Practices in Managing Pain and Other Symptoms in the Terminally Ill

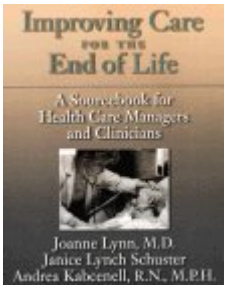
Current	"Best"	Better "Best"
• Most often not assessed or monitored. • Routinely receive inadequate treatment (e.g., drugs and dosages). • Usually treated only after serious symptoms occurred, rather than as prevention. • Gaps and delays in treatment are agonizing and commonplace. • Major symptoms are presumed untreatable, though most can be relieved or reduced (pain, dyspnea, depression, anxiety, nausea, itching, insomnia, and so on). • No one is held accountable for shortcomings. • Patients and families expect severe symptoms and are grateful for any relief. • Misinterpretation of patient's behavior as meaning "no pain," (e.g., sleeping, not writhing, etc.). • Professionals and patients do not fully understand concepts such as addiction,	• Pain and other symptoms assessed 100% of the time • WHO/APS/AHCPR guidelines for cancer pain followed • Low rate of orders for breakthrough pain--(repeated need for breakthrough symptoms triggers increased regular doses of pain medications) • Rescue dose always available • When pain is continuous, all opioids on regular dosing schedule • Patients and families control timing of dosing for breakthrough pain • Sufficient pain medication provided during medical procedures and transfers between units and facilities • Severe symptoms (e.g., on a 0 to 10 scale, pain greater than 3 requires intervention, and greater than 6 is an emergency) receive emergency response • Clinician performance routinely reviewed and shortcomings addressed • Attend to and manage predictable side effects	• Assess pain, depression, dyspnea, and anxiety on specified schedule (admission, change in status, and periodically) 100% of the time • Use all appropriate modalities, often on time-limited trials--including opioids, NSAIDS, adjuvant analgesics, physical therapy (apply heat and cold), massage therapy, behavioral techniques, hypnosis, steroids, neuroablative procedures, stimulants, and so on • Respond to severe symptoms as an emergency • Have skilled consultants readily available to patients in all

tolerance, titration of doses, and management of opioid side effects.
- Regulatory barriers (i.e., triplicate prescribing laws) create patient fears and affect physician prescribing practices.
- Serious under treatment of neuropathic pain and lack of knowledge about adjuvant analgesics.

- Educate patients and families about pain management

settings (including ICU, hospital, nursing home, and home)
- Create settings in which patients and loved ones expect competence, control, and comfort
- During transfers between units or sites, never leave a patient in pain
- There are routine care reviews and feedback opportunities for quality improvement, public education, and accreditation.

SOURCE



For further information on quality improvement in end-of-life care visit The Palliative Care Policy Center [www.medicaring.org].