Background
It is well documented that in older patients, pain is common but not always recognised or managed. In 2015, the British Geriatric Society formed a Special Interest Group called “Pain in Older People” (1). A national guideline was created in co-operation with the British Pain Society on how to assess pain in older patients and released in March 2018 (2).

Nationally, studies report pain in older people in the community has a prevalence of 50%. This increases to 83% in residential homes (2). In Northampton General Hospital, the baseline measure showed that pain was only documented in 75% of the patients who reported or demonstrated pain. Furthermore, 25% had regular analgesia prescribed; with most only receiving paracetamol.

Medical and nursing staff members were questioned as to their confidence in recognising and managing pain in this population. This showed that 78% of staff are “confident” or “very confident” in their assessment and management which shows a gap between expectations and current practice.

What are we trying to accomplish?
To improve recognition and management of pain in patients 70 years old and older on the medical admission ward by March 2019

Anticipated benefits:
- Better quality of life with sufficient analgesia and reduced side effects
- Increased engagement with therapy, potentially reducing length of stay
- Reduction in delirium; pain is a significant risk factor

What change can we make that will result in improvement?

PDSA 1: Nursing Seminar
Nursing seminars were held on the admission wards where both the importance and the practicalities of how to assess and manage pain were addressed. These lasted 20 minutes and included an interactive teaching session including evidence-based guidelines and followed by a game; see picture 1. 100% of attendees (n=12) agreed that the seminar would change their practice.

PDSA 2: Prescriber Seminar
These seminars were then adapted to prescribers and junior doctors and physician associates were educated on the same issues.

PDSA 3: Poster
Posters were created to highlight the problem and also to give succinct prescribing advice following feedback that doctors find it challenging to prescribe in older patients.

Future PDSA 1: Pharmacist Review
The ward pharmacist agreed to document in the pharmacist admission review if the patient was admitted with pain and whether they were or were not on any regular analgesia. This review also includes highlighting whether the patient has regular analgesia in the community

Future PDSA 2: Pain Assessment Proforma
After meeting with the Learning Disability Liaison Nurse, I discovered that there is a similar problem in assessment and management of pain in patients with learning disability. For this reason, we have agreed to review the existing pain assessment tool (see picture 3) and work together in rolling it out to the admission wards.

Process: % with pain documented in notes

Outcome measure – Percentage of patients 70 years old and over on a medical admission ward in pain that are on regular analgesia initially improved over two PDSA cycles and has fallen to baseline.

Process measure – Percentage of patients in pain who have pain documented in the medical or nursing notes. The percentage of patients with pain documented in the medical notes fell when the clerking documenta-
tion became electronic but prior to cycle 3, this was switched back to paper and has im-
proved to 100%.

Balancing measures – Percentage of patients on regular pain relief who have a side effect documented. There has been a fall in the percentage of patients on analgesia who have side effects documented. The side effects may have fallen due to effective use of appropriate analgesia and prophylactic prescribing of laxatives following the seminar sessions.

Patient experience – pain score. Despite an increase in the pain score documentation, it is unlikely that the score is accurate as a large proportion (64% over the three data sets) has a score of zero despite presenting.

Complexity of Patient Group
These graphs highlight the variability in the complexity of the patients on the ward over 6 months. Unsurprisingly, in PDSA cycle 3 when the percentage of patients with cognitive impairment and difficulty communicating was high, the percentage of patients with regular analgesia increased. This could be following the seminars, the doctors and nurses were more aware of the needs of these patient groups.

Outcome: % of patients regularly prescribed analgesia

Process: % with pain documented in notes

Balance: % side effects of analgesia

% with difficulty communicating pain

% with cognitive impairment

Summary
Thus far, this project has improved management of pain in older patients on the medical admission wards although the documentation of the pain has fallen. The project was welcomed, particularly by the frailty team and the senior nursing staff, on the admissions ward. However, barriers to improving clinical practice included difficulty arranging teaching that ward staff could attend due to winter pressures and staff shortages. This was addressed through short, flexible sessions that were repeated at different times and certificates were provided to encourage attendance. In particular, there was a rapid turnover of medical staff on the wards; as evidenced by a fall in prescribed analgesia. Furthermore, a move to a newly opened ward and a change to electronic documentation were factors which I had no influence over and certainly impacted on the project. This project could be adapted to most hospitals with medical admission wards and is an important topic as the patient population with dementia and frailty grows.

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References