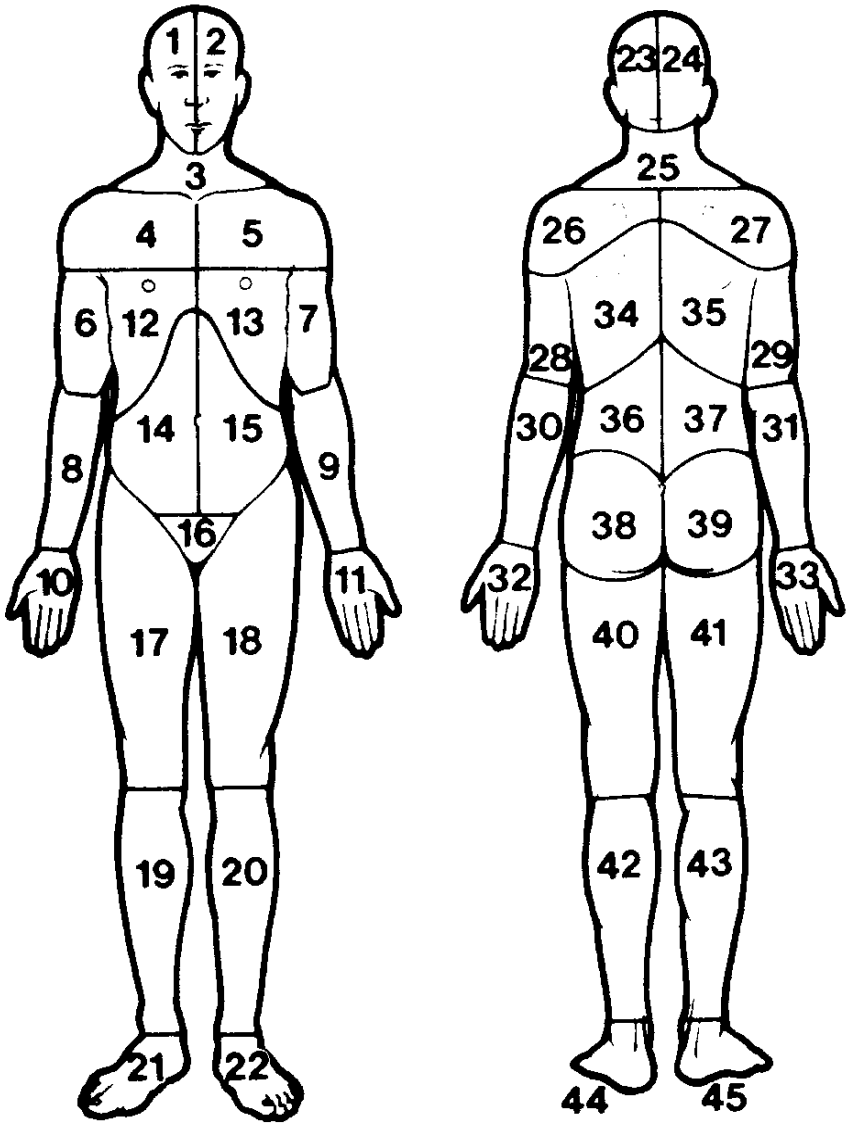


0	2	4	6	8	10
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst
전혀 아프지 않음	거의 아프지 않음	약간 아픔	상당히 아픔	심하게 아픔	가장 심하게 아픔

From Wong, DL, Hockenberry-Eaton, M, Wilson, D, Winkelstein, ML, & Schwartz, P. 2001. Wong's Essentials of Pediatric Nursing, 6ed, St. Louis, Mosby, P. 1301. Copyrighted by Mosby-Year Book, Inc.

Location . . .Where is your pain...point to where the pain is located using the chart below. 어디가 아픕니까**?** 아래의 차트를 사용하여 아픈 곳을 지적하십시오**.**

Does your pain travel to another location? Point to the area. 통증이 다른 부위로 이동합니까**?** 그 부위를 지적하십시오**.**



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Ask the Patient . . .

Duration . . .

When did the pain start? 시작한 날짜는?
Month / 월 Day / 일 Hour / 시

How long does the pain last? 지속 시간은?
Seconds / 초 Minutes / 분
Hours / 시 Days / 일

Does the pain come and go? 통증이 생겼다가 사라지곤 합니까?

Comfort Goal . . .

If 0 is no pain and 10 is the worst pain possible, where do you want your pain to be?
전혀 없는 상태를 0, 가장 심한 상태를 10 이라고 하면, 원하는 상태는 몇 번 입니까?

At what pain level do you expect to be treated? /기대하는 통증의 치료 상태는 몇 번 입니까?

_____

(If a translator is available have the patient answer the following questions)

Aggravating/Alleviating Factors . . .

What makes the pain better?
What makes the pain worse?

Treatments . . .

What treatments have you used in the past and how did they work?

Symptoms/Side Effects . . .

How does pain affect: sleep, appetite, energy, activity, relationships, and mood?
Are you having any other symptoms: nausea/vomiting, constipation, itching, sleepiness, confusion, weakness, problems urinating?

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Discomfort Indicator Scale For Cognitively Impaired

(Adapted from Beaver Dam Community Hospital)

Observe resident for 3-5 minutes and check indicators that relate to observed behavior.

A. Noisy breathing:

- Respirations are strenuous, labored, loud, harsh, or gasping
- Episodic bursts of rapid breaths or hyperventilation

B. Negative vocalization:

- Noise or speech with negative or disapproving quality
- Hushed, low sounds such as constant muttering with a guttural tone
- Monotone, subdued, or varying pitched noise with a definite unpleasant sound
- Faster rate than a conversation or drawn out as in a moan or groan
- Repetitive words with a mournful tone
- Grunting or groaning

C. Sad facial expression:

- Looking hurt, worried, lost, troubled, distressed or lonesome
- "Hang dog" look, wrinkled forehead
- Crying

D. Frightened facial expression:

- Scared, concerned looking face, fearful or troubled
- Alarmed appearance with open eyes and pleading face

E. Tense body language:

- Extremities tense, wringing hands, clenched fists
- Knees pulled up tightly
- Strained and inflexible position

F. Fidgeting:

- Restless impatient motion, squirming or jittering
- Guarding of a body part
- Forceful touching, tugging, or rubbing
- Rocking
- Aggressive behavior
- Hitting or biting
- Irritable

G. Other

Adapted from: Hurley, A.C.; Volicer, B.J.; Hanrahan, P.A.; Houde, S.; & Volicer, L (1992). Assessment of Discomfort in Advanced Alzheimer Patients. Research in Nursing & Health, 15, 369-377.

Reference: Hurley, A.C.; Volicer, B.J.; Hanrahan, P.A.; Houde, S.; & Volicer, L (1992). Assessment of Discomfort in Advanced Alzheimer Patients. Research in Nursing & Health. 15, 369-377.
Parke, B. (1992). Pain the Cognitively Impaired Elderly. The Canadian Nurse. 88 (7), 17-20.

VA/DoD Postoperative Pain Management Clinical Practice Guideline
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FLACC Scale : Behavioral pain scale for children age 3 months to 7 years

This is a behavior scale that has been tested with children age 3 months to 7 years. Each of the five categories (Faces, Legs, Activity, Cry, Consolability) is scored from 0-2 and the scores are added to get a total from 0-10. Behavioral pain scores need to be considered within the context of the child's psychological status, anxiety and other environment factors

Patients who are awake: Observe for at least 2-5 minutes. Observe legs and body uncovered. Reposition patient or observe activity, assess body for tenseness and tone. Initiate consoling interventions if needed.

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

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

Each category is scored on the 0-2 scale which results in a total score of 0-10:

0 = Relaxed and comfortable
1-3 = Mild discomfort
4-6 = Moderate pain
7-10 = Severe discomfort/pain

Merkel, S., Voepel-Lewis, T., Shayevitz J., & Maliviya, S. The FLACC: A behavioral scale for scoring postoperative pain in young children. Pediatric Nursing .1997, 23: 293-297. Used with permission.

N-PASS:
Neonatal Pain, Agitation, & Sedation Scale

Pat Hummel, MA, RNC, NNP, PNP & Mary Puchalski, MS, RNC

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals Consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking Constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex ↓ muscle tone	Relaxed hands and feet Normal tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	< 10% variability from baseline with stimuli	Within baseline or normal for gestational age	↑ 10-20% from baseline SaO_2 76-85% with stimulation – quick ↑	↑ > 20% from baseline $SaO_2 \leq 75\%$ with stimulation – slow ↑ Out of sync with vent

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Loyola University Health System, Loyola University Chicago, 2000

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Premature Pain Assessment

- + 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 hypoventilation
- 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 assessment is the fifth vital sign – assessment for pain should be included in every vital sign assessment
- 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 behaviors to assess response to medication
  - Post-operative → at least every 2 hours for 24-48 hours, then every 4 hours until off medications

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 cry with needle sticks
- No reaction to ETT or nares suctioning
- No response to care giving

-1 → Moans, sighs, or cries (audible or silent) minimally to painful stimuli, e.g. needle sticks, ETT 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 - intermittent silent cry

+2 → Any of the following:
- Cry is high-pitched
- Infant cries inconsolably
- 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 stimuli

+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

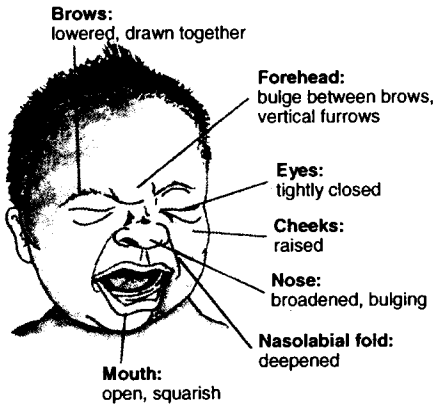
-2 → Any of the following:
- Mouth is lax
- Drooling
- No facial expression at rest or with stimuli

-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 is continual



Facial expression of physical distress and pain in the infant

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Extremities / Tone

-2 → Any of the following:
- No palmar or planter grasp can be elicited
- Flaccid tone

-1 → Any of the following:
- Weak palmar or planter 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, RR, & O_2 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 (SaO_2 76-85%) 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 (SaO_2 < 75%) and recovers slowly (> 2 minutes)
- Infant is out of synchrony with the ventilator - fighting the ventilator

We value your opinion.
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