Pain Management and Philosophy of Care in Veterans' Long Term Care at Camp Hill

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About us:

- 175 Veterans that served overseas in WW2 or Korean War living at Camp Hill, Capital Health, the largest health district in Nova Scotia, Canada
- Comprehensive long term care service
- Average age is 88 and over 85% of the Veterans have some degree of dementia or cognitive impairment

What the literature says:

Palliative Care in Long Term Care

- In Canada, 39% of all deaths occur in long term care facilities and projections are that 1 out of 2 people will die in a long term care facility by 2020.
- Literature reports – In Long Term Care (LTC) there are concerns about untreated pain, unmet emotional needs, and poor communication with and between family members and the interdisciplinary team members, unnecessary hospitalizations, family dissatisfaction around the quality of care, and care that is not in line with the clients' disease trajectory or preferences.

References: Brazil,K. 2006; Meier,D; Volicer,L. 2002; Health Canada, National Advisory Committee; Hanson,L. 2005; Kaasalainen,S. 2007; Meier,D.; Mitchell,S. 2004; Fisher,S. 2002; Abbey,J. 2004

Pain in Long Term Care

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- Statistics Canada (2008) reports that prevalence of pain is highest in seniors living in LTC facilities - 38% as compared to 27% for those living in the community.
- 38 - 83% of LTC residents experience pain at least some of the time and treatment of pain is lower amongst residents with cognitive impairment.

References: Feldt,K.S. 1998; Ramage-Morin,P.L. 2008; Volicer,L. 2002; Warden, V. 2003; Molony,S.L. 2005; Zwakhalen,S.M. 2006

What we decided to do:

1. Develop a formalized physical and spiritual/psychosocial pain assessment and management program.
2. Develop and implement a Veterans' care and service delivery philosophy.
3. Use John P. Kotter's change process - Planning for Change: Eight-Stage Process of Creating Major Change (Leading Change, 1996).

Step 1. Establishing a sense of urgency

1. 40% satisfaction surrounding pain management on Veteran's Satisfaction Survey
2. Accreditation recommendation - standardized pain assessment tools required
3. Changing length of stay decreasing from 22 months in 2005 to 5 months in 2008
4. Baseline pain data

Step 2. Creating the Guiding Coalition

Interdisciplinary team including Nursing, Occupational Therapy, Physician, Recreation, Spiritual Care, Social Work

Step 3. Developing a Vision and Strategy

Care and Service Delivery Philosophy

- "To improve care of the dying we need to improve care in general" Kevin Brazil, 2010

Resources: Canadian Hospice Palliative Care Association; Swedish Medical Centre, Palliative Care Resource Team; National Childcare Accreditation Council; experts

Pain Management Program

- Protocol, assessment processes and tools, pharmacological and other management strategies, institutionalization into practice

Resources: Registered Nurses Association of Ontario's Assessment and Management of Pain Best Practice Guideline for Long Term Care; Capital Health Edmonton Area's Continuing Care Interdisciplinary Pain Assessment and Management Standard; Joint Commission on Accreditation of Healthcare Organizations. Improving the Quality of Pain Management Through Measurement and Action; Australian Pain Society

Step 4. Communicating the Change Vision

- Interdisciplinary education/discussion sessions on units
- Newsletters, champions at weekly rounds and care conferences
- Meetings - staff, management, quality advisory, physicians
- Stakeholder consultations - Veterans, families and staff

Step 5. Empowering broad based action

- Staff choose assessment tool
- Family and Veteran communication
- Evidence based geriatric symptom management reference sheets (Alberta Palliative Care Resource, 2nd. Ed. (2001); IASHPC International Association for Hospice and Palliative Care, 2nd edition 2004; Care Beyond Cure (2000)

Step 6. Generating short term wins

- Improved equipment such as pressure relief surfaces provided.
- Improvement in processes that support work - i.e. flow sheets
- Sharing progress with staff

Results to Date

Care and Service Delivery Philosophy

- Developed with input from Veterans, family
- Members, staff, VAC and a variety of experts

Philosophy of Care

We believe in holistic care that is veteran-driven, supportive of family and is based on best practice.

Our Philosophy is supported by the following statements:

We understand care is working together to provide comfort, relieve suffering and improve quality of life for Veterans and to provide support for their families.

We value care that is Veteran driven and centered on the whole person.

We engage the Veteran and/or the family in developing the goals of care for each Veteran who is the focus of care.

We value care that is compassionate and sensitive to the Veteran's and family's personal, cultural, religious/spiritual values, beliefs, and needs.

We provide care that is individualized for the Veteran.

We encourage Veterans to do what they can for themselves and provide support and assistance when needed through timely and responsive care.

We recognize that we have a role in advocating for Veterans and their families.

We support each other while providing care.

We build and maintain positive relationships with other organizations to support Veterans' care goals.

We believe in open discussions between ourselves, Veterans and their family.

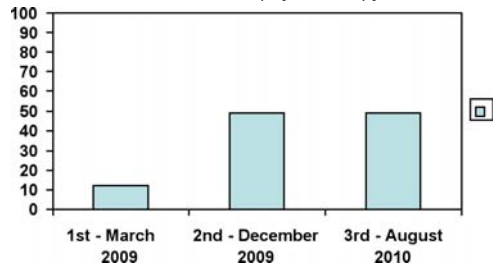
To cure sometimes, to relieve often, to comfort always.
Anonymous

Pain Management Program

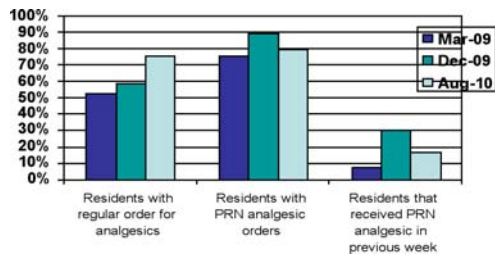
- Flow sheet incorporates pain as 5th vital sign
- Standardized assessment tools - Abbey Scale for cognitively impaired and Numerical 0 - 10 Scale for those who can self report
- Interdisciplinary education reached over 80% of staff
- Admission baseline pain screening
- Documentation continues to be an issue but improvement was noted from less than 10% to 16%

Non Pharmacological Pain Management Strategies

Non-pharmacological treatments for pain, i.e. acupuncture, massage therapy, music therapy, hot or cold packs, cervical collars, pressure reduction mattresses, physiotherapy, radiation, etc.



Analgesic Utilization



	Regularly Scheduled	PRNs
March 2009	Acetaminophen plain - 93% Other orders - Celebrex and Tylenol #1 - 3	Acetaminophen plain - 89% Other orders - Tylenol #2 - #3
Dec 2009	Acetaminophen plain - 49% Other orders - Celebrex, Tylenol #1 - 3, fentanyl patch, oxycodone, hydromorphone, morphine - 36% of residents	Acetaminophen plain - 80% Other orders - Tylenol #1 - 3, hydromorphone, codeine, oxycodone, morphine - 30% of residents (Some residents had more than 1 PRN ordered)
August 2010	Acetaminophen plain - 45% Other orders - Acetaminophen CR, diclofenac drops, Celebrex, Tylenol #1, hydromorphone, morphine, pregabolin, codeine, morphine - 41% of residents	Acetaminophen plain - 63% Other orders - Tylenol #1 - 3, morphine, belladona, hydromorphone, ibuprophen, codeine, diclofenac drops - 43% of residents (Some residents had more than 1 PRN ordered)

Outcomes

- Pain and palliative care needs - standing agenda item at Care Conferences and Rounds
- Staff - Increased knowledge and comfort with pain management
- Veterans' - 100% satisfaction rating on annual satisfaction survey in fall 2009
- Veteran experiences desired pain relief:

"I get pain medication whenever I need it and my medication is always on time."
"I feel very good with my medication and pain treatment."
Comments from 2 Veterans, November 2009

Step 7. Consolidating gains and producing more change, and

Step 8. Anchoring new approaches in the culture

- Results communicated
- Interdisciplinary orientation
- Ongoing interdisciplinary education and discussions
- Philosophy statement plaque mounted and displayed throughout organization