Pain Assessment

Pain is a complex, unique, and subjective experience. Even though pain does have some objective signs, every patient is different and these signs may not be observed. There are a number of misconceptions about pain, and a professional healthcare provider should never put his or her beliefs about pain on a patient. The failure to alleviate pain can cause inadequate healing and functional limitations that could decrease the patient’s activities of daily living.



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Types of Pain

Acute Pain
Acute-angle Pain-bolts
Acute pain is limited in duration and will resolve once tissue damage has healed. Acute pain has an identifiable cause and should be treated effectively to allow the healing process to begin.

Chronic Pain
Crone with Pain-bolts
Chronic pain is pain that last longer than 6 months. There are two types of chronic pain. Non-cancer pain which has a variety of causes: arthritis, myofacial pain, neuropathy, and sometimes unidentifiable pain are just a few causes. The other type is cancer pain. Not all patients that have cancer will experience pain, however, as the cancer progresses so will the pain. Both type of patient’s typically have a high tolerance for pain medicine, and will require higher than normal doses to control the pain.

OPQRST Mnemonic

Onset
On-switch
“When did the pain start?” It is important to know when the pain started. Getting as much information as possible will help the health care team make the proper diagnosis and treatment plan.

Provoking or Palliative
Provoking and Palliating Pain-bolts
“What makes your pain worse? What makes it better?” These questions will aid in therapeutic interventions. If pain is relieved with ice, then providing the patient with an ice pack is a great intervention to have in the care plan.

Quality
Quality of Pain-bolts
“How do you describe your pain?” It is important to ask open-ended question. Allow the patient to describe the pain will result in more information then asking if the pain is more stabbing than shooting.

Radiation
Radiating Pain-bolt
“Where does the pain hurt? Does it spread to another part of the body?” Knowing if the pain is radiating or maybe referred pain will help in diagnosing the exact cause of the pain.

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Severity

Severity-scale

“One a scale from 0 to 10, how bad is the pain?” A number scale is the best way to determine how the patient perceives his or her pain. It is also important to ask chronic pain patients, “On a number scale what number do you live at?” Some patients can live at a 5/10 and be happy there. Knowing their baseline will help determine the intervention that needs to be taken to manage the pain.

Timing

Time-of-day

When we ask, “Is your pain constant, intermittent, or both?” or "When does it occur?" we are assessing the timing of the pain. This means how long it lasts and specific times it arises. The patient could have constant pain with spasms resulting in an increase in pain. Knowing how the patient takes their medicine at home will help the healthcare team to manage the pain more appropriately.

Nursing Considerations

Subjective Findings

Subjective-thought-bubble

It is important to identify and separate patient subjective findings vs. objective. Subjective findings are what the patient says they feel. They are those explained by the patient in the OPQRST mnemonic, where they explain, in their own words, the onset, quality, radiation, timing and severity (0-10) of their pain. These findings are patient specific and are influenced by personal feelings.

Objective Findings

Objective-observation

Objective data can be examined by asking, "What do you see?" It can be seen, heard and measured. Objective data are directly observed by the examiner and include vital signs (blood pressure, pulse and respiration), patient behavior (grimacing, frowning, crying out or guarding) and emotional expressions such as anger, depression, irritability, fear.

Reassessment of Pain

Reminder-to-reassess Pain-bolt

The assessment of a patient's pain is not a one time event, but rather an ongoing event. If the interventions suggested for pain relief are implemented, certain outcomes are expected to result; for example, “Patient will experience pain relief within 30 minutes.” Evaluation in this case would consist of the nurse’s reassessment of the patient’s pain status 30 to 40 minutes after the intervention had been made and comparing that to the level of pain experienced before the intervention took place. If satisfactory pain relief has not been accomplished, the steps of the nursing process should be repeated. In this way, additional assessment data, analysis, or interventions as a result of ongoing assessment may lead to a more satisfactory outcome.

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