Pain Assessment Guide

People see pain and bear pain in their own way – Nurses know that it is unique to the person who has it. It is important to find out what the pain feels like.

Think of some pain you or someone you know had. Talk about how it felt as another student practices doing a pain assessment with you.

Location:

Where on your body is the pain? Right or left side, or both? Does it move toward any other body part? If so, where?

_____

_____

Description: (Mark below or write in descriptors. May include more than one.)

Aching	Dull	Stabbing	Tender
Sore	Burning	Stinging	Itching
Numbing	Pins and needles	Pulling	Sharp
Cramping	Jabbing	Shooting	Electric
Pounding	Splitting	Gnawing	Nagging
Pressure	Tiring	Pricking	Cutting
Throbbing	Radiating	Squeezing	Piercing
Crushing	Pinching	Nauseating	Constant (steady)
Other ways to describe your pain:			

Modified from Melzack, R. (1883). The McGill pain questionnaire. Retrieved from http://www.fcesoftware.com/images/16_McGill_Pain_Questionnaire.pdf

Timing:

Brief (quick pain), Intermittent (comes and goes), Constant?, Rhythmic? Other?

_____

What makes it better? What makes it worse?: (not necessary with every pain assessment)

_____

_____

What helped in the past?: (not necessary with every pain assessment)

_____

Goals: (not necessary with every pain assessment)

I would be satisfied with a pain rating of _____ out of __10___.

I would like to be able to do: _____.

Intensity:

Use pain scales to help you know how uncomfortable the patient is and if pain management efforts are working or not. By using a pain scale, treatment and comfort can be quicker and more effective.

The simplest pain scale is a 4 point scale (no pain = 0, mild = 1, moderate = 2 or severe = 3). Some use a numbers scale of 0 to 5. Standard pain scales are shown below.

Self-reports of pain go from the number 0 (or the happy face) meaning no pain, to the number 10 on the right of the scale (or the crying face) which means the worst pain you can imagine.

Practice by using one of the pain scales with your classmate, and write the pain ratings here:

Pain scale used _____. Pain rated _____ on a scale of 0 to _____.

Summarize your pain assessment for charting on the medical record:

(Include location, description, timing, and intensity rating)

_____

_____

_____

Use Pain Scales

FLACC: **F**(face) **L**(eg) **A**(ctivity) **C**(cry) **C**(onsolability): is a pain scale used in assessing infant's pain, but can be used with patients until the age of 5. It can also be used for people who are not responsive or are unable to express their pain.

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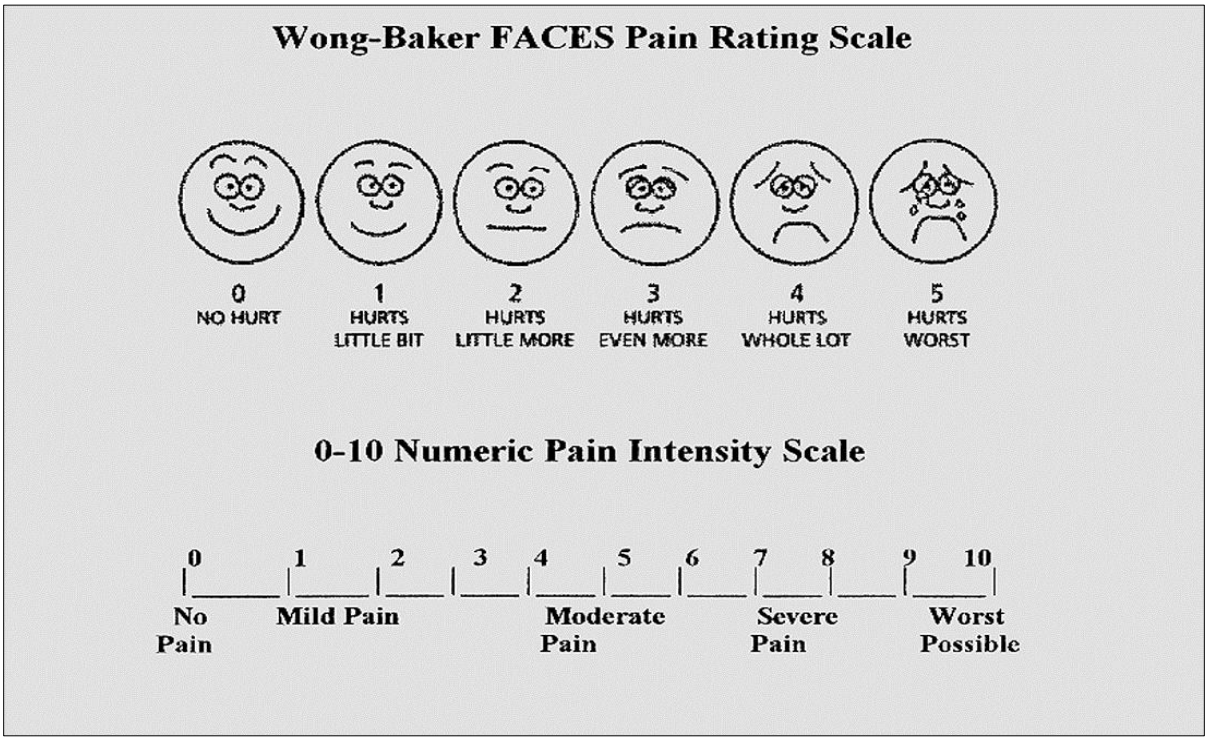
	Scoring		
Categories	**0**	**1**	**2**
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to; distractible	Difficult to console or comfort

Note: Each of the five categories Face (F), Legs (L), Activity (A), Cry (C), and Consolability (C) is scored from 0-2, which results in a total score between 0 and 10.

From Merkel, Voepel-Lewis, Shayevitz, & Malviya (1997). The FLACC: A behavioral scale for scoring postoperative pain in young children. *Pediatric Nursing, 23*(3) 293-297.

The **faces** scale is best used for preschool or early school age children. A **numeric** scale can be used for older school age, teenagers, or adults by saying. “On a scale of 1-10 what is your pain?”



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https://creativityandcompassion.files.wordpress.com/2015/04/wb-faces.jpg

Practice rating pain, using these scenarios:

A 2 year old patient is resting with a worried look on his face. His legs are pulled tight. He is tense and hesitant to move. He moans occasionally, but is calm when resting or repositioning. After observing for 2-5 minutes, how would you rate his pain on the FLACC scale? What does that pain rating mean?

Face _____ **L**egs _____ **A**ctivity _____ **C**ry _____ **C**onsolability _____

FLACC total score is _____. That means _____ on word scale or _____ pain.

A patient with back pain points to the 3rd picture from the left on the Faces scale.

Pain rating on Faces scale is_____. On Words scale, that means _____, or _____ pain.

A patient with headache using the Words scale said he has the "worst pain imaginable". That is _____ on Numbers scale or _____ pain.

A patient with shoulder pain points to number 2.

Pain rating on Numbers scale is_____. That means _____ or _____ pain.

An elderly patient with dementia is frowning and looks worried. Her arms and legs are rigid and flexed. She is restless and tense, positioned as if guarding a painful area. She is repeatedly calling out, but is able to be distracted by voice or touch. After observing for 2-5 minutes, how would you rate her pain on FLACC scale?

Face _____ **L**egs _____ **A**ctivity _____ **C**ry _____ **C**onsolability _____

FLACC total score _____ On Words scale, that means _____, or _____pain.

Your pain assessments are very important for communication in a "pain team". Effective interventions for pain management can improve quality of life for your patients.