About us:

- 175 Veterans that served overseas in WWII 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: Brazzil, L., 2005; Mohr, C., 2002; Health Canada, National Adapting-Dawn MacKinnon, L., 2005; Canadian Hospice Palliative Care Association, 2005; Abbott, J., 2004

Pain in Long Term Care
- 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: Field, K.S., 1998; Ramage-Morin, P., 2008; Volicer, L., 2002; Warden, D., 2003; Winse, J., 2005; Zwikker, E.W., 2009

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.

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 communities” Kevin Brazil, 2010

Step 4. Communicating the Change Vision
- Interdisciplinary education/discussion sessions on units
- Infobehand, champions at weekly rounds and care conferences
- Meetings - staff, management, quality advisors, 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); IASP/PCP International Association for Hospice and Palliative Care, 2nd edition 2004; Care Beyond Care (2008)

Step 6. Generating short term wins
- Improved equipment such as pressure relief surfaces provided.
- Improvement in processes that support work - i.e. flow sheets

Results to Date
Care and Service Delivery Philosophy
- Developed with input from Veterans, family
- Members, staff, VAC and a variety of experts
- Developed with input from Veterans, family

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 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 understand 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.

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.

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

Analogic Utilization

| 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

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

March 2009
- Acetaminophen plan: 93%
- Other orders - Celebes and Tylenol #1 - 3
- Acetaminophen plan: 89%
- Other orders - Tylenol #2 - 3

Dec 2009
- Acetaminophen plan: 49%
- Other orders - Celebes, Tylenol #1 - 3, fentanyl patch, oxycodone, hydrocodone, morphine 36% of residents.
- Acetaminophen plan: 80%
- Other orders - Tylenol #1 - 3, hydrocodone, codine, oxycodone, morphine 33% of residents.

August 2010
- Acetaminophen plan: 45%
- Other orders - Acetaminophen CR, dicyclisic drops, Celebes, Tylenol #1, hydrocodone, morphine, pregabolin, colbutol, codeine, morphine 41% of residents.
- Acetaminophen plan: 63%
- Other orders - Tylenol #1 - 3, hydrocodone, belladonna, hydrodine, oxycodone, codeine, dicyclisic drops 43% of residents.

Documentation continues to be an issue but improvement was noted from less than 10% to 16%

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