Bullet Point Nursing

Nursing Fundamentals – Pain assessment (OPQRST)

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Pain assessment:

- Performed any time a patient complains of pain
- Reassessed after any change or intervention
- Consider the onset of any pain medication to know when to reassess

OPQRST:

- Onset
    - What were you doing when the pain started?
- Provoking/palliative factors
    - Does anything make the pain better or worse?
        - Rest, movement, stretching, eating, etc.
- Quality
    - What does the pain feel like?
        - Stabbing, sharp, dull, diffuse, crushing, pinching, etc.
- Radiating
    - Does the pain extend anywhere else?
        - Also ask if they have pain anywhere else at all. This assesses for referred pain
- Severity
    - On a scale from 0-10. What is your pain?
        - Zero is no pain and ten is the worst pain ever
- Time
    - When did the pain start?

Other questions to ask (for initial assessment):

- Have you ever had these pain before?
    - Patient could be very familiar with this pain and know exactly the cause and treatment
- Have you taken anything for this pain?
    - You need to know if they have taken anything for the pain
- What do you think it is?
    - Patients often looked up their symptoms and may have an accurate idea of what it is

Additional notes:

- Pediatrics have a modified pain scale called the Wong-Baker FACES pain scale
- Another mnemonic for pain assessment is OLDCARTS
- Pain is what the patient states it is
- Always offer non-pharmacological interventions, with or without pharmaceuticals

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References

Dydyk, A. & Grandhe, S. (2021) *Pain assessment*. StatPearls Publishing. www.ncbi.nlm.nih.gov