Assessing Pain

Nursing

A structured pain history, and choosing a scale the patient can actually use.

Ask the history first; the scale is one line of it, not the whole assessment.

The history · OPQRSTU

- **Onset** — when it started, what began it
- **Provokes and palliates** — better and worse
- **Quality** — the patient's own words
- **Region and radiation** — where it travels
- **Severity** — a scale the patient can use
- **Timing and Understanding** — pattern, meaning

Choosing a tool

- **Numeric 0–10 for most adults**
- Verbal descriptors when numbers confuse
- Faces scales for children and some adults
- Behavioural tools if unable to self-report
- **Reassess after every intervention**
- Record the tool used, not just the number

Educational reference. Pain is what the patient says it is. Analgesic choices and thresholds follow local prescribing protocol.