SKILL COMPETENCY *checklist*

Pain Assessment in Older Adults: Performing

Standard Met/Initials	Competency Areas
Prerequisite Skills	
	Understanding of the importance of routine and thorough pain assessments in the management of acute or chronic pain in older adults
	Awareness that older adults are at high risk for inadequate pain assessment
	Understanding that cognitive impairment/dementia can impair ability to self-report pain
	Understanding of adverse effects that uncontrolled, persistent pain can have on older adults
	Familiarity with different pain assessment tools used in older adults; knowledge of and proper use of pain assessment tool(s) adopted for use by facility
	Understanding of facility protocol concerning pain assessment and documentation
Preparation	
	Reviews facility protocol and/or treating clinician's orders for pain assessment
	Identifies and assesses patient, and communicates with patient/family ‣ Identifies patient according to facility protocol ‣ Explains/reinforces the purpose of pain assessment to patient/family, and assesses for any knowledge deficits related to pain assessment and management; explains the use of pharmacologic and nonpharmacologic measures for pain control ‣ Assesses anxiety level and coping ability of patient/family with regard to the patient's pain; assesses patient/family expectations about pain
	Selects appropriate, clinically-validated pain assessment tool (e.g., based on patient's mental status, ability to communicate verbally, and language spoken)
Procedure	
	Provides privacy
	Assesses patient for the ability to communicate
	For patients who can communicate clearly, does the following: ‣ Asks patient if s/he is in pain using words like "pain," "hurt," and "discomfort" ‣ Asks about the patient's ability to sleep and perform ADLs, and how the pain is affecting work, relationships, and enjoyment of life ‣ Asks about previously used interventions and whether they relieved pain ‣ Asks about what triggers pain ‣ Asks what the pain feels like ‣ Asks the patient to show you where the pain is located ‣ Asks if the pain increases or decreases at different times of day ‣ Assesses for moaning, crying, reduced activity, grimacing, change in usual behavior, abnormal gait, guarding, diaphoresis, nausea, vomiting, constipation, muscle tension, sleep disturbances, headache, and increased blood glucose level ‣ Inspects site of pain for discoloration, swelling, drainage ‣ Uses the facility's clinically-validated pain assessment tool, asks the patient about pain intensity

Cinahl® information systems

Published by Cinahl Information Systems. Copyright©2011, Cinahl Information Systems. All rights reserved. No part of this may be reproduced or utilized in any form or by any means, electronic or mechanical, including photocopying, recording, or by any information storage and retrieval system, without permission in writing from the publisher. Cinahl Information Systems accepts no liability for advice or information given herein or errors/omissions in the text. It is merely intended as a general informational overview of the subject for the healthcare professional. **Cinahl Information Systems, 1509 Wilson Terrace, Glendale, CA 91206**

Standard Met/Initials	Competency Areas
Procedure	
	For patients who cannot communicate clearly, does the following: ▸ Assesses for potential causes of discomfort (e.g., infection, constipation, or emotional distress) ▸ Attempts to use a clinically-validated pain assessment tool that is easy to use with nonverbal, alert and oriented patients, such as the Visual Analogue Scale (VAS) or the Faces Pain Scale ▸ If self-report is not possible, documents in the patient's record why this is so, per facility protocol ▸ Assesses patient's pain by • observing the patient for changes in behavior that may indicate pain such as restlessness, grimacing, moaning, crying, or rubbing a body part • asking family members or in-home caregivers who know the patient well whether he or she seems to be in pain. They may identify subtle changes in behavior that typically indicate pain for this patient • taking the patient's vital signs and monitoring for increased blood pressure, respiration, and heart rate • assessing for conditions that typically cause pain, such as recent surgery; physical therapy or other rehabilitation treatment; phlebotomy; wound dressing changes, or other painful procedures; pressure sores or other skin injuries; and painful medical conditions, including neuropathies and musculoskeletal conditions
Post-Procedural Responsibilities	
	Initiates/adjusts pain management plan and provides appropriate pain management interventions in collaboration with the treating clinician
	Continues to evaluate presence and intensity of pain through routine use of a validated pain assessment tool
	Provides patient/family education, including written information if available, on ▸ the goal of the pain management plan to prevent, control, or completely alleviate the patient's pain ▸ specific interventions used for pain relief
	Provides information for contacting the treating clinician in case of questions/concerns or to report new, worsening, or unrelieved pain
	Documents the following information in the patient's medical record: ▸ Date and time of pain assessment ▸ Pain assessment scale used ▸ Any observable indications or patient self-report of pain ▸ Pain score obtained ▸ All patient/family education provided

Author
Sara Grose, MSN, RN, PHN, CNL, CLE

Editor
Diane Pravikoff, RN, PhD, FAAN
Cinahl Information Systems

December 2, 2011

Signature		Date	
Evaluator's Signature		**Date**	