

**Royal Hospital for Women (RHW)**  
**NEONATAL BUSINESS RULE**  
**COVER SHEET**



**Health**  
South Eastern Sydney  
Local Health District

**Ref: T26/1330**

<b>NAME OF DOCUMENT</b>	N-PASS – Neonatal Pain and Sedation Score
<b>TYPE OF DOCUMENT</b>	Clinical Business Rule
<b>DOCUMENT NUMBER</b>	RHW CLIN185
<b>DATE OF PUBLICATION</b>	January 2026
<b>RISK RATING</b>	Low
<b>REVIEW DATE</b>	January 2031
<b>FORMER REFERENCE(S)</b>	N/A
<b>EXECUTIVE SPONSOR</b>	Sally Wise, Nursing Co-Director Neonatal Services Srinivas Bolisetty, Medical Co- Director Neonatal Services
<b>AUTHOR</b>	R Jackson (Nurse Educator)
<b>SUMMARY</b>	To objectively assess acute and chronic pain experienced by preterm, term and surgical neonates, using a standardised and validated pain and sedation assessment tool in the Newborn Care Centre
<b>Key Words</b>	N-PASS, pain, sedation, score, neonate, assessment

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*Within this document we will use the term woman, this is not to exclude those who give birth and do not identify as female. It is crucial to use the preferred language and terminology as described and guided by each individual person when providing care.*

## 1 BACKGROUND

Hospitalised neonates are exposed to multiple painful and distressing procedures. Procedural, acute and chronic pain are all seen in the neonatal unit, often associated with invasive diagnostic procedures, treatment interventions and/or surgical care. Exposure to pain during the peak of brain development can result in pronounced changes to cognitive and motor function. The short, immediate and long-term consequences of these experiences to neurodevelopment require ongoing assessment, prevention and appropriate management of pain in the neonatal care environment. Therefore, pain assessment is considered a 5th vital sign.

The Neonatal Pain and Sedation Score (N-PASS) is a validated tool used to assess term, preterm and the surgical neonate's response to pain and sedation.<sup>1,2</sup>

## 2 RESPONSIBILITIES

### 2.1 Staff

- 2.1.1 Medical- provide individualised pain management according to the N-PASS, prescribe pain/sedation management as required, monitor neonates for response to pain/sedation management
- 2.1.2 Nursing- observe and assess neonate's using the N-PASS tool, document and inform medical officer of the score, provide individualised pain management according to the score given, monitor neonates for response to pain/sedation management

## 3 PROCEDURE

### 3.1 Equipment

- Cardio- respiratory and saturation monitoring

### 3.2 Clinical Practice

- Observe and assess neonates using the N-PASS tool (Appendix 1):
  - At least once per shift for all neonates
  - Neonates receiving analgesia or sedative/s:
    - 4 hourly
    - 30 minutes post administration of analgesia
  - Neonates with indwelling devices (i.e. endotracheal tube, intercostal chest drains)
    - 4 hourly
  - Post- operative neonates:
    - 2 hourly for first 24 hours
    - 4 hourly until 48 hours post-operative

#### 3.2.1 Pain/agitation Assessment

- Assess pain using the N-PASS tool (Appendix 1).
- Assess each criterion for pain individually allocating the correlating number.
  - Crying/irritability

- Behaviour state
- Facial expression
- Extremities/tone and
- Vital signs

#### Note

Neonates that are muscle relaxed can not be evaluated on their behavioural state for pain. Increases in heart rate and blood pressure may be the only indicator of a need for more analgesia.

- Pain is scored from 0 to +2 for each behavioural and physiological criteria, then combined for total score.
  - Add points to the premature neonate's pain score based on their gestational age to compensate for their limited ability to behaviourally or physiologically communicate pain
- Total pain score is documented as a positive number (0 → +10)
- The goal of pain treatment/intervention is a score ≤ 3.
- Treatment/interventions are indicated for scores >3.
- Individualise pain management based on the score given:
  - Scores of 3-7 require non-pharmacological intervention, such as offering non-nutritive sucking, sucrose, repositioning, containment, kangaroo care, swaddling, nappy change, etc.
  - Scores above 8 require medical escalation and prescribing of sedation and/or analgesia
  - Pharmacological intervention will be discussed and prescribed by the treating medical team

#### 3.2.2 Sedation Assessment

- Sedation is scored in addition to pain for each behavioural and physiological criteria to assess the neonate's response to stimuli (Appendix 1).
- Sedation **does not need to be assessed/scored with every pain assessment/score.**
- Assess each criterion for sedation individually allocating the correlating number.
  - Crying/irritability
  - Behaviour state
  - Facial expression
  - Extremities/tone and
  - Vital signs
- Sedation is scored from 0 to -2 for each behavioural and physiological criteria, then combined for total score (Appendix 1).
- Desired sedation should be individualised and based on clinical condition as decided by the multidisciplinary team:
  - Scores between -10 to -5 suggest deep sedation
    - Deep sedation is not recommended unless a neonate is receiving ventilatory support, related to the high potential for apnoea and hypoventilation
  - Scores between -5 to -2 suggest light sedation
- A negative score without the administration of opioids/sedatives may indicate:
  - The premature neonate's response to prolonged or persistent pain/stress
  - Neurologic depression, sepsis, or other pathology

**3.3 Documentation**

- eRIC

**3.4 Education Notes**

- Prevention of pain should be considered as first line management. Consideration of the necessity of each procedure/event is required and avoid or limit where possible.
- Limitation or avoidance of skin-breaking or other painful procedures
  - Review proposed blood investigations daily and limit blood tests to those necessary for clinical care and management of the neonate
  - Limit venepuncture/line insertion attempts per person (escalate after 2 unsuccessful attempts per person)
  - Suction only when necessary
  - Where clinically feasible, schedule painful or distressing procedures on separate days to minimise discomfort (e.g., retinopathy of prematurity examinations, immunisations).
  - Allow the neonate to fully recover from painful interventions and care giving activities
- Limit environmental stressors by reducing noise and light levels. This requires the carer to:
  - Close incubator doors gently
  - Adjust alarms to an appropriate level
  - Appropriate voice levels at the bedside
  - Avoid placing telephones/radios/pages close to incubators
  - Use incubator covers or drapes to decrease light levels as appropriate for each neonate
- Consider comfort measures such as boundaries/nesting, swaddling, positioning neonates with flexion of extremities, containment holding, music therapy and using pacifiers to encourage non-nutritive sucking.
  - The comfort measures facilitate the release of endorphins that readily binds to opiate receptors to inhibit pain signals
- Parental involvement and interaction should be actively encouraged and should be an integral part of the neonate’s care. Interventions may include:
  - Kangaroo care/skin to skin
  - Facilitated touch/gentle massage
  - Breastfeeding when appropriate
- Gestational age can alter the neonate’s response to pain.
- Sedatives may mask the neonate’s pain and alone do not provide pain relief.
- Parent/carers should be provided education to recognise and understand their neonate’s response to pain and stress.

**3.5 Abbreviations**

N-PASS	Neonatal Pain and Sedation Score		
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**3.6 Related Policies/procedures**

- RHW NCC CBR- Immuno-Supportive Oral Care (ISOC)
- RHW NCC CBR- Kangaroo Care - Non-ventilated and ventilated neonate

- RHW NCC CBR- Post-Operative Care

### 3.7 References

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## 4 ABORIGINAL HEALTH IMPACT STATEMENT DOCUMENTATION

- Considerations for culturally safe and appropriate care provision have been made in the development of this Business Rule and will be accounted for in its implementation.
- When clinical risks are identified for an Aboriginal and/or Torres Strait Islander woman or family, they may require additional supports. This may include Aboriginal health professionals such as Aboriginal Liaison Officers, health workers or other culturally specific services

## 5 CULTURAL SUPPORT

- For a Culturally and Linguistically Diverse CALD woman, notify the nominated cross-cultural health worker during Monday to Friday business hours
- If the woman is from a non-English speaking background, call the interpreter service: [NSW Ministry of Health Policy Directive PD2017 044-Interpreters Standard Procedures for Working with Health Care Interpreters](#)

## 6 NATIONAL STANDARDS

- Standard 2 Partnering with Consumers
- Standard 4 Medication Safety
- Standard 5 Comprehensive Care
- Standard 6 Communicating for Safety

## 7 REVISION AND APPROVAL HISTORY

List all previous revisions below

Date	Revision No.	Author and Approval
8.9.22	1	S Neale (A/NE); Primary document approved NCC CBR Committee
7.11.25 27.11.25	2	R Jackson (NE) Endorsed by NCC CBR Committee
12.1.26	2	RHW BRGC

N-PASS – Neonatal Pain and Sedation Score

RHW CLIN185

Appendix 1 Neonatal Pain and Sedation Score

BEHAVIOR INDICATORS	SEDATION SCORING	SEDATION		NORMAL/ PAIN 0/0	PAIN/AGITATION		PAIN/ AGITATION SCORING
		-2	-1		1	2	
<b>Crying Irritability</b>		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	
<b>Behavior State</b>		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)	
<b>Facial Expression</b>		Mouth is lax; No expression	Minimal expression with stimuli	Relaxed appropriate	Any pain expression, intermittent	Any pain expression, continual	
<b>Extremities Tone</b>		No grasp reflex; Flaccid tone	Weak grasp reflex; decreased 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	
<b>Vital Signs HR, RR, BP, SaO<sub>2</sub></b>		No variability with stimuli; Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline; SaO <sub>2</sub> 76-85% with stimulation – quick increase	Increase greater than 20% from baseline; SaO <sub>2</sub> less than or equal too 75% with stimulation – slow increase; Out of sync/ fighting vent	
<b>Gestation/ Corrected age</b>	<b>N/A</b>						
<b>TOTAL SEDATION SCORE</b>	<b>/-10</b>					<b>TOTAL PAIN/ AGITATION SCORE</b>	<b>/13</b>

**Premature Pain Assessment**

- +3 if less than 28 weeks gestation/corrected age
- +2 if less than 28 - 31 weeks gestation/corrected age
- +1 if less than 32 - 35 weeks gestation/corrected age