Core Principles of Pain Assessment for Clinicians

- All older adults have the right to appropriate assessment and management of pain. Pain should be assessed in all older adults at every encounter with a provider/clinician.
- A comprehensive evaluation should be performed identifying the underlying cause(s) of pain, pain characteristics and impact on physical and psychological function, and quality of life. Identify various factors (e.g., anxiety, depression, insomnia, language barriers, cultural beliefs and fear avoidance) that impact the pain experience.
- Pain is always subjective. The older adult's self-report of pain is the single most reliable evidence of pain intensity and impact on function.
- Use an interprofessional approach including providers, nurses, physical and occupational therapists, psychologists, pharmacists and social workers, particularly for persistent pain.
- Physiological and behavioral (objective) signs of pain (e.g., tachycardia, grimacing, increased blood pressure) are neither sensitive nor specific for pain. Such observations should not replace self-report unless the older adult is unable to communicate. Behavioral symptoms may offer better indicators of pain.
- Use standardized pain assessment scales (e.g., Numeric Rating Scale, Verbal Descriptor Scale, Faces Pain Scale, PAINAD), that are appropriate for the older adult. Special considerations are needed for those with difficulty communicating. Family members should be included in the assessment process, when possible.
- Use synonyms when assessing pain (e.g., discomfort, aching, soreness, burning) to provide additional dialogue if the older adult denies experiencing pain and the clinician observes pain behaviors.
- Pain can exist even when no physical cause is identified. 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 older adults. 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.
- Undertreated pain has adverse physical and psychological consequences. Clinicians should encourage the reporting of pain by older adults who are reluctant to discuss pain, deny pain when it is likely present, or fail to follow through on prescribed treatments.
- Recognize clinician implicit biases related to pain perception and tolerance in historically marginalized populations, as they might impact pain treatments and outcomes.

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References

Reuben DB, Herr KA, Pacala JT, Pollock BG, Potter JP, Semla TP. Geriatrics at Your Fingertips. 25th New York: The American Geriatrics Society; 2023. Pg 253-257.ISBN: 978-1-886775-77-0