Changing the Face of Pain: Pain Management in Seniors

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BC CARE PROVIDERS ASSOCIATION

Introduction of Panelists

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Disclosures

- Kim Knight
  - No disclosures
- Neemet McDowell
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- Alvin Singh
  - No disclosures

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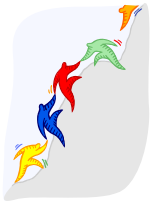


Time to move!

Get ready to collaborate!

Session Overview

- Fact or Fiction – You Decide!
- Case Introduction
- Clinical Tips and Pearls

How?

- Collaboration, Open Discussion & Group Interaction

Objectives

- Increase awareness of information gaps
- Develop patient-specific goals
- Identify pitfalls during care transitions and changes in therapy
- Implement clinical pearls in professional practice
- Motivate and inspire critical thinking in seniors' pain management

Fact or Fiction?

If the client or resident isn't reporting pain, this means pain is not a priority, and pain medication should be avoided…

Fact or Fiction?

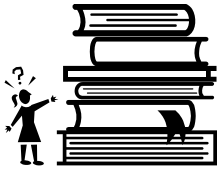
In the elderly, the benefits of narcotics do not outweigh the risk of side effects.

Fact or Fiction?

For the elderly, pain is to be expected.

Fact or Fiction?

Regularly scheduled, or long acting narcotics might be a good option in the elderly.



Meet Your Resident…

- 86 year old female, speaks no English
- Admitted to hospital from assisted living
- Pubic fracture

Question & Group Discussion

Is there a problem here?

Time Limits

- Group Discussion for 3 Minutes
- Prepare Summary
- Group Presenter

Clinical Pearl #1

- Investigation for relevant information
- Sources of information
  - Resident or client, family, caregivers, other staff members
  - Assessments
- Identification of Barriers
  - Language
  - Beliefs
  - Others…

The Story Continues…

- From the team - nursing and physiotherapy
  - Pain on turning, prefers left side, grimacing, refusal of pain meds
- From daughter/translator
  - Patient doesn't want to bother staff, wants to be a good patient, but daughter says that pain is quite severe

Questions & Group Discussion

What is possible for this patient?

Time Limits

- Group Discussion for 3 Minutes
- Prepare Summary
- Group Presenter

Clinical Pearl #2

- Goals of therapy and treatment plan
  - Control pain, improve function, stabilize mood and improve sleep
- Education
  - Support clients by discussing achievable goals

Consequences of Unrelieved Pain

- Delayed healing
- Altered immune function
- Increased stress and anxiety
- Physical and psychological decline

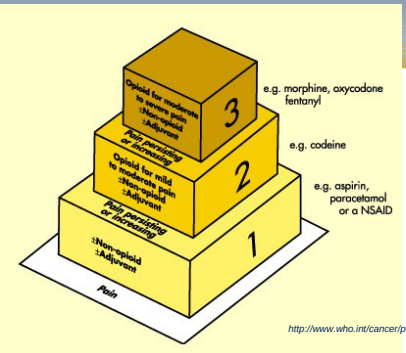
Principles of Pain Management with Medication

- Start low, go slow, but go
- Timing of analgesia
- Adequate trial
- Anticipate & prevent adverse outcomes
- Multiple drugs & interactions

Non-Pharmacological Interventions

- Cutaneous Stimulation
  - heat, cold, vibration, massage, TENS, acupressure
- Distraction
  - imagery, music/therapy, pet therapy, art therapy
- Relaxation
  - superficial massage, music, pet and art therapy, deep breathing, Reiki, Therapeutic and Healing Touch therapy
- Positioning for Comfort
  - Pillows, check the mattress (may need special mattress), check for proper support
- Companion

Principles of Pain Management



Regular Release Dosing

- Immediate-release preparations
  - E.g. Codeine, morphine, hydrocodone, hydromorphone (oral)
  - Morphine, hydromorphone, sufentanyl (injectable)
- Q 4 H - establish baseline analgesic needs
- Convert to LA (long acting)/SR (sustained release) formulation when stable

Long Acting/Sustained Release Dosing

- Extended Release Preparations
  - Morphine oral, Hydromorphone oral, Fentanyl patch
- Dosing Q8H, Q12H, Q24H, Q72H, etc. dependent on product
- Stay with same long acting and short acting drug, when possible

Adequate Trial

- Long acting oral products take 2-3 days to reach steady state
- Fentanyl takes up to 24 to 36 hours to reach steady state
- Allow adequate time, e.g. minimum 3 to 4 days, before switching dose and/or drug to prevent therapy failure and/or side effects

Breakthrough Dosing

- Need to assess breakthrough pain as well as baseline pain
- Timing of BTD is critical
  - oral/rectal = q 1 h
  - subcutaneous/intramuscular = q 30 min
  - IV = q 10-15 min
- Increase/Adjustment in regular or LA dosing may be warranted to prevent or reduce dosage of BTD
- Usually 1/2 of the q4h regular dosing
- 5-17% of total daily baseline analgesic dose

When to Increase Regularly Scheduled Dose?

- Frequency of Breakthrough Doses
  - IF < 3 BTD per day, then current regular or LA/SR dosing remains the same
  - IF > 3 BTD per day, then increase regular dose accordingly

Clinical Pearl #3

- Missing Link: Monitor & Reassess
- Documentation
- Communication during transitions of care
- Rock the boat – dose decrease?

Critical Thinking Challenge…

Based on today's session, what is first new strategy you will apply today to help seniors in your care who are struggling with managing pain?

How will you "change the face of pain"?

Write This Down!

Summary

- Investigate & seek the right information
- Goals of therapy through client-focused care
- Monitor, reassess & document
- Understanding principles of pain - myths and pain management

Thank you!

References: Assessments

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- www.geriatricpain.org – excellent articles, tools, assessments and resources specifically for nurses working with residents in care

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