Palliative Care and Pain Management in Older Adults

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Objectives-PALLIATIVE

• Explain important dimensions of assessing palliative care needs of older adults
• Describe important assessment parameters of palliative care needs
• Describe the nurse’s role in a multidisciplinary team approach to palliative and end-of-life care
Objectives-PAIN

• Identify the incidence, barriers, and consequences of pain in older adults
• Assess pain using validated self-report and/or behavioral pain instruments
• Identify problems and strategies in assessing pain in cognitively impaired older adults
• Identify principles of pain management in older adults
• Americans live longer, healthier lives, but most will spend their last years living with disabilities or chronic illnesses.
• The EOL must be understood as a period that typically spans years, not just weeks or months.
• Palliative care and conventional medical treatment should be thoroughly integrated rather than viewed as separate entities.
Integrating Palliative Care and Elder Care?
A NEW MODEL OF PALLIATIVE CARE FOR ELDERS

Dichotomous model

Curative/disease-modifying treatment

Hospice/Palliative Care

Diagnosis

Death

Continuum-of-care model

Curative/disease-modifying treatment

Pain relief and palliative care

Diagnosis

Death

Family Bereavement

World Health Organization, Cancer Pain & Palliative Care, 1990
Application of Palliative Care to Older Adults

- Chronically ill elderly have ambiguous medical prognoses. They may be sick enough to die from a small complication on any day or they may live for many years.

- Symptom management and support (palliative care) services are no longer restricted to a relatively short and easily recognizable end of life period.

- It is no longer appropriate to associate the beginning of palliative care with the cessation of conventional medical care. Rather, the proportion of palliative care services needed will gradually increase over time.
Where People Die*

- Hospital 48% (707)
- Nursing Home 20% (280)
- Home 17% (262)

*All deaths in 3 NH/VT counties surrounding DHMC
Palliative Care

- WHO definition:
  the active total care of patients whose disease is not responsive to curative treatment.

- Goals:
  to prevent and relieve suffering and to support the best possible quality of life for patients and their families, regardless of the stage of the disease or the need for other therapies.
Goal of Palliative Care

• Identify person’s values and preferences for care
• Enhance maximum comfort and function
• Encourage open and active communication among patient, family and health care team
• Coordinate holistic intervention by multidisciplinary team
• Enhance growth through activities of life closure/legacy
Goal of Palliative Care

• Identify person’s values and preferences for care – ADVANCE DIRECTIVES/DNR
• Enhance maximum comfort and function - EXPERT PAIN ASSESSMENT & MGMT
• Encourage open and active communication among patient, family and health care team - FAMILY MEETINGS
• Coordinate holistic intervention by multidisciplinary team - DISCHARGE PLANNING
• Enhance growth through activities of life closure/legacy - RESPECT & REFERRAL
Assessment Parameters

- Physical, psychosocial, and spiritual problems
- Functional status / environmental status
- Accomplishment of developmental tasks of life
- Family dynamics / relationship issues / opportunities
- Grief / loss / bereavement issues
Nurse’s role

• Think about every elder patient through a Palliative Care lens!
• Recruit health care team members
• Coordinate interdisciplinary team to manage pain and chronic coexisting problems
• Identify patient appropriateness for Palliative and Hospice services
• Encourage family to participate in goals, processes and evaluation of care
Pain defined…….

- “An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage” (American Pain Society)

- “Whatever the experiencing person says it is, existing whenever he says it does” (McCaffery).

- Nsg Dx: Alteration in Comfort

- Classifications:
  - Acute v. persistent (chronic) pain
  - Nociceptive v. neuropathic pain
Incidence

- Presence of persistent pain increases with age
  - 3fold increase between age 18 – 80
  - 50% of community dwelling older adults
  - 70% - 80% of nursing home residents
Etiology

- Chronic and degenerative conditions
  - Bone/joint/musculoskeletal disorders
    - Osteoarthritis
    - Osteoporosis
    - Fractures
    - Back problems
  - Ischemia/vascular conditions
    - Phantom limb pain
  - Neuropathy-Diabetic, Post-herpetic

- Pain is undertreated
Pain Myths in Older Adults

- Older patients experience less pain
- Older patients cannot tolerate opioids
- Standardized assessment instruments cannot be used in older adults.
- Cognitively impaired older adult cannot be assessed for pain.
- Agitation and confusion are always signs of delirium and/or dementia.
PHYSIOLOGICAL CONSEQUENCES OF UNRELIEVED PAIN

- Increased cholesterol and fatty acids in blood for energy production systems
- Increased blood pressure
- Localized inflammation (redness, swelling, heat, and pain)
- Increased production of blood sugar for energy
- Decreased protein synthesis; intestinal movement (digestion); immune and allergic response systems
- Increased metabolism; e.g., faster heartbeat, faster respiration
- Faster blood clotting
- Increased stomach acids
Psychological Consequences of Unrelieved Pain

- Fear
- Anxiety
- Helplessness
- Hopelessness
- Distress
- Depression
- Suffering
- Decreased will to live (euthanasia, suicide)
Assessment Principles

• Assess every older adult for evidence of acute or chronic/persistent pain

• Most accurate: Self-report

• Be diligent! Reluctance to report pain
  – fear of tests
  – medication side effects
  – metaphor for death
  – atonement for past actions
Why Elderly Don’t Report Pain

- I don’t want to bother the nurses
- I don’t like to give in to the pain
- After a while, you get tired of asking
- I don’t want to be a complainer
- It takes too long to get the medications
- I take my own supply of Bufferin
- I didn’t know I had anything ordered

Ferrell BA, Ferrell BR, Rivera L.
Assessment Parameters

• Intensity, quality, onset, duration, expression, aggravating factors, relief factors

• Many instruments assess ONLY INTENSITY-(not bad, but only a starting point for screening purposes)
Assessment Instruments

Visual Analog Scale

Verbal Descriptor Scale
Assessment Instruments

• Numerical Scale

0-10 Numeric Pain Distress Scale

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No pain</td>
<td>Distressing pain</td>
<td>Unbearable pain</td>
<td></td>
<td></td>
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NO PAIN | WORST POSSIBLE PAIN
Pain Thermometer

Pain as bad as it could be
Extreme pain
Severe pain
Moderate pain
Mild pain
Slight pain
No pain
Assessment Instruments

Wong-Baker FACES Scale

![Wong-Baker FACES Scale]


FACES Pain Scale - Revised

![FACES Pain Scale - Revised]
Assessment of Cognitively Impaired Older Adult

- Non-verbal pain behavior
  - Recent changes in function and vocalization
  - Moaning, crying, withdrawal or agitation
- Use objective pain assessment instruments:
  - Accommodate for sensory losses, fatigue, slower processing, timing
  - Present pain vs. recalled pain; evaluate analgesic use
- Caregiver Reports
Assessing Pain in Persons with Dementia

Ann L. Hoelscher, RN, PhD

Data: ________________________  Patient # ________________________
Hospital Day: ________________________

Checklist of Nonverbal Pain Indicators

<table>
<thead>
<tr>
<th>Verbal complaints: Nonverbal</th>
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<tbody>
<tr>
<td>(Expression of pain, not in words, moans, groans, grunts, sighs, groans, etc.)</td>
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</table>

1. Vocal complaints: Nonverbal
   (Expression of pain, not in words, moans, groans, grunts, sighs, groans, etc.)

2. Fetal-Gimnastic-Winces
   (Hunched back, bowed legs, tightened jaws, jaw drop, clenched fists, clenched expressions)

3. Bracing (Clutching or holding onto side rail, bed, tray table, or affected area during movement)

4. Posture (Constant or intermittent shift of position, rocking, intermittent or constant hand motion, inability to keep still)

5. Rubbing (Massaging affected area)
   (In addition, record Verbal complaints)

6. Vocal complaints: Verbal (Words expressing discomfort or pain, “ouch”, “that hurts”; cursing during movement, or statements of protest e.g., “stop that, that hurts”)

Subtotal Score

Total Score


# Pain Assessment IN Advanced Dementia (PAINAD)

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<th>0</th>
<th>1</th>
<th>2</th>
<th>Score</th>
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<tbody>
<tr>
<td><strong>Breathing</strong></td>
<td>Normal</td>
<td>Occasional labored breathing.</td>
<td>Noisy labored breathing.</td>
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<tr>
<td><strong>Independent of</strong></td>
<td></td>
<td>Short period of hyperventilation</td>
<td>Long period of hyperventilation.</td>
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<tr>
<td><strong>vocalization</strong></td>
<td></td>
<td></td>
<td>Cheyne-stokes respirations</td>
<td></td>
</tr>
<tr>
<td><strong>Negative Vocalization</strong></td>
<td>None</td>
<td>Occasional moan or groan.</td>
<td>Repeated troubled calling out.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low level speech with a negative or</td>
<td>Loud moaning or groaning.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>disapproving quality</td>
<td>Crying</td>
<td></td>
</tr>
<tr>
<td><strong>Facial expression</strong></td>
<td>Smiling, or inexpressive</td>
<td>Sad. Frightened.</td>
<td>Facial grimacing</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Frown</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Pulling or pushing away.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Striking out</td>
<td></td>
</tr>
<tr>
<td><strong>Consolability</strong></td>
<td>No need to console</td>
<td>Distracted or reassured by voice or</td>
<td>Unable to console, distract or</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>touch</td>
<td>reassure</td>
<td></td>
</tr>
</tbody>
</table>

TOTAL

Warden, Hurley, Volicer 2001
Pain Management Principles

• 1. Physiologic changes influence pharmaco-dynamics and pharmacokinetics of analgesics
• 2. Treat underlying conditions
• 3. Treat until patient is comfortable and can function!!
  – Relative to their baseline and unique perspective
Pain Management Principles

- 4. Keep a Pain Log or Diary
- 5. Reassess regularly for improvement, deterioration, or complications
- 6. Know and recognize physiological, psychological, and emotional responses to pain
- 7. Oral medications are best for long-term management
Pain Management Principles

8. Anticipate and treat the side effects

9. Use non-pharmacological approaches

10. Listen to the patient and include the family in the plan.
Pharmacologic Treatment

Least invasive route – careful titration, frequent assessment, adjustments, monitoring and managing side effects

WHO Ladder: non-opioids, co-analgesics (anticonvulsants, antidepressants), low-potency opioids, high-potency opioids
Pharmacologic Treatment

- **ACUTE, SHORT TERM**: fast-onset, short-acting analgesic
- **ACUTE or Persistent**
  - **MILD-TO-MODERATE** pain: acetaminophen, NSAIDs, tramadol
  - **SEVERE**: opioid analgesics
  - **Co-analgesics** when indicated
Analgesic Side Effects & Toxicities

- NSAIDs – contraindicated with abnormal renal function, peptic ulcer, bleeding
- Acetaminophen-liver toxicity
- Opioids-constipation, sedation, confusion
Pharmacologic Treatment

Precautionary measures:

• Encourage extra fluid

• Exercise

• Combination stool softener and non-bulk-forming laxative

• Patient safety concerns
Non-pharmacologic Strategies

• Physical methods: heat, cold, massage, chiropractic, physical therapy, exercise
• Psychoeducational program: problem solving, supportive
• Cognitive Behavioral program
  – Imagery, relaxation, biofeedback, hypnosis
• Acupuncture
• Spiritual healing/Prayer
Summary

• Assess: Teach nursing assistants to use scales to screen for pain
• Determine tolerable level of pain, activity, sedation
• Integrate pharmacologic and non-pharmacologic strategies
• Reevaluate often-especially after interventions
Summary

• Incidence, barriers, consequence of pain in older adults
• Pain assessment – instruments and scales
• Pain assessment in patients with cognitive impairment
• Pharmacologic and non-pharmacologic principles of pain management.
Physical
Functional Ability
Strength/Fatigue
Sleep & Rest
Nausea
Appetite
Constipation
Pain

Psychological
Anxiety
Depression
Enjoyment/Leisure
Pain Distress
Happiness
Fear
Cognition/Attention

Social
Financial Burden
Caregiver Burden
Roles and Relationships
Affection/Sexual Function
Appearance

Spiritual
Hope
Suffering
Meaning of Pain
Religiosity
Transcendence

Total Pain

Adapted from Ferrell, et al. 1991
Summary

• Assessing quality of life and palliative care needs is vital in older adults

• Nurses are important members of interdisciplinary teams and contribute to meeting palliative care needs of older adults
“When medicine can no longer promise an extension of life, people should not fear that their dying will be marked by neglect, care inconsistent with their wishes, or preventable pain and other distress. They should be able to expect the health care system to assure reliable, effective, and humane care-giving. If we can fulfill that expectation, then public trust will be strengthened.”

C. Cassel, MD in Preface IOM report, vii
Acknowledgements

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