

How's your knowledge of basic pain and symptom assessment?

Do you ask about the **PQRSTU's**?

P: What **Provokes** or **Palliates** the pain—i.e. what makes it worse or better? (standing, sitting, lying down, wt bearing etc.) What meds have been tried in the past? What worked, and what didn't?

Q: What is the **Quality** of the pain—i.e. dull, achy, sharp, burning, shooting, hypersensitivity etc.

****Practice Tip: Different qualities of pain may suggest different etiologies, such as bone and neuropathic pain, and these require different pain medications****

R: Where does the pain **Radiate**?

S: What is the **Severity** of the pain—are you using the following tool: “**On a scale of zero to ten, where zero is no pain and ten is the worst pain you can imagine**, how would you rate your pain?” (. . . right now, when at its worst, when at its best, etc.)

T: **Timing**—i.e. how long does it last? What times of day are worst?

U: What meaning does the pain have for “**U**” (the patient)?

****Practice tip: patients who have been in pain for months or years do not LOOK like they are in pain. Instead, they look “flat”, almost like depression. We should kick ourselves every time we hear ourselves say the patient “doesn't look painful” ****

- Do you ask about the pain scale at every visit?
- Do you use open-ended questions (How is your pain? Tell me about your pain) rather than suggesting the answer to the patient? (What answer would you expect if you said “you seem less painful today”?)
- Do you ask how often the patient's bowels are moving and when they last moved?
- Do you ask about nausea and vomiting?
- Do you ask about appetite?
- Do you ask about energy level?

Are you aware that there are treatments for each of these symptoms? Want to learn more?

Call us: Palliative Care Community Advice Line: (905) 548-5565 —available 24 hrs a day.

We're here to help you.