

Core Principles of Pain Assessment for Providers

- Every older adult has the right to appropriate assessment and management of pain.
- Pain is always subjective. Therefore, the individual's self-report of pain¹ 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, R.A. (2011). Nursing management of pain. In Lewis, S.L., Dirksen, S.R., Heitkemper, M.M., Bucher, L., Camera, I.M (Eds.), *Medical-Surgical Nursing: Assessment and Management of Clinical Problems (8th Ed.)*. (127-152). Philadelphia: Elsevier.

¹ Self-report of pain is defined as the ability to indicate presence and/or severity of pain verbally, in writing, or by other means such as finger span, pointing, head movement, or blinking eyes to answer yes or no questions.