Pain Control in the Geriatric Trauma Patient

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Pain in the Geriatric Trauma Population

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Transitional Trauma Unit
Geriatric Trauma Data:
LVHN
(excludes burns)
Delirium

▪ Associated with many negative outcomes including but not limited to:
  • increased hospital expenditures,
  • longer hospital stays,
  • increased use of physical and chemical restraints,
  • decreased functional ability which can lead to a higher level of care on discharge

▪ In a study completed by Karp et al. suggested that chronic and acute unmanaged pain can precipitate delirium

▪ Rao and Cherukuri in their study stressed that narcotics may not increase the risk for delirium rather that inappropriate post operative pain management puts patients at a high risk for delirium
The purpose of this project was to explore a better way to control pain in the Geriatric Trauma population in order to better prevent delirium related to inadequately or non-controlled pain, as well as to improve delirium prevention.
Pain in the older adult population is not being adequately controlled

The risk of delirium is high in older adult patients and especially in surgical patients

Delirium is poorly recognized and may be the only symptom of a life threatening complications such as infection, metabolic abnormalities, or medication reactions. Delirium needs to be treated as a medical emergency.

There is a misconception that older adult patients have a higher pain threshold than younger patients.
Most postoperative pain is relieved only with opioid analgesics, and the American Geriatric Society recommends opioids for moderate to severe pain.

Avoid benzodiazepines, anticholinergics, and other inappropriate medication contraindicated for the elderly as noted in the Beers Criteria.

Encourage non-pharmacological interventions, such as physical therapy, relaxation exercises, ice, heat, repositioning, music, and distraction.

Scheduled administration of medication leads to better perceived pain control by the patient.

Lack of pain control can lead to delirium, decreased mobility, and inhibit deep breathing. These can cause changes in level of consciousness, pneumonia, pressure ulcers, and functional decline.
PICO Question

- **PICO Question** – In the geriatric trauma population, how does ordered (around the clock/scheduled analgesic) compared with as needed (PRN) analgesic affect pain score, length of stay and discharge?

- **P**: Geriatric Trauma patients

- **I**: Around the clock/scheduled analgesic

- **C**: As needed/PRN analgesic

- **O**: Pain score <4 or within patient goal, decreased length of stay, and discharge to prehospital level of care
Barriers and Strategies

- **Barrier:** The barriers to potential adequate geriatric pain control are the misconception that narcotics cause delirium, fear of addiction to pain medications, fear of side effects, chronic pain, and non-reporting of pain.

- **Strategy to Overcome:** Better education to nurses to explain how to adequately treat pain in the Geriatric Trauma population.
Expected Outcomes

- Better perceived pain control by patients
- More use of scheduled pain control, i.e. (Acetaminophen, low dose narcotics)
- Increase in patient mobility and independence
- Decrease in use of PRN pain medication
- Decreased length of stay
1. Process Indicators and Outcomes: Pain score <4 or within patient goal, and discharge to prehospital level of care

2. Baseline Data: None
3. Design (EBP) Guideline(s)/Process: Chart reviews of geriatric trauma patient’s who were inpatient in a 4 month period. Average pain score, whether or not the patient had scheduled analgesic and prehospital to discharge levels of care. Information was obtained through trauma history and physicals, consults and nursing flowsheets.

4. Evaluation (Post data) of Process & Outcomes

5. Modifications to the Practice Guideline: Changing the current policy of documenting pain scores from every 8 hours to every 4 hours for tighter pain control

6. Network Implementation-Implement a new policy of adequate pain documentation every 4 hours, if an intervention was completed and 1 hour after intervention
Pain control for Geriatric Trauma Patients age 65 and older should be assessed every 4 hours at minimum. This change in nursing documentation would help to gain a tighter control on pain for these patients who are typically poor reporters of pain. It also would pick out the patient who’s pain in not controlled leading the RN to recognize that this patient’s pain regimen may need to be changed.
Results

- Average pain score for patients who received scheduled pain medication: 2.96
- Average pain score for patients who received only PRN pain medications: 3.13
- For the patients who received scheduled pain medication 61% of patients returned to their previous level of care
- For the patient who received only PRN pain medication 58.5% of patients returned to their previous level of care
Next Steps

- Push to change documentation of pain for Geriatric Trauma patients to every 4 hours
- Study the reporting of pain using a different pain scale, like the Baker-Wong for this patient population
- Work with the Geriatrics team and the Trauma team to develop an algorithm to determine which Geriatric Trauma patients should receive scheduled pain control
- Introduce findings to other parts of the hospital-geriatric patients with pain not related to trauma.
In our ever changing healthcare scene in the United States, there is an increased push for improving the care of older adults. With the projected increased in this particular patient population, it is more vital than ever to be doing research and finding ways to better care for this population of patients.
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