

# Pain management in palliative nursing essay



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Pain management has been chosen as the aspect of care. It is the symptom that the writer has been confronted with very often in her daily work with palliative patients; this has been very distressing for carers, patients and family. Various assessments were explored to measure pain and whether they would be more effective than the assessment tool used to assess Mrs Patel. The aim is to give a rationale for the management strategies that are in use to control pain, in order to be able to deliver more effective care, support and information to patients and families in end-of-life care.

NICE (2004) advocates the use of the Liverpool Pathway for dying patients to ensure that all patients are afforded optimal palliative care. Pearce and Duffy (2005) and Fisher (2006) explain that diagnosing end-of-life care is potentially more difficult in patients with diseases other than cancer.

. All patients approaching the end of life need to have their needs assessed, their wishes and preferences discussed and an agreed set of action reflecting the choices they make about their care recorded in their care plan. The care plan should be subject to review as and when the patient's condition or wishes change (DOH 2009).

The Initial Pain Assessment Tool (Appendix 1) used in the community setting will be used to assess Mrs Patel. This tool will give a base line and a thorough knowledge of her condition and how to help control her pain. After the first assessment Mrs Patel was found to be competent and able to communicate, in this case she became the most reliable assessor of pain and where possible the prime judge of her pain (GAIN, 2011).

NICE (2004) and the Department of Health (2009) end-of-life strategy advocates the use of necessary tools and an integrated approach to assessment and care between disciplines in order to support patients and their families.

The writer reviewed the literature for pain assessment tools and found there were many scales and methods of assessing pain. The use of the Initial Pain Assessment Tool has already revealed the clinical history of Mrs Patel. Regular review to determine the effectiveness of treatment is very important.

The frequency of review depends upon the severity of the pain associated with distress. In patients where it is difficult to assess the response to interventions, a

pain assessment chart may be helpful. Many different pain assessment tools are available, with no universally accepted tool.

Other tools may include the 11-point Numerical Rating Scale, a simple and commonly used tool. McGill Pain Questionnaire (MPQ) Melzack (1987), is a valid and comprehensive, multi-dimensional pain assessment tool, providing a list of descriptive words to help the individual to express their pain. A body chart is a quick visual aid for both patient and professional and Faces Pain Scale, this uses faces to score pain, Brief Pain Inventory (BPI) (Appendix 2) (McCaffery and Pasero 1999), the Hospital Anxiety and Depression (HAD) Scale (Zigmond&Snaith 1983).

The BPI has been used extensively in research, with questions focussing on pain during the past 24 hours. The HAD scale is often used with a pain assessment scale, as depression commonly co-exists with pain. The HAD tool consists of 14 questions, seven anxieties related and seven depressions related. A score of eight or more is significant and 11 or more is highly significant of a depressive complaint.

The MPQ measures pain on a multi-dimensional scale, which includes sensory, affective and cognitive aspects. Although the use of MPQ scale may appear time consuming to complete, it is essential to determine appropriate treatment regimens.

It is also important to determine the patient's understanding and explanations for their pain, and to explore the individual's expectations of proposed treatment. This is

vital if healthcare professionals are to collaborate with patients with pain, over what is likely to be a long period (Mackintosh 2005, Allock et al 2007).

People with cancer like Mrs Patel should be assessed using a formalised pain assessment tool which reflects the multidimensional nature of pain, an example being the Brief Pain Inventory (Cleeland, 2004). This will provide the opportunity to identify and record each individual site of pain experienced by the patient and its impact. The assessment should include the effectiveness of any pain management strategies employed (SIGN, 2000).

Fear, anxiety, depression and a lack of sleep have been reported as increasing pain and suffering in people with cancer (Anderson, 2003),

Portenoy, 1994). A comprehensive pain assessment should include the personal and social influences that determine how pain is experienced and perceived (Miaskowski, 2005

The key component of comprehensive palliative care is symptom control (Robert et al 2001). The prevalence of people receiving palliative care has been extensively studied, although the emphasis of such study has been on people with cancer. However, people with end-stage diseases other than cancer experience similar symptoms – in particular fatigue, nausea and anorexia are common symptoms that occur in 70 – 90% of people with advance cancer (NCHSPCS 1998). Other common

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symptoms include weight loss, nausea, constipation, confusion, and breathlessness (Oxberry, 2009). Psychological symptoms, such as anxiety and depression, are increasingly understood to be common experience for people who are dying.

The experience of the symptom breathlessness is profoundly distressing for patients, their families and health-care professionals (Roberts et al 2001). Although people receiving palliative care commonly experience breathlessness, the problem has been under-acknowledged and remains difficult to manage (Higginson & McCarthy 1989). An integrated approach to managing breathlessness uses a range of strategies to help patients and families to manage breathlessness. These strategies have been divided into cognitive, behavioural, and psychotherapeutic (Bredin 2001).

Williams (2006) argues that there is no objective test to measure the subjective sensation of breathlessness: assessment of this symptom is based on the patient's self report, and recommends that a full assessment must be multidimensional. Not only does it include the patient's description of symptom but also searches for the underlying cause and the role anxiety and depression plays in the expression of breathlessness.

Psychosocial and spiritual dimensions also play important role in pain at the end of life. Psychosocial assessment includes the effect that pain has on mood, sleep, coping, goals and finances (Elliot 1997). Spiritual assessment includes the effect of suffering on the person's understanding of meaning and purpose in life. Nurses can

give people 'permission' to verbalise their personal feelings about pain and suffering (Spross & Wolff 1995).

The process of assessment should be seen as on-going. Information from an initial assessment should be built upon and revised as knowledge of the person and their symptom experience develops (Roberts & Bird 2001).

Patients dying of lung cancer have significant limitations affecting their physical, social and emotional functioning.

Quality of assessment depends on the skills of the individual healthcare professional, and their ability to establish a relationship with the patient, carer and their family (Maher & Hemming, 2005). This is needed to develop a rapport and build trust to facilitate a meaningful holistic assessment, rather than superficial information gathering. Such skills are difficult to prescribe or standardised.

Cox (2001) explains it is essential to expand assessment skills to provide a comprehensive and holistic assessment of the patient, in order to enhance the care that patient receives. If necessary as a further aid to ensure a thorough assessment, other standardised and validated assessment tools may be used.

Lugton et al (2005) also stated that effective symptom control is impossible without effective communication in order to understand how the family copes with a person's illness. District Nurses (DN's) must establish relationships between both patient and carer. Understanding, empathy and the ability to be supportive, whilst caring for the patient and their family are essential in forming a therapeutic relationship. According

to NMC Code of Conduct (2008) informed consent should be ascertained before performing any form of treatment and the patient's right to accept or refuse treatment should be respected.

This also echoed in the NHS 2000 plan on consent where it states that a patient with capacity has a right to refuse treatment (DOH 2009). As Mrs Patel has the capacity and is competent and has all the necessary information on the side effects of the medication and the benefits, then the ethical principle of autonomy applies because a decision to make a choice with regards to one's own healthcare should be supported and respected (SIGN 2008).

Reid and McCormack (2005) explains that symptoms management is a fundamental aspect of palliative care and Twycross and Wilcock (2002) recommend a systemic approach to symptom management. Reid and  
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McCormark (2005) states that it is essential to discuss with the patient not only their symptoms but also their wishes regarding treatment and management of this final phase of their life. Patients with cancer may have a number of fears about their pain and might be reluctant to report pain. Pain control can be enhanced if management strategies include interventions on relieving anxiety and depression (Loftus, 2007). It is also important for health professionals to alleviate any fears and anxieties the patient and carers may have and to explain the drugs and treatments available to relieve any suffering.

Treatment regimens are diverse. It is common for patients with pain to have tried a number of management approaches with limited success. Pain is not easy to treat, is highly variable, the exact mechanisms of transmission are unclear, and diagnosis is frequently tentative. what works for one individual may have no effect on another (Robb KA et al 2008).. Many treatment plans are based on the health care professional's previous experience, but have limited evidence based. Patients should be fully informed of the variable nature of some treatments, where even the most successful may only result in diminished pain, with complete pain relief being a rare outcome (Carr & Mann 2000, Chronic Pain Policy Coalition 2007).

Pain control is one of the challenging tasks that family physicians face when providing care for patients at the end of life. Despite recent advances in the understanding of pain management, pain is often untreated or undertreated (Ingham JM & Foley KM, 1998). Consequently a significant number of patients needlessly suffer physical pain and mental distress at the end of life (Horgas AL & Tsai PF, 1998). The challenge to physicians is to provide aggressive



pain management and implement strategies to alleviate suffering in patients with pain that is difficult to control.

Three principles should be followed in providing pain control at the end of life (McCaffery M & Pasero CL, 1999). First, pain can be controlled in most patients by following the World Health Organisation's step-care approach. Second, acute or escalating pain is a medical emergency that requires prompt attention. A delay in responding to this pain makes it more difficult to control. Third, addiction is not an issue in patients with terminal illness. When pain is treated appropriately, addiction problems are rare (Freidman DP, 1990).

The World Health Organisation's (WHO, 1990) devised structure is assisting nurses and other health-care professionals in the management of cancer pain. The recommendations include managing pain by the ladder, by the clock and by the mouth. By ladder refers to the WHO analgesic 'ladder' a stepwise approach to effective pain management..

Because pain at the end of life is often constant, it is best to choose an opioid that is controlled-release or long-acting. It is important to consider the efficacy of the agent, its half-life, the delivery and dosing options and potential side effects. In addition the patient's age, comorbidity factors, and previous opioid use should be considered. It should also be noted that some opioids should not be used chronically because of their metabolites and ceiling doses (APS 1999). These include pethidine, buprenorphine and pentazocine.

Suitable weak opioids for mild to moderate pain include codeine and dihydrocodeine. For moderate to severe pain, morphine is the opioid of choice. Alternative opioids include hydromorphone, oxycodone, methadone and transdermal fentanyl (Hanks et al 2001). It is important to continue the opioid analgesics throughout the dying process, even when the patient is sedated or unresponsive. Restlessness and

agitation can indicate increased pain, and doses might have to be increased to maintain adequate analgesia. If the patient can no longer take the prescribed opioid orally, an alternative route should be selected. If the opioid is stopped abruptly, the patient may experience withdrawal (Elliot 1997).

The most common side effects of opioids include constipation, nausea and vomiting, sedation, confusion and pruritus. Myoclonus (muscle spasm) can occur if opioids are used in high doses. Studies by Miaskowski (1995), Robinson et al (2000) have identified constipation as the most troublesome side effect of pain management and it is especially associated with opioid medication. Studies by Miaskowski (1995), Robinson et al (2000) have identified constipation as the most troublesome side effect of pain management and it is especially associated with opioid medication. Prophylactic bowel management can assist in managing this common problem (Portenoy, 2006).

Other interventions in pain management include adjuvant analgesics, which are agents that have independent analgesic efficacy, or work synergistically with other agents to enhance comfort, or relieve symptoms associated with pain such as anxiety. The adjuvants are used with each step of the WHO

analgesic ladder, and are often prescribed for specific somatic, visceral, and neuropathic pain symptoms (NICE 2010).

Mrs Patel was given regular paracetamol and morphine when needed. This was a continuous medication from the hospital. Anticipatory drugs were prescribed in case of deterioration and syringe driver was available at home.

Mrs Patel also started having panic attacks from her breathlessness which is common in patients with lung cancer. She was prescribed Lorazolan, as it is a short and quick acting drug and as a result helped her to regain control of her breathing.

Oxberry (2009) explains that breathlessness is often caused by anxieties and panic attacks. As in the case of Mrs Patel she was supported and encouraged to learn to develop ways of coping and living with the problem, while adjusting to the inevitable loss and change such a symptom brings (O'Connor et al 2003).

The concept of spiritual pain requires practitioners to go beyond clinical treatments and be prepared to devote time to provide supportive and understanding care (Mako, 2006). Spiritual care is not necessarily religious. However, religious care, at its best, should always be spiritual (NHS HDL, 2002). Spiritual care is given in a one-to-one relationship, is completely person-centred and makes no assumptions about personal conviction or life orientation (NHS HDL: 2002).

There are no easy solutions to ethical problems faced by health-care professionals in palliative care. Ethical might mean conforming to recognised

standards of practice. (Otis-Green et al, 2002), (Neerkin& Riley, 2006) claims deciding what is right and wrong is not quite as simple in palliative care.. In difficult situations the parallels of

right and wrong can be difficult to tease apart and we often make decisions within a complex tangle of emotions, options and outcomes. Decision making in terms of treatment and interventions can involve deciding what ought to be provided, what is optional and what not ought to be provided (Becker, 2009). Even though the multidisciplinary team involved in Mrs Patel's care were part of any decision making it was still difficult at times to arrive at one conclusion

The assessment tools used on Mrs Patel were useful in regards to her condition. The Brief Pain Inventory enabled Mrs Patel to be in control of her symptoms. She was able to determine using the assessment tool and how effective the treatment was. The initial assessment tool was useful in giving baseline information on Mrs Patel's condition and enabled the writer to review regularly inorder to manage her care. Mrs Patel was informed about all the Multidisciplinary Team (MDT) involved in her care as well as her family. She was able to get in touch with any of the MDT members in case of any concerns.. The care of Mrs Patel was satisfactory as she was seen not in distress. The writer found these tools useful as it enabled her to assess Mrs Patel effectively and knew how and when to treat her. From the assessment tools the nurse was able to know when to reassess and treat.

The writer will recommend that in future the Brief Pain Inventory be adopted in assessing palliative patients with pain as it is very useful, easy to

understand. And less time consuming . And further gives a clear picture of patients symptoms. It will also be helpful in future if all staff members are given the opportunity to attend study

Day's on principles of palliative care. Because the writer finds this module very useful and beneficial to patients, family and the health care professionals. Pain is one of the most feared symptoms that patients and families face at the end of life. Nurses have a primary responsibility to assess for pain diligently and to manage uncontrolled pain aggressively. By using opioid analgesics, adjuvants, and alternative methods of relief, comfort can be achieved in the majority of people. These people are then better able to focus on the psychological and spiritual issues that give meaning to their last days, thereby optimising their quality of life.

#### PAIN MANAGEMENT IN PALLIATIVE RESIDENT

The case study will be focusing on a palliative resident experiencing severe pain in his last days of life in a Nursing Home.

To maintain confidentiality in accordance to Nursing and Midwifery Council code of Conduct (2008), the patient's name will be Mr. B

Mr. B is an 80 years old gentlemen diagnosed with lung cancer two months ago after being hospitalised for three weeks due to a severe chest infection/ aspiration pneumonia.

He has two sons, five grandchildren, two daughters in law and a lovely wife, all being very supportive and actively involved in his care.

Mr. B was discharged from hospital with a poor prognosis ( he was given less than two months to live ). That's why he refused surgery, chemotherapy and radiation therefore according with NMC Code of Conduct (2008 ) consent needs to be given before performing any type of treatment or intervention.

In NHS 2000 plan it is stated also that a patient with capacity has a right to refuse treatment ( DOH 2009 ). As Mr. B has fully capacity being able to make decisions and choices regarding his own healthcare should be supported and respected ( SIGN 2008 ).

He was dependent on Oxygen therapy due to his continuously breathlessness. His family is unable to cope with his care at home therefore a decision was made that he would be better looked after in a Nursing Home with the support from an Multi Disciplinary Team ( MDT ) and closely monitored by the qualified and experienced staff to manage his needs.

On admission to Nursing Home , Mr. B was fully aware of his diagnosis and poor prognosis also. He was fully symptomatic of his known recently diagnosis. He was breathlessness, in need of continuous oxygen, coughing up fresh blood, persistent tiredness, lack of energy and appetite ( severe weigh loss ), dry and sore mouth and persistent severe chest and shoulder pain.

The holistic approach to his disease is not really useful at present: lung cancer grade 3- spread to surroundings structures. All natural alternative medicine principles such as detoxification, support of the immune system and physiological balance are accomplished.

The aspect of care chosen is pain management.

Pain being the symptom I am confronting daily in my work looking after palliative residents.

Pain is very common with lung cancer and can be very distressing for carers, residents and family.

Thus, The International Association for the study of pain (IASP) defines pain " an unpleasant sensory and emotional experience associated with actual or potential tissue, damage, or described in terms of such damage" ( Merskey and Bogduk 1994: 210).

In other accepted definitions, pain is described as being " whatever the experiencing person says it is, existing whenever he says it does" (Mc Chaffey 1968, cited by Freak and Gates 2001: 95) or as " what the patient says hurts" (Twycross and Wilcock 2002: 17).

Mr B was discharged to Nursing Home to be offered the comfort, reassurance and pain relief and all the support to him and his family needs throughout this stage of his condition.

Both, Mr B and family are fully aware of his poor prognosis and tend to accept the situation.

That's why approaching the end of life he needs continuously monitoring and his needs assessed, his wishes and preferences discussed to enable us to draw a person centred care plan reflecting his choices and decisions.

An MDT was involved (GP, Palliative Community Specialists, named nurse, key worker, social support/worker) , together with Mr B and his family and an advanced care plan was discussed and agreed.

His wishes are to be kept comfortable in Nursing Home, pain free as much as possible , active treatment for chest infection only with oral intake as long as tolerated.

His wishes were very clearly expressed that as long as the pain is well controlled he is happy and comfortable, ready to live the life to take its natural course-DNAR in the event of cardiac arrest and also that he does not wish to be readmitted to hospital for any reason.

The care plan should be subject to review as and when his condition or wishes change (DOH 2009). Even Mr B accepting his condition , his anxiety and fear become more acute, general condition deteriorating gradually. He was calling very often with the fear of his pain becoming unmanageable.

Fear , anxiety depression and lack of sleep have been reported as increasing pain and suffering in people with cancer (Anderson, 2003),(Portenoy, 1994). A comprehensive pain assessment should include the personal and social influences that determine how pain is experienced and received (Miaskowski , 2005).

It is proved that pain can negatively affect your quality of life making you feel down and irritable but there are many options available for treating pain.

In 1986, WHO published guidelines for managing cancer pain. Using this approach, as well as .....techniques the most majority of people can

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experience good pain control throughout their lung cancer treatment. Our aim is to control his pain following his care plan.

At present, he is able to verbalise his pain: location and intensity also the effectiveness of painkillers.

Effective pain management requires careful assessment and regular review of pain . Pain is a subjective symptom. We are using different tools to assess Mr B's pain.

The aim is to give a rationale for the management strategies that are in use to control pain, in order to be able to deliver more effective care, support and information to residents and families in end of life care.

Pain assessment tools are therefore based on the patient's own perception of their pain and its severity. Pain assessment involves initial, detailed evaluation of each type of pain, an regular reassessment of

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