Pain is the most common symptom that leads patients to seek advice from nurses. Acute pain occurs with many illnesses and it is estimated that chronic or persistent pain affects nearly 20% of adults in the UK (Breivik et al 2006). Unfortunately, despite many advances in medicine, many patients continue to suffer unnecessary pain. Accurate pain assessment is the first step in managing pain and has been shown to improve pain management. The aim of this article is to help improve knowledge of pain assessment.

**What is pain?**

The sensation of pain can be difficult to define. The most commonly used definition describes pain as ‘an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage’ (International Association for the Study of Pain [IASP], 1979). This definition highlights the ‘unpleasantness’ of pain and that it is both a physical and emotional experience. Although the definition mentions tissue damage, patients may experience pain without any obvious tissue damage. Another helpful definition by McCaffery (1968) defines pain as ‘what the patient says it is, and exists whenever the patient says it does’. This highlights the subjective, personal nature of pain and reinforces the need to believe the patient. They are, after all, the only ones who can describe their experience.

**Types of pain**

To be able to assess pain accurately, an understanding of the types of pain and some definitions is necessary (Table 1).

**Managing pain**

Pain needs to be managed for humanitarian reasons, to improve recovery and to prevent...
complications. The harmful effects of unrelieved pain can include stress, increased pulse, blood pressure, cardiac workload and decreased gastrointestinal motility. It is even possible that continuing pain may lead to increased pain sensitivity and persistent pain. Pain often also affects the patient’s mood, sleep, mobility and appetite. This can have devastating effects, e.g. if patients are unable to mobilise due to pain, they are at risk of pressure ulcers and if they are unable to eat a nutritious diet, this can affect wound healing.

**Pain assessment**

Safe and effective pain management is only possible if pain is assessed regularly. Pain is often not directly observable or measurable, which can make it difficult to assess. As pain is a subjective experience, asking the patient about their pain is the most appropriate way to assess it. Accurate assessment also relies on the patient understanding what we are asking and why. For some patients, it may not be possible for them to describe their pain, e.g. in the case of cognitive impairment or decreased consciousness. In these situations, assessment based on objective signs can be used. However, objective signs including grimacing, moaning and increased pulse and blood pressure, should not be relied on alone to determine whether a patient has pain or not. These are generally signs of very severe pain, may only occur for a brief period and are not always present. Despite this fact, many nurses often rely on observations and the way patients look to determine whether they have pain or not.

### Aims of pain assessment

The aim of assessment is to help determine the cause of pain, the impact on quality of life, the best treatments and the effectiveness of current treatment (Table 2).

### Full pain assessment

Pain assessment includes more than the use of a ‘pain scoring tool’, which only measure intensity or how strong the pain is. Information about the location, what it feels like and the pattern of the pain is also important. Assessment should also include asking about dynamic pain (pain when the patient moves, takes deep breaths and coughs). A thorough assessment will also reveal issues such as patient’s fears of taking analgesics. The acronym OPQRSTU is a useful reminder of questions to ask (Table 3).

<table>
<thead>
<tr>
<th>Table 2. The aims of pain assessment</th>
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<tr>
<td>To find out information which helps determine the cause and type of pain</td>
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<tr>
<td>To help the patient to describe their painful experience</td>
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<td>To find out about the impact the pain is having on their quality of life and ability to function</td>
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<td>To allow documentation of the patient’s pain in a standardised way</td>
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<td>To allow an understanding of what treatments would be most helpful and effective</td>
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<tr>
<td>To find out about the patient’s beliefs, which may affect their pain management, i.e. fear of taking medication</td>
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<td>To find out whether current treatments are effective</td>
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### Onset: when did your pain begin?

Even if the patient has had surgery and the answer to this question may seem obvious, it is important to find out when the pain started. Any new pain needs to be investigated and a new diagnosis considered. If pain from a chronic wound has become worse, this may then lead an investigation into whether perhaps there is an infection.

### Provoking/palliating: what makes the pain better or worse?

Asking the patient what makes the pain worse or better may help to find the cause and treatment, i.e. if a patient has a wound that is painful when lightly touched, there may be an element of neuropathic pain. Some patients may have found a position which makes the pain better, i.e. elevating the leg, or they may find a particular pain medication

![](image-url)
helps. If medications help, it is useful to ask how much of the pain it relieves using a pain relief scoring tool (Figure 1).

Quality: what does the pain feel like?
The way patients describe their pain may provide many clues as to what is causing the pain, the type of pain and the appropriate treatments, i.e. crampy abdominal pain may be colic, which may respond to antispasmodic drugs. Cardiac pain is often described as ‘crushing’.

Region and radiation: where is the pain and does it spread anywhere?
This may seem obvious, especially if the patient has just had an operation, however sometimes the pain is not where we think it is. For example, a patient with a large sacral pressure ulcer may complain of hip pain. Asking if the pain radiates or spreads anywhere may help determine the cause.

Severity: how strong or severe is the pain?
There are no objective ways of measuring pain like there is, for example, for blood pressure. The most reliable way is to ask the patient and to use a tool to help the patient ‘measure’ the intensity. The tools are based on numbers, words or pictures.

Treatment: what treatments have been tried so far?
It is important to ask what medications or treatments have been tried so far and how much they helped.

Understanding: what is your understanding about the pain and the treatments?
It is useful to talk to patients about their understanding of their pain and treatments. This helps the patient to be an active participant in their care and improves communication. Discussions may also reveal any fears about taking analgesics (including fear of addiction and side-effects). Cues for a full pain assessment are outlined in Table 3.

Pain assessment tools
A variety of pain assessment tools can be used. The tool needs to be one that is easily understood by staff and patients, should be quick to apply and easy to document. The tool should be explained and the patient should not feel rushed. Many organisations include pain assessment on the vital signs chart to ensure regular assessment. Once an appropriate tool is chosen for a patient, the same tool should be applied each time. Commonly used tools are outlined in Figure 2.

Assessing wound pain
Patients may have acute or persistent pain with wounds. It is important to ask what the pain is like at rest, on movement and when procedures such as dressing changes are being undertaken. Many patients fear dressing changes because dressing removal and cleansing the wound can cause pain. If a patient has a chronic wound, attention needs to be paid to how it affects their quality of life. Pain can affect their quality of life in the following ways:

» Decreased appetite
» Difficulty sleeping
» Altered mood

### Table 3.

| O | Onset | When did the pain start?  
 Is it an old pain, a new pain or an old pain that has become worse?  
 How long does it last?  
 How often does it come on?  
 Any other symptoms that have started along with the pain? |
|---|---|---|
| P | Provoking, palliating | What starts the pain?  
 What makes it worse?  
 What makes it better? |
| Q | Quality | What does the pain feel like?  
 What type of pain is it? |
| R | Region, radiation | Where is the pain?  
 Does it spread anywhere? |
| S | Severity | How strong or intense is the pain?  
 Use the appropriate pain scoring tool, e.g. on a scale of 0–10, with 0 being ‘no pain’ and 10 being ‘worst possible pain’, how strong would you say the pain is? |
| T | Treatment | Have you tried treatment for this pain?  
 If so, did it help?  
 Are you allergic to any painkillers or had any side-effects from them? |
| U | Understanding | What do you believe is causing this pain?  
 How does it affect you and/or your family? |
Relationship problems
Mobility.

Assessment tools for specific conditions
There are also assessment tools for specific types of pain, i.e. the LANSS assessment tool helps detect neuropathic pain (Bennett, 2001) and the Brief Pain Inventory (Daut et al, 1983) includes questions for persistent pain. For patients in the community, it may be appropriate for them to keep a ‘pain diary’ which can be discussed at each visit.

Frequency of assessment
Patients should be regularly asked about pain. Hospital patients should be asked on admission, and if they do have pain a full assessment should be carried out. Thereafter, pain intensity should be assessed when assessing vital signs, and more frequently for acute or uncontrolled pain. If any new pain develops, a full assessment should be repeated. In the community, pain should be assessed at every contact with the patient as part of their general assessment. It is also important to assess pain before and after analgesia to ensure that it is effective. This is often not the case and in one study looking at pain reassessment following analgesia, only 15.3% of patients with hip fractures had their pain reassessed within one hour following analgesia (Bucknall et al, 2007).

Challenging patient groups
For some patients, assessment is more complex, e.g. older people, those with dementia and children.

Older people
Many older people think physical pain is an inevitable part of ageing and may be hesitant to report it. Unfortunately, studies show that older people are more likely to have pain, but less likely to experience good pain management (Help the Aged, 2008). Some older people may deny they experience ‘pain’ but if the nurses uses words such as soreness, they may acknowledge this. National guidance outlining specific needs for older people including assessment tools provides useful guidance (Royal College of Physicians, British Geriatrics Society and British Pain Society, 2007).

Patients with cognitive impairment
Most traditional scoring tools rely on the patient being able to communicate and understand the tools. However, there are many tools based on objective signs which are helpful. Examples include the checklist of nonverbal pain indicators (Feldt, 2000), the Abbey pain scale (Abbey et al, 2004) and the PAINAD scale (Lane et al, 2003).

Children
An appropriate pain assessment tool for children is vital, especially when they are too young or unable to tell the nurse about their pain. There are many tools available and a specific one needs to be chosen according to the patient’s age and level of understanding. Updated guidance on the recognition and assessment of pain in children including validated assessment tools has been published (Royal College of Nursing [RCN], 2009).

Barriers to effective pain relief
There may be many barriers to effective pain assessment including lack of staff, time, knowledge deficit, attitudes or beliefs. A summary of barriers is outlined in Table 4.

Nurse-related barriers
Some studies show that healthcare staff do not always assess pain well. For example, studies showed that some nurses tend to doubt what patients say about their pain (White, 1999), that nurses do not always ask about pain (Watt-Watson, 2001) and that they overestimate the percentage of patients who over-report their pain (O’Brien et al, 1996; Brown et al, 1999).

Other studies have shown that when questioned, nurses stated that they relied on what the patient said about their pain; however, in practice many in fact relied on how the patient looked and the...
in the nurse’s own experience of ‘how it usually is’ to clarify the intensity of the patient’s pain (Kim et al., 2005).

Although pain is a subjective experience, these examples show that some nurses do not necessarily practice the principle of listening to what the patient says about their own pain.

**Patient-related barriers**

Many patients will not tell nurses about their pain unless asked specific questions. They are often reluctant to interrupt busy nurses, or are fearful of being regarded as a ‘nuisance’. Some patients may avoid reporting pain because they fear medications (Ward et al., 1993). Others wish to ‘be brave’, may fear that staff do not believe them, or have not been taken seriously in the past. Culture may also influence patients’ behaviors and willingness to report pain.

**Importance of good communication**

Good communication with the patient allows nurses to gain an understanding of the patient’s experience and enhances rapport. This in turn may encourage patients to report pain and to do so without fear that they are ‘disturbing’ staff. Verbal and written communication within the multidisciplinary team is important. Assessments and response to treatments must be accurately documented and an adequate handover provided to ensure continuity of care.

**Conclusion**

While pain management is the responsibility of all healthcare staff, nurses and support workers have a pivotal role. Accurate pain assessment helps nurses to make decisions about when and how to give analgesia and what information they need to share with the multidisciplinary team. Nurses have a responsibility to ensure that they have the knowledge and skills to assess pain and provide effective and safe pain management. Pain

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**Visual analogue scale (VAS)**

A 10cm line with no markings except ‘no pain’ at one end and ‘worst imaginable pain’ at the other end. The patient should be asked to mark a point on the line that represents their pain. The distance from no pain to the patient’s mark is then measured in millimetres to give a score out of 100.

![Visual analogue scale](image)

**Verbal rating scale (VRS)**

The patient is asked to select from a list of words describing the severity. Some patients find it easier using words than numbers. For ease of documentation, many organisations provide a number alongside which can more easily be documented.

- No pain (0)
- Mild pain (1)
- Moderate pain (2)
- Severe pain (3)

**Numerical rating scale (NRS)**

The patient is asked to give a number between 0 and 10, where 0 is no pain and 10 is the worst pain imaginable.

![Numerical rating scale](image)

**Faces e.g. Wong-Baker FACES Pain Rating Scale**

Originally used for children, has also been used successfully in older adults.

![Faces rating scale](image)

**Brief word instructions:**

Point to each face using the words to describe the pain intensity. Ask the child to choose the face that best describes their own pain and record the appropriate number.

*Source: Hockenberry et al (2005)*

**Figure 2. Various pain intensity scoring tools.**
management is an essential part of good quality care to which all patients are entitled.

**Key points**

- Pain is a common symptom.
- Pain is a subjective, personal experience.
- Effective pain assessment and appropriate response to the assessment improves pain management.
- Pain assessment is more than just obtaining a ‘pain score’.
- Pain assessment helps determine the cause of the pain, the type of pain and the best treatments.
- There are many pain assessment tools for patients, including tools for patients who can communicate and for those who cannot.


International Association for the Study of Pain (IASP) (1979) International Association for the Study of Pain sub-committee on taxonomy, pain terms: a list of definitions and notes on usage. *Pain* 6(3): 249–52


McCaffery M (1968) *Nursing Practice Theories Relate to Cognition, Bodily Pain and Man-Environment Interactions*. University of California at Los Angeles Students’ Store, Los Angeles


