Learning Forum Questions and Answers – 13/3/24

Palliative Care - Pain

Q. Does phantom pain come under emotional pain?

A. Yes it might but as well as this, the **brain has memory of where the pain has been before**. **Remember never to dismiss phantom pain**. We treat it because we are listening to the resident who is reporting it. Where there is cognitive impairment, it can be very challenging and complex. Involve other team members and multi-disciplinary team. **Pain can often be emotional**.

Q. If a resident's pain is complex, how do I get further help?

A. Initially, **CHLN team and GP's will provide generalist palliative care advice** (or District Nursing and Advanced Nurse Practitioner teams for Residential Care Homes and out of hours for nursing care homes). There may come a time when **specialist palliative care advice is needed**. This can be sourced from your **local hospice**. See NHSGGC Palliative Care Website for more information.
Hospices (palliativecareggc.org.uk)

Q. In the following scenario, what should be done? Resident 'A' is nearing end of life and is on 'Oramorph' immediate release, oral liquid morphine for pain, when required. At night she is settled and nursing assessments show she does not require analgesia to be administered. Despite this, her family feel she requires it often and are anxious that she is not receiving Oramorph when it has been prescribed.

A. Although this is one issue, it can be looked at as two separate issues. One is **communication** and the other is the **pain** assessment itself. These can both be brought together eventually but initially I would ensure **both are given equal attention**.
Ensure the **family are fully updated** on pain assessment results. If there is **a pain tool** in use, explain this to the family so they are aware what is being assessed and why as well as the interventions when pain is seen. Discuss the **importance of sleep in pain management** and the **importance of clinical judgement in any medication administration.**

It may be worth exploring a long acting modified release analgesic if in fact pain is felt often. This would help during waking hours and provide pain relief for long periods. The pain assessment would be useful in providing the prescriber with evidence of what has been used and when, in order to decide what modified dose is required.

As this resident is nearing end of life it would also be worthwhile remembering that her ability to swallow may soon become compromised. If this were the case, Oramorph would no longer be an appropriate preparation. An added risk would be if

she was to wake from sleep and be asked to swallow. A patient should be alert for >5mins if swallow is to be safe and it may present an increased choking/aspiration risk if she is not.

Remember, rather than be in disagreement with the family, **it's always a good idea to ask them what is causing them such distress**. Given the resident is reported not to be in pain overnight, are they in fact in distress about something else? Scared their loved one is dying? Perhaps they are fearful that if the resident is not woken regularly, they cannot check they are still alive? Being able to **respond to the family's distress with compassion and empathy** as well as get to the core of the issue can go a long way in terms of trust, rapport and the overall relationship between all parties which might in turn improve their faith in the fact you know what you are doing.

Palliative Care – Terminal Agitation

Q. Can itch be a cause of terminal agitation and if so, what can we do about it?

A**.** Yes, this can be a cause of terminal agitation.
As before, it is worth assessing **Pruritus** as a symptom, especially if you think it might have a bearing on the resident's levels of terminal agitation.
Itch or Pruritus as it's technically known**, can cause discomfort, frustration, poor sleep, anxiety and depression**. It might be localised or due to systemic disease such as liver disease. It is often worse at night. Some causes of Pruritus are independent of histamine, meaning antihistamine medications might be ineffective depending on the cause. Simple methods to manage Pruritus should always be considered first. Does the resident have dry skin that can be easily treated? Are they taking medication that is causing a pruritic rash? Has the itch been over a long period? If so, it might mean that persistent scratching has led to skin damage, excoriation and discomfort.

Once the itch has been assessed and a management plan decided, only then can it be determined if treatment will have a positive effect on reducing a resident's terminal agitation. It is worth noting that Pruritus can be a complex palliative symptom and specialist advice may be required if generalised advice has not helped.

Q. How do I know if I need specialist palliative care advice for a resident's terminal agitation? And how do I access this?

Once a resident's symptoms have been assessed, including their past medical history and any previous effective methods/treatments, this can be shared with the wider team who may have more experience and knowledge to assist. If this is not sufficient, then it may be that specialist palliative care involvement is required. As **with any complex symptoms, specialist palliative care advice is available** for all from your local hospice. Referrals might be accepted via helpline, SCI gateway referral, paper form etc. Whatever the preferred method, find out what is needed to

access specialist palliative care services in your area. See NHSGGC Palliative Care Website for more information.
Hospices (palliativecareggc.org.uk)

Q. How does terminal agitation differ from 'normal' agitation? For example, an infection, and how do we differentiate?

A**.** Often it's difficult to differentiate! **The best way to identify terminal agitation is to complete an assessment** as discussed in the presentation. Use slide 7 from the presentation (this can be found on the CHC website) to ask the important questions. Gather a history, find out what's new for that resident, what's changed? From this, widen the discussion to include your colleagues both in the care home and multi-professionals. Once all this information has been gathered the likelihood of whether the agitation is terminal agitation will be much clearer. Only then can you be confident in your treatment of it.
It may be, that to determine whether you are seeing agitation secondary to infection or terminal agitation, you require to treat for infection. The appropriateness of any treatments will become clear when all aspects of the assessment are known.
Realistic medicine principles should always be considered. "Treat the treatable" but where treatment side effects outweigh any benefits, it may not always be in a resident's best interest. **Realistic medicine allows for open discussion of positives and negatives of a treatment**.