EXTRA Project

Palliative Philosophy of Care and Pain Management in End of Life Care

Veterans' Services

"To cure sometimes, to relieve often,
to comfort always"
Author Unknown

How I choose my project

- Results of a Veterans Satisfaction Survey
- The average length of stay for people admitted in 2005 was 22 months, in 2006 it had dropped to 12 months and in 2008 it was 5 months
- Veterans' story

Start and spin-offs

- Tools, Guidelines and Protocols for Geriatric Palliative and End of Life Care in Continuing Care
- LTC Palliative Care
- Support for Veterans at End of Life
- Awareness raising - Bereavement processes for staff

Palliative Care in LTC

- In Canada, 39% of all deaths occur in long term care facilities
- Projections are that 1 out of 2 people will die in a nursing home by 2020
- Literature reports - inadequate or suboptimal palliative care in LTC.
- 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 LTC

- Statistics Canada (2008) reports that the prevalence of pain amongst seniors is the highest in seniors living in nursing homes – 38% as compared to 27% for those living in the community.
- These percentages may be underestimates as seniors have been known to underreport their pain experience.
- Between 38% and 83% of nursing home residents experience pain at least some of the time.

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

Pain

- Pain and its management affects many aspects of life including:
- mobility
- sleep
- development of pressure ulcers and contractures
- depression and aggression
- reducing or preventing social activity
- reduced appetite
- reduced quality of life

References: Tuch, H. 2003; Teno,J.M. 2003; Warden, V. 2003; Abbey,J. 2004; Brazil,K. 2006; Kapo,J. 2007

Pain Treatment in the Elderly

- The World Health Organization has developed guidelines for analgesic treatment of mild, moderate and severe pain. According to these guidelines older adults receive less that adequate analgesic treatment.
- The most commonly prescribed analgesics are aspirin and acetaminophen and in a recent study 60% of the subjects who had at least 1 diagnosis that would cause pain had not received analgesic in the month prior to the study.

References: Miller,L.L. 2002: Feldt,K.S. 1998

Pain assessment

- The first barrier to effective pain management is a failure to assess pain.
- The use of pain assessment scales, rather than just asking if someone has pain, increases the frequency of pain being diagnosed. Kamel,H.K. 2001
- Pain assessment tools: - Gold standard is self-report
  - Cognitively intact
  - Cognitively impaired and can not reliably report pain

Baseline Information

- 98% of the 49 residents reviewed had a diagnosis that could cause pain
- On average each resident had 2.63 diagnoses that could cause pain, e.g. arthritis, wounds or skin breakdown, congestive heart failure, chronic obstructive pulmonary disease, osteoporosis, paralysis, diabetes, gum disease, joint replacements, etc.

Pain assessment from MDS

	Pain Frequency			Pain Intensity		
	No pain	Less than daily	Daily pain	Mild pain	Moderate pain	Horrible, excruciating pain
March 2009	57%	29%	14%	62%	28.5%	9.5%

Pain Management - Analgesics

	Residents with regular order for analgesic	Residents with PRN analgesic orders	Residents that received PRN analgesic in previous week
March 2009	53%	75.5%	8%

- Regularly scheduled analgesics orders – 93% were for regular Acetaminophen 1 – 3 tablets, daily to QID
- PRN analgesic orders – 89% were for acetaminophen. The other orders were for Tylenol #2 and #3

Pain Management – Other Treatments

- 12% of those who had pain were receiving non-pharmacological treatments for pain, i.e. exercises, hot packs, massage therapy, physiotherapy

Other points

- 19 of the 49 residents reviewed had diagnosis of arthritis

→ 8 were noted on the MDS as not having pain.

→ For those getting analgesic, mainly receiving acetaminophen plain.

- 9 residents had stage 1 or 2 pressure sores or cellulites.

→ Of these 4 were seen as having no pain, 2 had it less than daily, and 3 had it daily.

→ 4 received regular analgesic. Others had PRNs ordered and of those only 1 received analgesic at least daily

What we are doing?

- Interdisciplinary Team focusing on:

  1. Development and implementation of a care and service delivery philosophy that focuses on a palliative approach.
     - ♦ Values statements and Guiding principles
     - ♦ End of Life physician orders for symptom management
     - ♦ Education to interdisciplinary team

  2. Pain assessment and management
     - ♦Daily flow sheet revisions, incorporate pain as fifth vital sign
     - ♦Assessment tools
     - ♦Protocol for pain assessment and management
     - ♦WHO analgesic ladder
     - ♦Education program - interdisciplinary

Progress to date – Palliative Philosophy

- Values statements and guiding principles
- Involving staff in the development of the philosophy
- Education – residents, family and staff
- End of life orders

Palliative Philosophy of Care

- Values statements:

  √ value of autonomy and uniqueness of each individual

  √ people have the capacity to learn and engage in life in some manner until they die

  √ the team is guided by what the individual deems is quality of life

  √ a unified approach to care delivery – includes Veteran and family with staff

References: Canadian Hospice and Palliative Care Association, Newsletter of the National Childcare Accreditation Council, PERT Program

Palliative Philosophy of Care

- Guiding Principles:

√ Interdisciplinary care aims to provide comfort, relieve suffering and improve or maintain the Veterans' quality of life.

√ Care is Veteran and/or family driven.

√ Culturally and spiritually sensitive care is provided in a manner that is respectful of the Veterans developmental state and preparedness to deal with the dying process.

√ When realistic and desired by the Veteran, functional independence is a priority.

References: Canadian Hospice and Palliative Care Association, Newsletter of the National Childcare Accreditation Council, PERT Program

Progress to date – Pain Management

- Daily flow sheets
- Analog scale – Capital Health policy
- Pilot Abbey Pain Scale for cognitively impaired unable to self report reliably
- Complete protocol
- Education – process and information

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