

Core Principles of Pain Assessment

- Every older adult has the right to appropriate assessment and management of pain. Pain should be assessed in all individuals living in nursing homes.
- Pain is always subjective. Therefore, the individual's self-report of pain is the single most reliable indicator of pain. The clinician needs to accept and respect this self-report.
- Physiological and behavioral (objective) signs of pain (e.g., tachycardia, grimacing) are neither sensitive nor specific for pain. Such observations should not replace individual self-report unless the individual is unable to communicate.
- Assessment approaches, including tools, must be appropriate for the individual. Special considerations are needed for those with difficulty communicating. Family members should be included in the assessment process, when possible.
- Pain can exist even when no physical cause can be found. Thus, pain without an identifiable cause should not be routinely attributed to psychological causes or discounted.
- Different levels of pain in response to the same stimulus may be experienced by individuals; that is, a uniform pain threshold does not exist.
- Pain tolerance varies among and within individuals depending on factors including heredity, energy level, coping skills, and prior experiences with pain.
- Individuals with chronic pain may be more sensitive to pain and other stimuli.
- Unrelieved pain has adverse physical and psychological consequences. Therefore, clinicians should encourage the reporting of pain by individuals who are reluctant to discuss pain, deny pain when it is likely present, or fail to follow through on prescribed treatments.
- Pain is an unpleasant sensory and emotional experience, so assessment should address both physical and psychological aspects of pain.

Adapted from: Ersek M, Polomano RA. (2011). Nursing management of pain. (In) Lewis SM, Heitkemper MM, Dirksen SR, O'Brien P, Giddens J, Bucher L. (Eds.) Medical-Surgical Nursing: Assessment and Management of Clinical Problems, 8th Edition. Philadelphia: Elsevier.

Pain Scale



Pain Checklist Older Adults

Checklist

- Consider pain as the first vital sign that is best measured by the patient.
- Ask about the presence of pain when examining an older person.
- Console patient for atypical manifestations of pain in the elderly, such as changes in function or gait, withdrawn or agitated behavior, or increased confusion.
- Use standard geriatric assessment tools to evaluate function, affect, cognition, gait, and psychosocial issues.
- Rely on the input of caregivers, particularly in elderly patients with cognitive impairment and communication disorders.
- Do a comprehensive pain assessment evaluating pain quality, intensity, and factors that exacerbate or relieve the pain.
- Use standard pain scales such as a numerical scale, a pain thermometer scale, or a visual analog scale.
- Identify the etiology of pain in the elderly (keeping in mind that it may be multifactorial) by use of geriatric assessment tools, the history and physical examination, and appropriate diagnostic tests.
- Conduct a careful structural examination to identify regions of somatic dysfunction.
- Monitor and measure presence of pain regularly by use of a pain log or diary and by readministering the pain scales to assess the efficacy of the intervention.



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