11.3: Pain Assessment Methods

Asking a patient to rate the severity of their pain on a scale from 0 to 10, with “0” being no pain and “10” being the worst pain imaginable is a common question used to screen patients for pain. However, according to The Joint Commission requirements described earlier, this question can be used to initially screen a patient for pain, but a thorough pain assessment is required. Additionally, the patient’s comfort-function goal must be assessed. The comfort-function goal provides the basis for the patient’s individualized pain treatment plan and is used to evaluate the effectiveness of interventions.

PQRSTU, OLDCARTES, and COLDSPA

The “PQRSTU,” “OLDCARTES,” or “COLDSPA” mnemonics are helpful in remembering a standardized set of questions used to gather additional data about a patient’s pain. See Figure 11.4 for the questions associated with a “PQRSTU” assessment framework. While interviewing a patient about pain, use open-ended questions to allow the patient to elaborate on information that further improves your understanding of their concerns. If their answers do not seem to align, continue to ask focused questions to clarify information. For example, if a patient states that “the pain is tolerable” but also rates the pain as a “7” on a 0-10 pain scale, these answers do not align, and the nurse should continue to use follow-up questions using the PQRSTU framework. Upon further questioning the patient explains they rate the pain as a “7” in their knee when participating in physical therapy exercises, but currently feels the pain is tolerable while resting in bed. This additional information assists the nurse to customize interventions for effective treatment with reduced potential for overmedication with associated side effects.
Figure 11.4 PQRSTU Assessment

Sample questions when using the PQRSTU assessment are included in Table 11.3a.

Table 11.3a. Sample PQRSTU Focused Questions for Pain

<table>
<thead>
<tr>
<th>PQRSTU</th>
<th>Questions Related to Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provoke/Palliation</td>
<td>What makes your pain worse?</td>
</tr>
<tr>
<td></td>
<td>What makes your pain feel better?</td>
</tr>
<tr>
<td></td>
<td>What does the pain feel like?</td>
</tr>
<tr>
<td>Quality</td>
<td>Note: You can provide suggestions for pain characteristics such as “aching,” “stabbing,” or “burning.”</td>
</tr>
<tr>
<td>Region</td>
<td>Where exactly do you feel the pain? Does it move around or radiate elsewhere?</td>
</tr>
</tbody>
</table>
Note: Instruct the patient to point to the pain location.

**Severity**

How would you rate your pain on a scale of 0 to 10, with “0” being no pain and “10” being the worst pain you’ve ever experienced?

When did the pain start?

What were you doing when the pain started?

Is the pain constant or does it come and go?

**Timing/Treatment**

If the pain is intermittent, when does it occur?

How long does the pain last?

Have you taken anything to help relieve the pain?

**Understanding**

What do you think is causing the pain?

An alternative mnemonic to use when assessing pain is “OLDCARTES.”

- **O**nset: When did the pain start? How long does it last?
- **L**ocation: Where is the pain?
- **D**uration: How long has the pain been going on? How long does an episode last?
- **C**haracteristics: What does the pain feel like? Can the pain be described in terms such as stabbing, gnawing, sharp, dull, aching, piercing, or crushing?
- **A**ggravating factors: What brings on the pain? What makes the pain worse? Are there triggers such as movement, body position, activity, eating, or the environment?
- **R**adiating: Does the pain travel to another area or the body, or does it stay in one place?
- **T**reatment: What has been done to make the pain better and has it been helpful? Examples include medication, position change, rest, and application of hot or cold.
- **E**ffect: What is the effect of the pain on participating in your daily life activities?
- **S**everity: Rate your pain from 0 to 10.

A third mnemonic used is “COLDSPA."

- **C**: Character
- **O**: Onset
- **L**: Location
- **D**: Duration
- **S**: Severity
- **P**: Pattern
- **A**: Associated Factors
No matter which mnemonic is used to guide the assessment questions, the goal is to obtain comprehensive assessment data that allows the nurse to create a customized nursing care plan that effectively addresses the patient’s need for comfort.

### Pain Scales

In addition to using the PQRSTU or OLDCARTES methods of investigating a patient’s chief complaint, there are several standardized pain rating scales used in nursing practice.

#### FACES Scale

The FACES scale is a visual tool for assessing pain with children and others who cannot quantify the severity of their pain on a scale of 0 to 10. See Figure 11.5\(^2\) for the FACES Pain Rating Scale. To use this scale, use the following evidence-based instructions. Explain to the patient that each face represents a person who has no pain (hurt), some pain, or a lot of pain. "Face 0 doesn’t hurt at all. Face 2 hurts just a little. Face 4 hurts a little more. Face 6 hurts even more. Face 8 hurts a whole lot. Face 10 hurts as much as you can imagine, although you don’t have to be crying to have this worst pain.” Ask the person to choose the face that best represents the pain they are feeling.\(^3\)

![Wong-Baker FACES Pain Rating Scale](https://med.libretexts.org/Bookshelves/Nursing/Nursing_Fundamentals_(OpenRN)/11%3A_Comfort/11.03%3A_Pain_Assess…)

Figure 11.5 The Wong-Baker FACES Pain Rating Scale. Used with permission from [http://www.WongBakerFACES.org](http://www.WongBakerFACES.org).

#### FLACC Scale

The FLACC scale (i.e., the Face, Legs, Activity, Cry, Consolability scale) is a measurement used to assess pain for children between the ages of 2 months and 7 years or individuals who are unable to verbally communicate their pain. The scale has five criteria, which are each assigned a score of 0, 1, or 2. The scale is scored in a range of 0–10 with “0” representing no pain.\(^4\) See Table 11.3b for the FLACC scale.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Score 0</th>
<th>Score 1</th>
<th>Score 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face</td>
<td>No particular expression or smile</td>
<td>Occasional grimace or frown, withdrawn, or uninterested</td>
<td>Frequent to constant quivering chin; clenched jaw</td>
</tr>
<tr>
<td>Legs</td>
<td>Normal position or relaxed</td>
<td>Uneasy, restless, or tense</td>
<td>Kicking or legs drawn up</td>
</tr>
</tbody>
</table>

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https://med.libretexts.org/Bookshelves/Nursing/Nursing_Fundamentals_(OpenRN)/11%3A_Comfort/11.03%3A_Pain_Assess…

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<table>
<thead>
<tr>
<th>Activity</th>
<th>Lying quietly, normal position, and moves easily</th>
<th>Squirming, shifting, back and forth, or tense</th>
<th>Arched, rigid, or jerking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cry</td>
<td>No cry (awake or asleep)</td>
<td>Moans or whimper or occasional complaint</td>
<td>Crying steadily, screams or sobs, or frequent complaints</td>
</tr>
<tr>
<td>Consolability</td>
<td>Content and relaxed</td>
<td>Reassured by occasional touching, hugging, or being talked to; distractible</td>
<td>Difficult to console or comfort</td>
</tr>
</tbody>
</table>

**COMFORT Behavioral Scale**

The COMFORT Behavioral Scale is a behavioral-observation tool validated for use in children of all ages who are receiving mechanical ventilation. Eight physiological and behavioral indicators are scored on a scale of 1 to 5 to assess pain and sedation.\[6\]

**Pain Assessment in Advanced Dementia (PAINAD) Scale**

The Pain Assessment in Advanced Dementia (PAINAD) Scale is a simple, valid, and reliable instrument for assessing pain in noncommunicative patients with advanced dementia. See Table 11.3c for the items included on the scale. Each item is scored from 0-2. When totaled, the score can range from 0 (no pain) to 10 (severe pain).

Table 11.3c The PAINAD Scale \[7\]

<table>
<thead>
<tr>
<th>Item</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative vocalization</td>
<td>None</td>
<td>Occasional moan or groan. Low-level speech with a negative or disapproving quality.</td>
<td>Repeated troubled calling out. Loud moaning or groaning. Crying.</td>
</tr>
<tr>
<td>Consolability</td>
<td>No need to console</td>
<td>Distracted or reassured by voice or touch.</td>
<td>Unable to console, distract, or reassure.</td>
</tr>
</tbody>
</table>

https://med.libretexts.org/Bookshelves/Nursing/Nursing_Fundamentals_(OpenRN)/11%3A_Comfort/11.03%3A_Pain_Assess...
Comfort-Function Goals

Comfort-function goals encourage the patient to establish their level of comfort needed to achieve functional goals based on their current health status. For example, one patient may be comfortable ambulating after surgery and their pain level is 3 on a 0-to-10 pain intensity rating scale, whereas another patient desires a pain level of 0 on a 0-to-10 scale in order to feel comfortable ambulating. To properly establish a patient’s comfort-function goal, nurses must first describe the essential activities of recovery and explain the link between pain control and positive outcomes.

If a patient’s pain score exceeds their comfort-function goal, nurses must implement an intervention and follow up within 1 hour to ensure that the intervention was successful. Using the previous example, if a patient had established a comfort-function goal of 3 to ambulate and the current pain rating was 6, the nurse would provide appropriate interventions, such as medication, application of cold packs, or relaxation measures. Documentation of the comfort-function goal, pain level, interventions, and follow-up are key to effective, individualized pain management.

1. This work is a derivative of The Complete Subjective Health Assessment by Lapum, St- Amant, Hughes, Petrie, Morrell, and Mistry and is licensed under CC BY-SA 4.0.