Management of pain in residents requiring a palliative approach

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The prevalence of pain in residents living in residential aged care facilities (RACFs) is reported to be as high as 83-93%.[1] Many residents have advanced life-limiting illnesses that contribute to the experience of pain including rheumatic diseases, vascular diseases, cancer and atherosclerotic and diabetic peripheral neuropathies. Unrelieved pain is associated with poor quality of life leading to a decrease in physical function, social isolation, sleep disturbance, and depression as well as an increase in family distress.[1]

Pain assessment

There are a number of challenges for nurses when conducting pain assessments in residents with advanced life-limiting illnesses.
These include:

- Under-reporting of pain by residents. This may be due to declining cognition, impaired sensory function, denial, avoidance behaviours, and concerns about being a burden.[2]
- Multiple concurrent medical problems and multiple sources of pain.[2]
- Lack of knowledge and skill among nursing staff on the use of verbal and non-verbal pain assessment tools have been identified as a barrier to effective pain management.[3]

The Palliative Approach (PA) Toolkit contains a section on evidence-based pain assessment tools (*PA Toolkit, Module 3: Clinical Care*).

Access PA Toolkit resources at:
www.caresearch.com.au/PAToolkit

Strategies to manage pain in residents with advanced life-limiting illness

The goal of pain management for residents requiring a palliative approach is to optimise comfort and function in the face of inevitable deterioration. This can be achieved more effectively when both pharmacological and non-pharmacological approaches are incorporated into treatment plans.

Pharmacological strategies

Pain-relieving medicines used by older people include paracetamol, nonsteroidal anti-inflammatories, opioids, and adjuvants that commonly include antidepressants and anticonvulsants.[4] Specialists agree that, when used appropriately, analgesic medicines are safe and effective in the management of pain in older people.[5] Recent Australian research found that pharmacological management of pain in RACFs is improving.[6] However, studies have found that nurses who administer analgesics require further education to ensure analgesic use is optimal and adverse side effects are prevented.[5]

Nurses who administer analgesic medication to residents with life-limiting illnesses require advanced knowledge of the pharmacology of pain-relieving medications. This information is available in *Therapeutic Guidelines: Palliative Care (2010; Version 3).* A copy of the Guidelines is included in the PA Toolkit. Pharmacists who provide a service to RACFs may be willing to provide education and information on analgesic therapy in older people.

Non-pharmacological strategies

Evidence-based non-pharmacological approaches can be included in pain management plans. These include:

- Expert manual handling involving safe and comfortable repositioning and transfers in and out of bed.
- Mobility equipment and pressure relieving devices.
- Counselling to address emotional and psychological contributors to pain.
- Complementary therapies including aromatherapy, massage, and music therapy.[4]

Pain management in last days of life

All residents who are approaching the last days of life have the potential to develop pain. This can be caused by disease-related factors or as a result of increasing weakness and debility causing joint stiffness, pressure areas, and contractures. Pre-emptive prescribing of opioids to be administered via the subcutaneous route will ensure there is no delay in responding to pain if it occurs. The dose prescribed is dependent on the resident's previous exposure to opioids and the dose required to relieve pain. Opioid-naïve residents should be commenced on the lowest opioid dose possible and titrated to effect. Continuous monitoring is required to assess for efficacy, side effects, and toxicity.[7]

Residents who are receiving regular oral opioids to manage existing pain and who are experiencing symptoms impacting on their ability to swallow, gain benefit from conversion to a continuous subcutaneous infusion of opioids using a syringe driver. It is important for nurses to be aware of opioid conversion formulas and safe opioid titration practices. Further information is available in the *Therapeutic Guidelines: Palliative Care (2010; Version 3)* and the PA Toolkit: *Guidelines to the Pharmacological Management of End of Life (Terminal) Symptoms in Residential Aged Care Residents*. Transdermal opioid patches are not suitable to commence when a resident is in the last days of life as patches have a prolonged onset time and therefore rapid safe titration to manage escalating symptoms is not possible.[8]

Case study

Jean is an 89-year-old lady with multiple co-morbidities including advanced osteoarthritis, osteoporosis, and chronic renal failure (eGFR 27). Jean required opioid medication to manage severe back pain and had been on oxycontin 40 mg bd for some months. Nursing staff carried out regular pain assessments and evaluated treatment efficacy. Jean's condition, including her ability to swallow, deteriorated significantly. Her family requested that the focus of care be on maintaining her comfort in the RACF. The GP reviewed Jean's medication and converted oxycontin 40 mg bd to its parenteral fentanyl equivalent to be administered subcutaneously by syringe driver over 24 hours. She considered fentanyl the preferred opioid for Jean as it is better tolerated in renal failure (see PA Toolkit: *Guidelines to the Pharmacological Management of End of Life (Terminal) Symptoms in Residential Aged Care Residents*). Subcutaneous fentanyl PRN was ordered for breakthrough pain. Nursing staff continued to assess pain and evaluate treatment efficacy. They notified the GP if three or more opioid doses per 24 hours were needed to manage breakthrough pain as this is an indication that the opioid dose in the syringe driver may need upward titration. Mindful repositioning and gentle massage were also incorporated into the pain management plan.

Conclusion

Early recognition, comprehensive assessment and the use of both pharmacological and non-pharmacological approaches are required to ensure effective management of pain experienced by residents with advanced life-limiting illness.

References

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Further reading

Edith Cowan University (2007). The PMG Kit for Aged Care. Funded by the Australian Government Department of Health and Ageing.

Kris McAnelly: Nurse Practitioner - Brisbane South Palliative Care Collaborative
Tel: 07 3710 2223 **Email:** patoolkit@health.gov.au

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