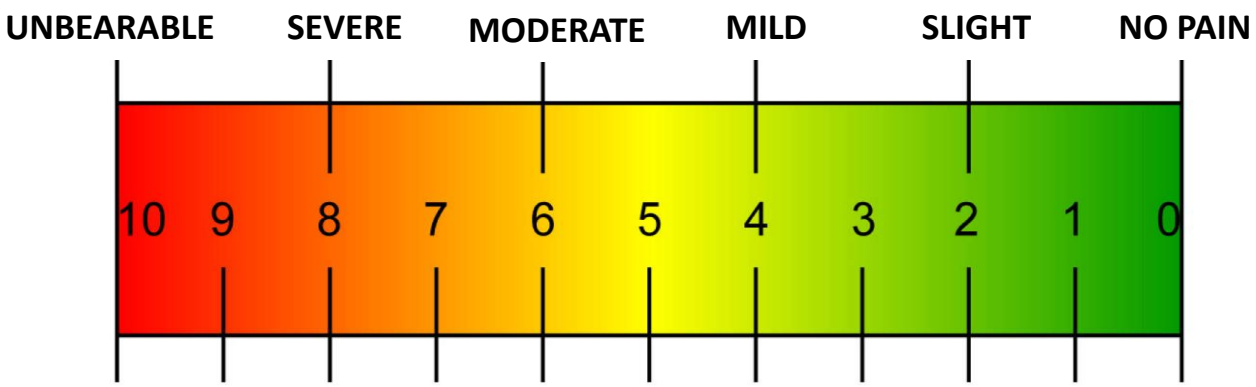
Pain Assessment:
Able to Self-Report

An individual's self-report provides is the primary evidence for the determination of pain. This is the **S**everity component of the PQR**S**T.

- The numeric (0-10 out of 10) or visual analogue (shown below) should be included in the pain assessment whenever the patient can self-report.
- The actual score is not as important as the patient's perception of change during reassessment (worse or better).
- When pain is reported by the patient, the characteristics of the pain should be evaluated using the PQRST mnemonic (next page). This will help to identify the cause of the pain and the most appropriate treatment plan.



Pain Assessment: Able to Self-Report

PQRST Mnemonic for Pain Assessment

P (provokes, precipitates):

- Location of pain
- What brings it on (e.g., activity, specific movement, eating, breathing)?
- What relieves it?

Q (quality):

- What is the quality of the pain (in the patient's own words)?
- Prompt only if necessary, to determine if pain is dull, sharp, stabbing, pins and needles, "electrical", etc.

R (radiation, referral):

- Does the pain move to any other spot?
- Are there any other symptoms with the pain (e.g., nausea, vomiting, shortness of breath)?

S (severity):

- How does the patient rate the severity of the pain on a scale of 1-10?

T (time):

- When did the pain start?
- Has this pain occurred before?
- Is the pain intermittent or constant?

Pain Assessment: Unable to Self-Report

Critical-Care Pain Observation Tool (CPOT)

Score each item 0, 1 or 2 out of 2. Total the sum of the four items to produce a CPOT score of 0-8/8

Indicator	Assessment	Score	Description
Facial Expression (score 0, 1 or 2)	Relaxed, Neutral	0	• No muscle tension observed
	Tense	1	• Presence of frowning, brow lowering, orbit tightening or contraction of upper eyelid; or, • Any other change (e.g., opening eyes or tearing during noxious procedures)
	Grimacing	2	• All above facial movements plus eyelids tightly closed (may present with mouth open or biting ETT)
Body Movement (score 0, 1 or 2)	Absence of movement/normal position	0	• Does not move at all (doesn't necessarily mean absence of pain); or, normal position (movements not aimed toward the pain site or not made for the purpose of protection)
	Protection	1	• Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements
	Restlessness	2	• Pulling tube, attempting to sit up, moving limbs/thrashing, not following commands, striking at staff, trying to climb out of bed
Ventilator Compliance (ventilated patient) **OR** ***Vocalization*** *(non-intubated)* **(score 0, 1 or 2)**	Tolerating ventilator or movement; *or, talking in normal tone or no verbal sound*	0	• Alarms not activated, easy ventilation; or, *Talking in normal tone or no sound*
	Coughing but tolerating ventilator; *or, sighing or moaning*	1	• Coughing, alarms may be activated but stop spontaneously; or, *Sighing, moaning*
	Fighting ventilator; or, *crying out or sobbing*	2	• Asynchrony, blocking ventilator, alarms frequently activated; or, *Crying out, sobbing*
Muscle Tension (evaluate by passive flexion and extension of upper limbs when patient is at rest or during turning) **(score 0, 1 or 2)**	Relaxed	0	• No resistance to passive movements
	Tense, rigid	1	• Resistance to passive movements
	Very Tense or rigid	2	• Strong resistance to passive movements, incapacity to complete them
TOTAL SCORE		**__/8**	Sum of scores from each of the 4 categories.