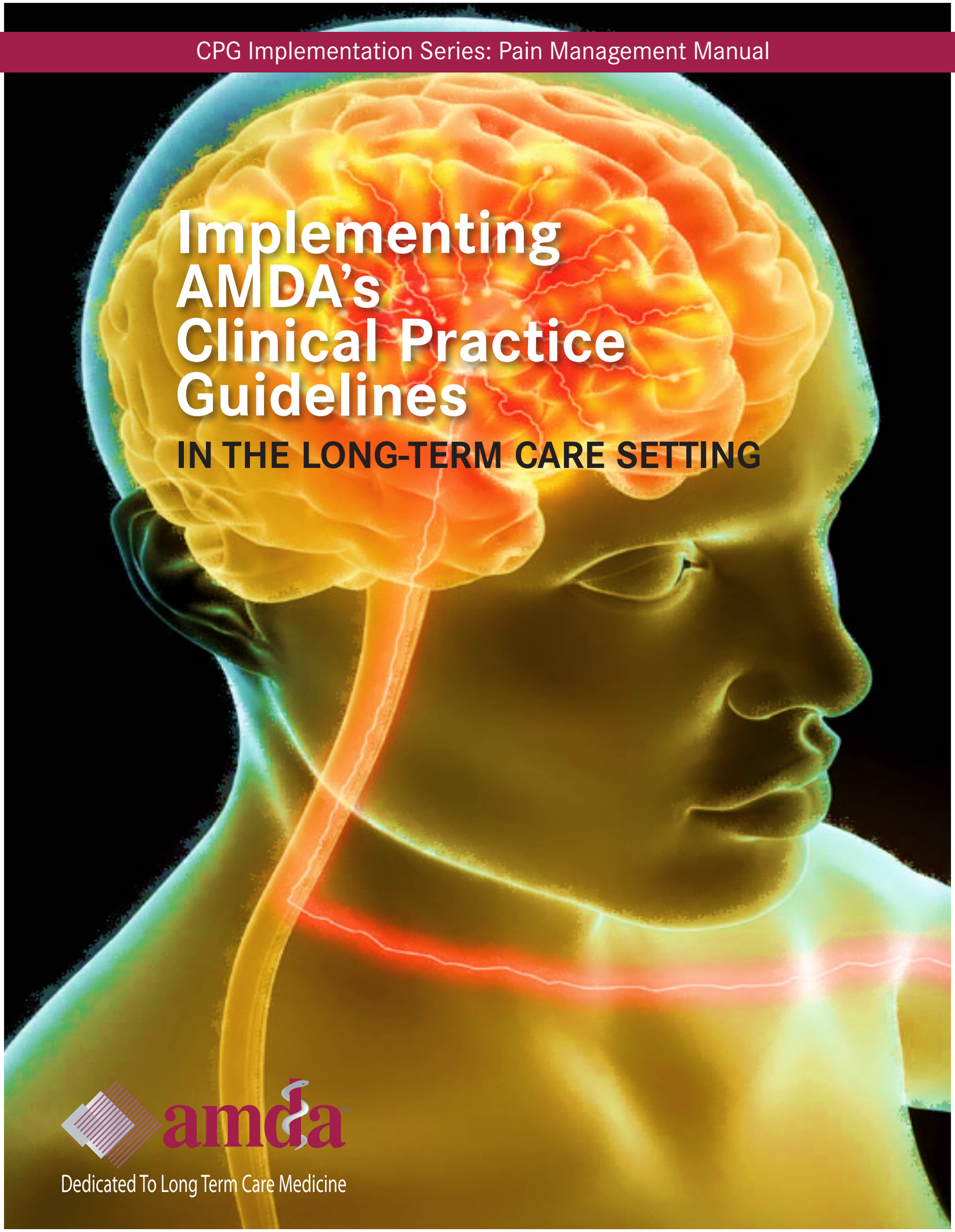
CPG Implementation Series: Pain Management Manual

Implementing AMDA's Clinical Practice Guidelines

IN THE LONG-TERM CARE SETTING



amda

Dedicated To Long Term Care Medicine

AMDA – Dedicated to Long Term Care Medicine™, the professional association of medical directors, attending practitioners, and others practicing in the long-term care continuum, is dedicated to excellence in patient care and provides education, advocacy, information, and professional development to promote the delivery of quality long-term care medicine.

It is with great pleasure that AMDA releases the second edition of its CPG Implementation Series. This manual is a comprehensive resource, grounded in theory, research, and experience. It brings practical processes, strategies and tools to clinicians and others committed to initiate and sustain practice change in long-term health care, and support the creation of healthy and thriving work environments. AMDA is delighted to provide this key resource which walks you through each step of implementing the specific clinical practice guideline (CPG).

Now, it is your turn — the health care provider and the organization at which you work — to put these tools and the specific clinical practice guideline into action, ensuring successful implementation. Creating excellence in long-term care and healthy work environments is both an individual and collective responsibility. Evidence and compassion are central pillars to secure quality patient care.

Disclaimer

This Implementation Manual is provided for discussion and educational purposes only. The information in this manual is not intended and should not be construed as a substitute for a practitioner's medical advice or judgment.

The utilization of this clinical practice guideline implementation manual does not preclude compliance with State and Federal regulation as well as facility policies and procedures. This manual is not a substitute for the experience and judgment of clinicians and caregivers. AMDA's Clinical Practice Guidelines are not to be considered as standards of care but are developed to enhance the clinicians' ability to practice.

AMDA expressly disclaims responsibility for any adverse effects or consequences resulting from the use of any of the advice or procedures presented or discussed in this Implementation Manual and the corresponding clinical practice guideline. AMDA shall not be liable for any damages whatsoever resulting from use of this Implementation Manual and the corresponding clinical practice guideline. The American Medical Directors Association, its heirs, executors, administrators, successors, and assigns hereby disclaim any and all liability for damages of whatever kind resulting from the use, negligent or otherwise, of this Implementation Manual and the corresponding clinical practice guideline.

The authors and publisher have made every effort to ensure that the information contained in this manual and the corresponding guideline reflects accepted standards and practices at the time of publication. However, because research evidence and clinical standards continually evolve, the reader is urged to check recent publications and monographs for guidance on treatment decisions where the clinical practice guideline is concerned.

For more information about the AMDA guidelines and implementation manuals or to order copies of these implementation manuals, call 800/876-2632 or 410/740-9743 or visit our web site at www.amda.com.

Contact information:
AMDA – Dedicated to Long Term Care Medicine™
11000 Broken Land Parkway - Suite 400
Columbia, MD 21044
Main: 410-740-9743
Fax: 410-740-4572
Website: www.amda.com

Table of Contents **page** **tab**

[Both appendices reprinted from Registered Nurses' Association of Ontario. (2012). Toolkit: Implementation of best practice guidelines *(2nd ed.). Toronto, ON: Registered Nurses' Association of Ontario.]*

CD-ROM Content

Training Tools:

1. PowerPoint Presentation – Pain Management Implementation for Certified Nursing Assistants (CNA)
2. CNA Slide Notes
3. PowerPoint Presentation – Pain Management Implementation for Licensed Nurses (LN)
4. LN Slide Notes
5. Frequently Asked Questions
6. Administrator Letter to Interdisciplinary Team
7. Administrator Letter to Family Member/Legally Authorized Representative
8. Quality Indicators for Reviewing Pain Management
9. Clinical Process Measures
10. Checklist for Policies and Procedures
11. Task Assignment Grid – Staff Selection
12. Appendix 1: Facilitators and Barriers: Questions to Guide You
13. Appendix 2: Action Plan Template
14. Possible Pain "Clues" in the MDS 3.0
15. Pain Scales
16. Summary of Recommendations in the Assessment and Management of Pain (RNAO - Appendix J, p 130-170)
17. Pain Tools and Web Links

Practitioner Tools:

18. PowerPoint Presentation – Pain Management Implementation for Medical Directors (MD) and Attending Practitioners
19. MD and Attending Practitioners Slide Notes
20. Medical Director Letter to Practitioners
21. Summary of Practitioner Responsibilities
22. Drug Information Common to the Class of Extended-Release and Long-Acting Opioid Analgesics
23. Specific Drug Information for Extended-Release and Long-Acting Opioid Analgesics

CPG Implementation Manuals
The implementation manuals walk you through each step of implementing the specific clinical practice guideline (CPG). This manual delineates a systematic, well-planned implementation process and is designed to assist nurses and other health care professionals to support evidence-informed clinical and management decision making. It is intended to accompany the CPGs developed by AMDA in order to facilitate their implementation and sustained use in health care settings.

Users will also find this manual helpful in all types of evidence-informed clinical innovation. This manual is based on emerging evidence that the likelihood of achieving successful uptake of clinical practice in health care increases when:

- Leaders at all levels are committed to support facilitation of guideline implementation.
- Guidelines are selected for implementation through a systematic, participatory process:
  - Barriers and facilitators to guideline use are assessed and addressed
  - Interventions are selected that
    1. Promote guideline use,
    2. Address the barriers, and
    3. Reinforce the facilitators.
- Evaluation of the impacts of guideline use is an integral part of the entire process.
- There are adequate resources to complete the activities related to all aspects of guideline implementation.

The manuals include:
- Template letters to the care team and family members informing them of your initiative;
- A letter to the attending practitioner along with an at-a-glance summary of practitioner responsibilities;
- A Task Assignment Grid to select care team members for performance of specific tasks within the CPG, a policies and procedures (P&P) document that lists those P&Ps needed to implement the specific guideline; a one-page checklist for training staff on those P&Ps;
- A list of Quality Measures for the CPG, to use in your facility's quality process;
- A Measurement Tool for Clinical Practice Implementation that contains a quantitative process and clinical outcomes measures related to implementation of the CPG, to use pre- and post-implementation;
- Three inservices on CD-ROM, one for practitioners, one for licensed nurses, and one for certified nursing assistants, that cover the topic and that discipline's role in carrying out the steps in the guideline;
- Slide notes so that anyone can present them;
- An instructor's manual;
- A CD-ROM with customizable tools.

These manuals are a "must have" for medical directors to demonstrate their mastery of Tag F501!

- Guided by these premises, this comprehensive manual – grounded in theory, research and experience – brings practical processes, strategies, and tools to clinicians and others committed to initiating and sustaining evidenced based practice change in long-term health care.
- The manual was developed as a user-friendly resource to facilitate systematic identification and implementation of CPGs. Since the content relies on currently available knowledge, the manual will undergo regular review and updating.

Using the Manual

What is the Purpose of this Manual?

Manual Objective(s)
- To improve the quality of care delivered to patients with acute or chronic pain in long-term care settings
- To guide care decisions and to define roles and responsibilities of appropriate care staff
- To serve as a foundation for a systematic approach to recognition, assessment, treatment, and monitoring of pain in patients in long-term care settings

Target Population
Elderly residents of long-term care facilities with acute or chronic pain or who are at risk of pain.

Who is the Manual Designed for?

Intended Users

Advanced Practice Nurses	Nurses	Physician Assistants
Allied Health Personnel	Occupational Therapists	Practitioners
Dietitians	Pharmacy Consultants	Social Workers
Health Care Providers	Physical Therapists	
Medical Directors	Physicians	

Icon Identification

IDEA
Specific approaches or new strategies are shared to assist you further when moving knowledge to action through guideline implementation.

These can be shared with your team to assist you as you proceed along your journey.

CAUTION
There are areas that require your close attention to avoid risk.

Remember the goal at hand and understand that you may not please everyone, all the time, know there will be delays, and keep communication clear, consistent, and regular.

Being prepared for these requirements in any change process will assist you to have a positive experience in implementing your chosen guideline.

EVALUATION
Become familiar with the various stages of evaluation, the methods of evaluation, the tools and the time you will need to evaluate your process, progress and the implementation of the guideline.

SUSTAINABILITY
Once the CPG and Implementation Manual has been implemented it is important to build a process for sustainability that may include evaluation, audit, celebration, re-training, publication, presentations.

The sustainability process may require additional resources and these should be identified as part of the entire process for implementation.

CPG Implementation Series:
Pain Management Manual
Instructor's Guide

TABLE OF CONTENTS

1. Preparing for the Project

Why use clinical practice guidelines (CPGs) in long-term care?

CPGs have been developed to help systematically assess and manage diseases and conditions. They are based on research, evidence and expert consensus.

Facilities caring for the elderly and chronically ill should use evidence-based care wherever possible. A primary objective of geriatrics is not to do harm while trying to do good. Although there is usually more than one approach to manage most conditions and problems, much is also known about inappropriate and harmful interventions that should be avoided.

CPGs are a convenient way to identify both desirable and problematic approaches to caring for long-term care (LTC) residents and patients. They help busy staff and practitioners, who may not have time to keep up with the literature or the training, to interpret what this information means for the care of individual residents and patients.

AMDA–Dedicated to Long Term Care Medicine™ CPGs emphasize common problems and conditions in the LTC population and factors that influence practices in that setting. Guidelines from other sources often limit or omit considerations that are relevant to the LTC population, especially, the frail elderly. For example, many nursing facility residents are at or near the end of life, so care goals may shift from cure of disease or functional improvement to palliation or comfort care. AMDA's guidelines address such situations and suggest appropriate care plan modifications.

AMDA's CPGs are developed by an interdisciplinary workgroup to guide everyone's participation in the care delivery process, including: (1) nurses (2) practitioners (3) directors of nursing, (4) medical directors (5) consultant pharmacists (6) social workers (7) dietitians (8) nursing assistants (9) therapists, and 10) others. Each guideline follows a consistent format. The introduction explains the purpose, development process, and terminology used in the guidelines. The main text covers a definition and the steps of recognition, diagnosis, treatment, and monitoring of the condition. An algorithm summarizes the steps involved in addressing the condition. The algorithm illustrates key actions and decision points to facilitate its use and reinforce learning.

Evaluate your facility's data sources for potential problems with pain.

Identify areas of potential concern related to pain management. Review actual cases as your primary source of information; for example, see if: new admissions were screened for risk factors and pain symptoms, documentation includes appropriately detailed symptom descriptions, practitioners and staff sought and identified causes of pain, practitioners ordered appropriate interventions, and residents were monitored over time. Conduct both random reviews and selected reviews of individuals with known pain. Your quality improvement statistics related to pain management will come from these collective reviews. For example, the percentage of cases reviewed with a detailed description of pain symptoms (see AMDA Pain Management CPG, pp. 7-10). Conduct both concurrent (completed while the individual is receiving care or having symptoms) and retrospective (completed on discharged individuals, after previous episodes, or after records are closed) reviews.

Other sources of information might include internal quality indicator and quality assurance reports, Minimum Data Set (MDS) data; issues raised by the medication regimen review; and patterns of resident or family complaints. Review MDS reports and resident level summaries for individuals who flag in areas of concern

related to pain. For example, look at individuals with pain to see if they also have potential complications such as depressed mood, weight loss, disturbed sleep cycle, and decline in activities of daily living (ADLs) or little or no activity. Also, check for appropriate follow-up of individuals who have or trigger for diseases or conditions commonly associated with pain such as arthritis. Consider whether staff and practitioners are consistently seeking, identifying, and addressing pain.

Finally, discuss areas of clinical concern with the medical director and consultant pharmacist (for example, how many residents are on medications used for pain management; see Tables 5 through 11 in the AMDA Pain Management CPG). Consider whether these individuals taking pain medications may also have a problem with falls, anorexia, changes in mental status, or functional decline that could be caused by medication side effects. These or other investigations may suggest areas for staff and practitioner improvement in pain management.

What is your facility's pain culture?

Your facility leadership should be committed to improving pain management, including using the processes and approaches in the Pain Management CPG. In turn, their commitment will influence the staff and practitioners.

First, review and compare your current approaches to pain management. How do they compare to those in the AMDA Pain Management CPG? Are they based on comparable information and evidence from the literature? Do they include similar key steps? Discuss how the information in this CPG could help improve current care approaches.

Use the Pain Management CPG to help identify misconceptions or knowledge deficits regarding pain among your staff and practitioners (see the AMDA Pain Management CPG, pp. 4 and 5); for example, staff may not recognize that pain can present in various ways or they may not know how to use a common assessment tool.

Your facility probably has a culture of caring, but could nevertheless improve aspects of your current pain management. This manual can help your facility achieve that.

Familiarize yourself with AMDA's Pain Management CPG.

As you read the AMDA Pain Management CPG, its relevance to your long-term care setting should become clearer. Countless nursing home residents have pain or risk factors for having pain. Because pain may be difficult to identify and to manage, but is often treatable, this guideline implementation project should be a critical component of your overall quality improvement program.

After you read the Pain Management CPG, you should be prepared to employ the pain management implementation manual. You will find that it helps get the job done while making guideline implementation more practical and less mysterious.

Share Frequently Asked Questions (FAQs) with staff.

As a supplement to the guideline and related policies and procedures, share the Frequently Asked Questions (FAQs) - Pain Management in the Long-Term Care Setting document with supervisors and managers of direct care disciplines in your facility. For example, you might distribute and discuss it at a weekly management meeting or team conference.

It is hard to estimate just how long it will take to decide to implement this particular CPG. However, you will at least know you are on the right track when the administrator, director of nursing, and medical director all recognize and agree on how guidelines and protocols can help you improve care. Other key facility managers also need to identify and agree on the value of reviewing and improving care processes and practices.

Introduce CPG implementation to appropriate parties.

You will need to communicate the decision to use this guideline to help revamp your approaches to managing pain. The manual contains Template Letters to use (as is or modified) to introduce the Pain Management CPG implementation project to the practitioners and members of the treatment team. It is best to wait to send out the family letters until after the staff has been trained and you have implemented this CPG, to avoid raising family expectations prematurely. The letter introduces the project as a means to improve pain assessment and management, including many issues not covered by nursing home regulations.

2. Training

The Clinical Practice Guideline process systematically follows these steps:

1. **Recognition** – identifying the presence of a risk or condition

2. **Assessment** – clarifying the nature and causes of a condition or situation and identifying its impact on an individual

3. **Treatment / Management** – selecting and providing appropriate interventions for the individual

4. **Monitoring** – reviewing the course of a condition or situation as the basis for deciding to continue, change, or stop interventions

All of the AMDA guidelines follow this "medical care process" as the best way to incorporate scientific information and medical knowledge into the actual care environment. AMDA's CPGs are unique in recommending actions to be taken by various treatment team members in a defined sequence.

Review and reinforce the care process for pain management.

Pain Management in the Long-term Care Setting CPG Implementation Manual contains three sets of "ready-to-use" PowerPoint presentations for training practitioners, licensed nurses and certified nursing assistants. These presentations discuss, in detail, expected actions related to the pain management process. They should also help you identify relevant skills and information prior to beginning the implementation process. (See presentations with speaker notes for Medical Directors and Practitioners, Licensed Nurses, and Certified Nursing Assistants [CNAs].)

The first presentation is intended for medical directors and practitioners. The slides review all steps in the Pain Management CPG, since the practitioner is involved with all 4 areas of the care process, especially in selecting and prescribing appropriate treatments and should also coordinate overall pain management. The slides also provide more detail about choosing and prescribing pain medications in accordance with the World Health Organization (WHO) Pain Ladder and managing medication side effects. Other presentations cover guideline steps that are pertinent to nurses and CNAs. The nurse slides provide detail about monitoring the effectiveness and complications of drug therapy. They also include a section on how to assess for pain in patients who are uncommunicative and cognitively impaired. The CNA slides cover aspects of the guideline that are appropriate to their training and responsibilities, primarily observation, reporting, and providing comfort measures for individuals with pain.

The following table provides a Summary of AMDA's "R.A.T.M." process for Pain Management:

Summary of AMDA'S PAIN MANAGEMENT "R.A.T.M."

Recognition, Assessment, Treatment and Monitoring

RECOGNITION

Every patient should be regularly and systematically evaluated for pain. The process described in the following steps should be conducted, at a minimum:

	ROLE
• Upon a patient's admission to an LTC facility 1. Is pain present? 2. Have the characteristics and likely causes of pain been adequately defined? 3. Provide appropriate interim treatment for pain • Whenever a patient has an acute illness or injury or experiences a decline in function or a change in mood or cognition • When vital signs are obtained (as the "fifth vital sign") • Daily, for patients with a known painful condition • Before and after administration of as-needed (PRN) analgesic medication • At each quarterly and annual review	CNAs Licensed Nurses Practitioners Others

ASSESSMENT

Pain management is most successful when the underlying cause(s) of pain can be identified and treated. Effective diagnosis depends on the use of accurate historical and clinical information along with physical evidence derived from an appropriate examination. Identify those conditions in a timely manner, assess them appropriately, and plan effective pain management wherever possible.

	ROLE
• Perform a pertinent history and physical • Are the cause(s) of pain identified? • Perform further diagnostic testing, as indicated • Have the probable cause(s) of pain been identified? • Obtain additional evaluation or consultation as necessary • Summarize the characteristics and causes of the patent's pain and assess the impact of pain on function and quality of life	Licensed Nurses Practitioners

TREATMENT

All patients with pain should be cared for in an environment that is as comforting and supportive as possible. Additional interventions include the following:

	ROLE
• Adopt a person-centered interdisciplinary care plan • Set goals for pain relief • Implement the care 1. Medications are one approach to treating pain. When medication use is appropriate, individualize selection and administration to meet the patient's needs, taking into account his or her existing conditions and medication regimen	Practitioners

continued

CONTINUED

Summary of AMDA'S PAIN MANAGEMENT "R.A.T.M."

Recognition, Assessment, Treatment and Monitoring

MONITORING

Reassess patients with pain regularly. All caregivers should be continually vigilant for signs or symptoms suggesting pain during daily activities.

ROLE

- Re-evaluate the patient's pain
  1. Systematic pain monitoring should be implemented:
     a. Every day;
     b. Every shift;
     c. Before and after administration of analgesics;
     d. Before, during and after ADLs; and
     e. With associated procedures or therapy that may cause pain.
- Adjust treatment as necessary
- Is pain controlled?
  a. Ability to perform ADLs;
  b. Attainment of personal and therapeutic goals;
  c. Mood, cognition, and behavior;
  d. Participation in usual activities; or
  e. Sleep pattern
- Monitor the facility's performance in the management of pain
  a. Review and reassess characteristics of pain, impact of pain, treatment plan and etc.

CNAs
Licensed Nurses
Practitioners
Others

SUMMARY

Education about pain assessment and treatment is an essential element of training and orientation programs for all employees and affiliated professionals in LTC facilities. By implementing the steps described in this guideline, health care providers can meet the expectations of patients, their families, substitute decision makers, and policy makers for adequate, compassionate management of pain in the LTC setting.

Following is an outline of the specific Steps of AMDA's "R.A.T.M." process for Pain Management.

1. **Recognition**
   - **Step 1** – *Is pain present?* This section includes information on signs/symptoms that might suggest pain, how to elicit information about pain from the patient, and use of the Visual Analog Scale.
   - **Step 2** – *Have characteristics and causes of pain been adequately addressed?* This section includes possible indicators of pain in the MDS and includes documentation of an initial pain assessment with detailed descriptors (location, intensity, nature, etc.).
   - **Step 3** – *Provide appropriate interim treatment for pain.*

2. **Assessment**
   - **Step 4** – *Perform a pertinent history and physical examination.* This section covers obtaining a pain history and potential elements of the work-up including laboratory testing.
   - **Step 5** – *Are the cause(s) of pain identified?*
   - **Step 6** – *Perform additional diagnostic testing, as indicated.*
   - **Step 7** – *Have the probable cause(s) of pain been identified?*
   - **Step 8** – *Obtain additional evaluation or consultation as necessary.* This section identifies many therapeutic options.
   - **Step 9** - *Have the probable cause(s) of pain been identified?*
   - **Step 10** – *Summarize the characteristics and causes of the patient's pain and assess the impact on function and quality of life.*

3. **Treatment / Management**
   - **Step 11** – *Adopt a person-centered interdisciplinary care plan.* There is information here about factors that may influence the choice of treatment(s).
   - **Step 12** – *Set goals for pain relief.* This includes information about an appropriate environment for managing pain, reasons why practitioners may not treat pain adequately, and goals of pain management.
   - **Step 13** – *Implement the care plan.* This section discusses the principles for prescribing analgesics including the selection of regular or PRN dosing. Charts and text cover (a) non-opioid analgesics (b) opioid therapy and practitioners' related professional obligations (c) oral and transdermal opioid analgesics that are commonly used with approximate equianalgesic doses and starting doses (d) oral morphine compared to transdermal fentanyl (e) topical analgesics (f) analgesics of particular concern in the long-term care setting and (g) adjuvant drugs. The section also discusses the use of complementary treatments for pain relief.

4. **Monitoring**
   - **Step 14** – *Re-evaluate the patient's pain.*
   - **Step 15** – *Adjust treatment as necessary.* This section addresses dilemmas in pain management.
   - **Step 16** – *Is pain is controlled?* This section discusses how to monitor the effectiveness of opioids and ways to try to prevent debilitating constipation.
   - **Step 17** – *Monitor the facility's performance in the management of pain.* Review the management of patients with pain through the facility's quality improvement process.

Summarize Practitioner responsibility

The Summary of Practitioner Responsibilities - Implementing the AMDA Pain Management Guideline document identifies key practitioner roles and tasks in managing pain. It should help practitioners recognize how they can best help the staff and their patients to address pain.

3. Assessing the Capability of your Facility Infrastructure and Clinical Team

Strategies to remedy knowledge and skill gaps.

As noted previously, a CPG presents a step-wise approach to care that requires specific competencies. Therefore, it will help you to define the knowledge and skills needed to implement the steps in this CPG. For example, managing pain requires the ability to (1) assess pain using a scale (2) identify behaviors that may suggest pain in the cognitively impaired (3) describe pain characteristics such as duration, location, character and exacerbating/relieving factors, and (4) determine whether the current treatment is effective by seeking information such as improved mood, sleep, and activity levels.

After identifying knowledge and skills related to pain management and showing the presentations, ask the staff and practitioners to evaluate their current knowledge and skills and to advise you as to where they think they might need help. Important: You will need to reinforce this information through practical "hands on" demonstrations in practice sessions or actual patient situations.

"Spot training" can be an efficient way to reinforce your CPG training by offering 15-20 minute in-services on one segment of the CPG. For example, pain management can be broken into these smaller topics:

- Pain – The 5th Vital Sign
- Pain scales and the pain vocabulary
- Identifying signs and symptoms of pain in cognitively intact and impaired individuals
- How to be a "pain detective" - look for Possible Pain "Clues" in the MDS 3.0
- The value of exercise in pain management
- Communicating with care partners and residents about pain management and realistic pain management goals

Also, consider using games to help maintain interest in these sessions, e.g., hangman, concentration, word puzzles etc. (For assistance in creating such games, refer to the web site www.edcreate.com/learnmore.php.

- Make the spot training sessions interactive and creative. For example, you may want to role play being a "Pain Detective." Review the environment for factors related to pain such as noxious or distracting stimuli, ill-fitting clothes or the need to change an incontinent individual's clothing. Review the medical record for possible conditions that may affect the pain response. Conduct a basic physical assessment for potential causes of pain.

- Finally, the medical director and attending practitioners should all be encouraged to take nursing staff with them on clinical rounds to observe and assess specific cases and to identify and document a change in pain status. Important lessons can be reinforced in 10 minutes or less!

Select team members and assign staff.

The Task Assignment Grid – Pain Management in the Long-term Care Setting – Staff Selection document allows you to assess and assign tasks to members of the interdisciplinary team, such as the nursing assistant or physical therapist. The key here is to assign tasks to individuals who have the necessary knowledge and skills, as well as what is allowed by your state scope of practice laws, and to identify those who need to improve knowledge and skills related to specific tasks. You can use this checklist (found on the CD-ROM) to record your evaluation of each person's qualifications and ability to perform the following steps:

- Assess for the presence of pain
- Define the characteristics and causes of pain
- Select appropriate treatment for pain
- Select and interpret diagnostic studies
- Perform a relevant history and physical
- Identify the causes of pain
- Select and incorporate appropriate consultations
- Summarize characteristics and causes of pain and assess impact of pain on function and quality of life
- Develop and coordinate an interdisciplinary care plan
- Set goals for pain relief
- Reevaluate pain symptoms over time
- Adjust treatment as necessary

Remember, assign tasks related to pain management based on the appropriate scope of practice and licensure, skills and knowledge, and responsibilities identified in protocols and job descriptions.

Develop policies and procedures for pain management.

In addition to matching skills to required clinical competencies, you will want pertinent policies and procedures to help standardize these desired approaches. Your management and administration should support a systematic approach as identified in the CPG as a means to achieve success. The document entitled Policies and Procedures for the Pain Management Guideline should help you identify key policies and procedures and their content. Next, move to the Checklist for Policies and Procedures To Implement the Pain Management Guideline document. This is a supplemental tool to help you identify policies that may need to be revised or developed in order to manage pain consistent with the Pain Management CPG. It can also be used to help track topics for in-service education. Don't forget to involve your medical director in the selection or modification of policies and procedures related to pain management.

Consider these tips for overcoming obstacles

Organizational "buy in" is crucial before beginning to use a CPG to review and improve care. Time spent establishing a strong foundation is time well spent. Make sure that your key administrative and clinical management staff understand and support the notion of using CPGs to help review and improve care. This will help you to:

- **Strengthen your policies and procedures to help ensure compliance with federal and state requirements**
- **Estimate realistically the time and cost needed to review and modify existing approaches**
- **Give nurses and practitioners time to review and discuss their responsibilities so they will support, not obstruct, desired approaches**
- **Measure how changes in processes and practices impact care results**
- **Implement changes more effectively and efficiently**
- **More effectively deploy individuals to review and modify processes and practices**
- **Identify how key facility management and staff can help implement programs to improve care**

4. Implementing the CPG

Use indicators for reviewing pain management to help review processes.

Set a date and have a "kick-off" event to begin the process of improving pain management in your facility by using the Pain Management CPG.

Subsequently, you will want to validate whether the steps in pain management are being followed effectively. The Quality Indicators for Reviewing Pain Management worksheet can help you identify and document, as part of your quality improvement activities, whether desired steps and approaches are being done correctly and consistently.

For example, consider the recognition phase of the CPG.

- Have the staff and practitioners considered or ruled out other significant causes (for example, fluid and electrolyte imbalance or medication side effects) of non-specific symptoms such as restlessness, grimacing, fidgeting, etc. that could also represent pain?
- Or, consider the treatment phase. In performing chart reviews, is there evidence that treatment goals (for example, pain reduction, correcting causes, controlling pain despite not being able to address causes) have been identified?

Methodical use of this tool should help you identify how well the staff and practitioners are following the desired steps.

You can also use this worksheet to monitor compliance over time. Auditing the records of individuals with pain or risk factors for having pain is an excellent way to determine whether the desired care process is now "standard operating procedure".

5. Evaluating Performance

Use a tool to measure CPG implementation.

You will want to collect data to compare actual to desired performance and results. Staff and practitioners should know what is being measured and how it relates to their assigned functions and tasks. Periodically, you can then interpret the findings for them and identify whether practices and performance are optimal. This can be done partially by establishing "thresholds" for results; for example, compare results to industry norms or to identified best practices.

One widely used approach to measuring performance is to calculate both process and outcome measures as percentages. Measurement Tool for CPG Implementation: Measures for Pain Management lists such measures. For example, one process measure in the recognition phase is the percentage of patients who have had a documented pain assessment on admission using a standardized tool. The percentage is derived by dividing the numerator (the number of individuals with a pain assessment on admission using a standardized tool) by the denominator (total number of admissions) and then multiplying by 100 to obtain a percent. An example of an outcome measure is the percentage of patients who have an identified Adverse Drug Reaction (ADR) to pain medications. It is derived by dividing the number of individuals who had an ADR by the number of individuals who received at least one pain medication and then multiplying the result by 100.

Next, interpret the findings for each audit period and over time, look for trends and patterns. Identify and address individual accountability, i.e., staff and practitioners who have totally or partially met expectations. While it is often difficult to be objective when looking at accountability issues, sustained improvement depends on doing so fairly and objectively. While case mix, seasonal variations, and other factors may be relevant to your interpretations of results, it is important to remain objective and not underestimate the importance of your care delivery processes.

Provide objective feedback regarding performance and relate it to specific job responsibilities; that is, offer enough detail to show individuals what they have done well and how they can improve specific aspects of performance. Try to communicate findings to staff and practitioners frequently and respectfully. However, do not gloss over real issues and do emphasize acceptance of legitimate responsibility. Also report general findings in writing to the QA Committee and have QA committee documentation summarize corrective actions.

Summary

CPG implementation means, simply, using recognized management principles and practices systematically to check and improve a facility's care processes and practices, based on the approaches recommended in a clinical practice guideline. Good clinical practice guidelines represent current thinking about managing common conditions and problems in the long-term care population. They also reflect a basic care delivery model that never goes out of style. Thus, the effective use of clinical practice guidelines is a primary route to efficient, effective care that meets the needs of a facility's population while complying with relevant laws and regulations in an increasingly challenging health care environment.

Good Luck!

To All Practitioners:

This facility is reviewing and attempting to improve the care we deliver. One area selected for review is pain management. Pain in frail elderly patients can often be reliably detected and effectively treated, despite challenges. Our success in addressing pain is an important indicator of quality of care. Applying relevant medical and geriatric principles should help us refine and improve the care.

A key tool in this initiative is the AMDA clinical practice guideline (CPG) on pain management. The CPG gives us a relevant process that we can all use. It offers us current information about practices and it covers many issues that the nursing home regulations omit. We want to use the information in this guideline in our education and training programs and in our policies and procedures, to help everyone coordinate their efforts. The main purpose of this collaboration is to ensure adherence to the pain management clinical practice guideline and to identify barriers to management and treatment. Our responsibility is to provide the necessary support services through pain management.

Please review the attached summary of practitioner responsibilities in relation to pain management, as well as the clinical information within the guideline (for example, appropriate selection of pain management approaches, including use of pain medications). We need everyone's commitment in order for this project to succeed. I am counting on each of you to help. Our success can help show that we can improve care through voluntary efforts.

Sincerely,

Medical Director

To All Interdisciplinary Care Team Members:

We wish to review and strengthen our approach to pain management at this facility. Pain in frail elderly patients often can be reliably detected and treated effectively, despite the challenges. Our success at managing pain in our residents is an important indicator of our quality of care. Applying geriatric principles in all aspects of care should help us meet our residents' needs. In turn, this will help us ensure that we are meeting the intent of the nursing home regulations.

One of our key tools is AMDA's clinical practice guideline on pain management. The clinical practice guideline gives us a framework for our practices and offers information not found in the nursing home regulations. We want to apply the information in this guideline to our policies and procedures, as well as our education and training programs, to ensure that everyone understands and follows the key steps. The main purpose of this collaboration is to ensure adherence to the pain management clinical practice guideline and to identify barriers to completion of management and treatment. Our responsibility is to provide the necessary support services through pain management.

Please review the attached information, including information that is relevant to your responsibilities. For example, nursing assistants and others who have direct resident contact will want to know how they can better recognize when someone is in pain; licensed nurses will want to be sure they can identify common causes of pain.

The success of this project requires everyone's commitment. I am counting on each of you to participate. Our success in this area can help demonstrate that we can improve care through voluntary efforts.

Sincerely,

Administrator

Dear Family Member / Legally Authorized Representative,

We are in the process of improving our resident care. Pain management is one key area we have identified. We have provided our staff, management, and practitioners with information and training about identifying and managing pain.

If you believe your family member or friend is experiencing pain, or if that person is receiving pain medications, please observe and let us know how we are doing. For example, how often do you see staff asking the person about whether they are having pain or how well pain treatments are working? Do you see your family member making progress in pain control; for example, has their pain been reduced to a tolerable level, if not eliminated?

The goals of early identification and treatment of pain management, completion of treatment, and prevention of pain are the cornerstone of our pain management clinical practice guideline. Achieving these goals requires everyone's participation throughout the course of an individual's pain management. If you would like more information about the recognition and management of pain, or how we are approaching our project to improve our management of pain, please let us know.

Your support will help us improve our care.

Sincerely,

Administrator

Policies and Procedures for the Pain Management Guideline

I. Policies and procedures related to **recognition** of pain should include:
   a. A common vocabulary to describe pain and a standard set of pain assessment tools with instructions on how to use them
   b. Important pain characteristics that should be included in nursing and practitioner progress notes (duration, intensity, frequency, location, etc.)
   c. Directions on how to choose the most appropriate pain scale for a given resident/patient
   d. Instructions on documenting pain assessment, including: who should do it, where it should be documented, how often it should be done, and desired content
   e. How frequently and who should ask about the presence of pain in someone who is not complaining of pain or in an individual who cannot give a history
   f. How staff can attempt to distinguish whether non-specific symptoms such as grimacing and restlessness in an uncommunicative individual represent pain

II. Policies and procedures related to the **assessment/analysis** of pain should include:
   a. Who is responsible for seeking the causes of pain and what they should document
   b. How to decide whether the cause of a person's pain can or should be treated and what should be documented if it is concluded that the cause cannot or should not be treated
   c. What to document if the practitioner determines that the causes of pain cannot be identified or it would not make a significant difference if they were identified

III. Policies and procedures related to the **treatment** of pain should include:
   a. Who is responsible for selecting approaches to pain management and how it will be done
   b. Storage and administration of controlled substances
   c. How to document identification of appropriate goals for pain management
   d. When and how to identify and address possible side effects or complications from trying to treat pain
   e. Policies and procedures related to CAM and non-pharmacological approaches to pain management

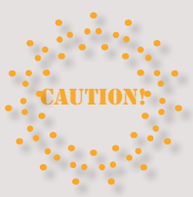
IV. Policies and procedures related to the **management** of pain should include:
   a. The prevention and management of constipation in patients on opioid analgesics
   b. When and how to offer pain interventions
   c. The approach to individuals who are continually offering non-specific complaints of pain despite multiple efforts to medicate, manage, etc.

V. Policies and procedures related to the ongoing **monitoring** of pain should include:
   a. Who is responsible for the evaluation of residents after pain medication is given, when should it be done, how and where this evaluation should be documented
   b. How often and how the staff should document or demonstrate follow-up monitoring of pain status
   c. How the staff should monitor for ADRs in relation to pain management
   d. The approach to adjusting pain medications and other interventions appropriately

Checklist for Policies and Procedures

To Implement the Pain Management Guideline

Policies and Procedures	*P&P OK as is*		*P&P revised*		Staff education planned		Staff education complete	
	Yes	No	Yes	No	Yes	No	Yes	No
Recognition	01-06-14							
Assessment/Analysis								
Treatment								
Management								
Monitoring								



- Be sure to write in the date under the Yes or No areas. See example above.
- Use with the Policies and Procedures for the Pain Guideline document.
- Write in the policies and procedures you will need to implement this guideline under each phase of the process.

Recognition – Assessment/Analysis – Treatment – Management – Monitoring

Possible Pain "Clues" in the MDS 3.0

In addition to section J on the MDS, a combination of MDS "clues" could indicate that the resident is having pain. To assess for hidden "clues" look at the resident's MDS to complete the following. One or more checks could indicate the presence of pain and should prompt further investigation (although most of them do not by themselves prove that pain is present).

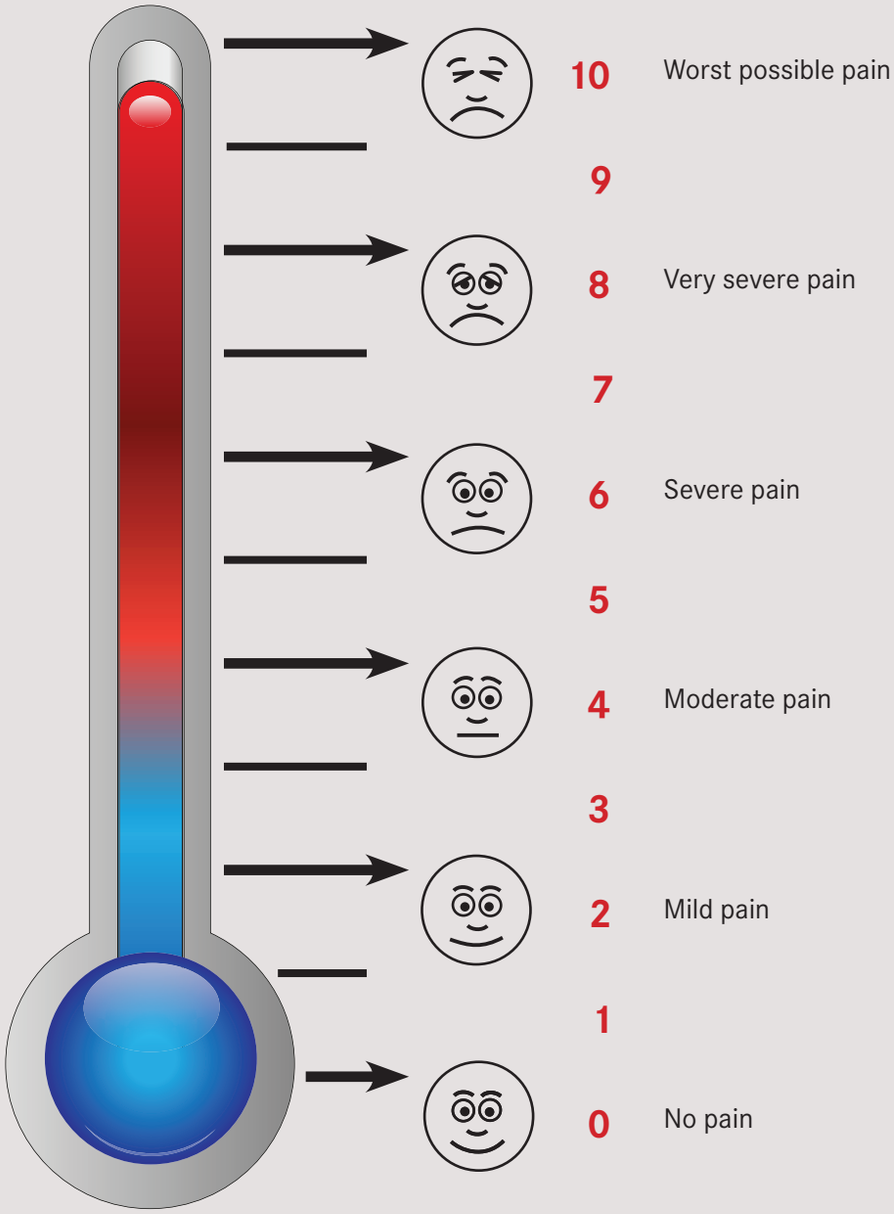
	Diseases and conditions that may cause pain (diagnosis OR signs/symptoms present)
☐	Cancer (I0100)
☐	Circulatory/heart _____ Angina, Myocardial Infarction (MI), Atherosclerotic Heart Disease (ASHD) (I0400) _____ Deep Vein Thrombosis (I0500) _____ Peripheral Vascular Disease (I0900)
☐	Skin/Wound _____ Pressure ulcer (section M) _____ Other ulcers, wounds, incision, skin problems (M1040)
☐	Infections _____ Urinary tract infection (I2300) _____ Pneumonia (I2000)
☐	Neurological _____ Head trauma (from clinical record) _____ Headache _____ Neuropathy _____ Post-stroke syndrome
☐	Gastrointestinal _____ Gastroesophageal Reflux Disease/Ulcer (I1200) _____ Ulcerative Colitis/Crohn's Disease/Inflammatory Bowel Disease (I1300) _____ Constipation (H0600, clinical record, resident interview)
☐	Hospice care (O0100K)

continued

CONTINUED
Possible Pain "Clues" in the MDS 3.0

☐	Musculoskeletal _____ Arthritis (I3700) _____ Osteoporosis (I3800) _____ Hip fracture (I3900) _____ Other fracture (I1400) _____ Back problems _____ Amputation (O0500) _____ Other
☐	Dental problems (section L)
	Pain effect on function
☐	Disturbs sleep (J0500A)
☐	Decreases appetite (from clinical record)
☐	Adversely affects mood (D0200, D0500, clinical record)
☐	Limits day-to-day activities (J0500B) (social events, eating in dining room, etc.)
☐	Change in ADL function (G0110)
☐	Functional Limitation in Range of Motion (G0400)
	Associated signs and symptoms
☐	Bedfast (G0800)
☐	Agitation or new or increased behavior problems (E0200)
☐	Rejection/Resisting Care (E0800)
☐	Delirium (C1600)
☐	Weight Loss (K0300)
	Other Considerations
☐	Improper positioning
☐	Contractures G0400)
☐	Immobility
☐	Use of restraints (P0100)
☐	Recent change in pain (characteristics, frequency, intensity, etc.) (J0400, J0600)
☐	Insufficient pain relief (from resident/staff interview, clinical record, direct observation)
☐	Pain relief occurs, but duration is not sufficient, resulting in breakthrough pain

Thermometer Pain Scale
Source: Mountain Pacific Quality Health Foundation



The enclosed material was prepared by Northeast Health Care Quality Foundation (NHCQF), the Medicare Quality Improvement Organization (QIO) for Maine, New Hampshire and Vermont, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

Quality Measures for the Pain Management Guideline

Recognition:

1. Is a standardized pain assessment tool used on admission?
2. Does the pain assessment process address all pertinent pain characteristics?
3. Does the pain assessment process account for patients with impaired communication due to cognitive or language problems?

Assessment:

1. Has the patient had an appropriate assessment of the characteristics and causes of pain?
2. Is a cause for pain given?
3. If there is no specific diagnosis for the cause of pain, and it is decided no work-up should be done, has the reason for not performing a work-up been given?

Treatment:

1. Is there a care plan for managing pain?
2. Have appropriate pain interventions been ordered?
3. Have medications been titrated/adjusted consistent with the WHO pain ladder?
4. Have medications that are not generally recommended been avoided, or is there clear justification for their use?

Monitoring:

1. Are the practitioner and nurses documenting the effectiveness of pain interventions?
2. Is an appropriate bowel management regimen instituted for individuals receiving narcotics to treat pain?
3. Are adverse drug reactions related to analgesics identified and addressed?

Quality Indicators for Reviewing Pain Management

SUPPORTING EVIDENCE FOR AN EFFECTIVE PROCESS	Met	Partial	Not Met	N/A
RECOGNITION / PROBLEM IDENTIFICATION				
Identifying the presence of pain - Periodically, there is an effort to identify the presence of pain, especially in individuals with predisposing conditions (recent surgery, symptomatic arthritis, neuropathy, etc.)				
- In the presence of non-specific symptoms (restlessness, grimacing, fidgeting, etc.), there is an effort to distinguish pain presence from other possible reasons for similar non-specific symptoms (dementia, depression, delirium, etc.)				
Characterizing the pain - The characteristics of the pain (scope, frequency, intensity, and other important features) are identified as far as possible				
ASSESSMENT / DIAGNOSIS / CAUSE IDENTIFICATION				
Identifying causes of pain - Cause(s) of pain are sought OR reasons why the individual should not be tested or evaluated are indicated OR the reason why identifying causes would not change the treatment is documented				
TREATMENT / PROBLEM MANAGEMENT				
Rationale for Treatment - Goals (pain reduction, correcting cause, controlling pain despite not being able to address causes, etc.) for treating pain and its causes are identified				
- Selection of pain management approaches are targeted to the individual's conditions, causes, risks, ability to cooperate, etc.				
- If pain is not readily controlled by initial interventions, other feasible approaches are identified OR there is evidence as to why other potentially relevant options were not tried				
Symptoms and causes - If an identified underlying cause of an individual's pain is not treated, there is a documented explanation as to why not				
Rationale for medication selection in presence of ADR or high ADR risk - If a higher-risk pain medication or a dose more likely to be associated with undesired side effects is used, reasons are identified why benefits were considered to outweigh risks, or why another lower-risk analgesic could not be used				

continued

CONTINUED

Quality Indicators for Reviewing Pain Management

SUPPORTING EVIDENCE FOR AN EFFECTIVE PROCESS	Met	Partial	Not Met	N/A
MONITORING				
Basis for continuing treatments - There is periodic reassessment of status of pain				
- Anticipated goals of pain management are modified based on changes in condition and responses to treatment				
- Periodically, there is documentation about whether current treatments are working and whether they should be continued, adjusted, or discontinued				
Managing adverse drug reactions (ADRs) - There is periodic monitoring for significant effects, side effects, and complications of pain medication				
- A significant ADR related to a pain medication is identified and managed in a timely fashion, by changing or stopping pertinent medication(s) OR there is a clinically relevant explanation as to why alternatives are not feasible				

Measurement Tool for Clinical Practice Guideline Implementation: Measures for Pain Management

Establish process and clinical outcomes measures before implementing the Pain Management in the Long-term Care Setting Clinical Practice Guideline (CPG). As much as possible, identify measurable (quantitative) indicators.

Process measures evaluate how well a facility is implementing related processes of care, e.g., number of patients admitted that are assessed for pain. Outcomes measures look at measurable changes in a patient's condition as a result of treatment or other interventions, e.g., number of patients with documented reduction of pain symptoms. In the past, health care facilities have mostly relied on process measures. Recently, however, quality monitoring organizations have begun to demand outcomes measures. Both are important.

Here are AMDA's suggested quantitative process and clinical outcomes measures related to using a Pain Management CPG in a long-term care facility. These measures are based on the four components of the AMDA pain management process: Recognition, Assessment, Treatment, and Monitoring. Where noted, certain terms will require additional definition by the facility.

All process and clinical outcomes measures should be defined using selected benchmarks, e.g., national norms or the facility's historical norms, if others are not available.

General Process Measures

Note: "Documentation" refers to written evidence as to whether a procedure/discussion was indicated/done or not indicated/not done.

*Rates (percentages) are obtained by multiplying each calculated fraction by 100 (for example, if 15 people were assessed for pain out of 45 who should have been assessed for pain, then the rate is (15/45) * 100 = .33 *100 = 33.3%.*

All measures marked with an asterisk (*) are applicable for practitioners only.

Clinical Process Measures
Recognition

Measure	Numerator (N) Denominator (D)	Pre-Implementation Rate	3 Month Post-Implementation Rate	6 Month Post - Implementation Rate	9 Month Post-Implementation Rate	12 Month Post-Implementation Rate
% of patients with documented assessment for pain using standardized tool on admission	N = # of patients with documented assessment for pain using standardized tool D = # of all patients on admission					
% of patients with documented assessment for pain using standardized tool at each quarterly review	N = # of patients with documented assessment for pain using standardized tool at each quarterly review D = # of all patients at quarterly review					
% of patients with documented assessment for pain using standardized tool at each reported change of condition requiring MDS assessment	N = # of patients with documented assessment for pain using standardized tool at each reported change of condition requiring MDS assessment D = # of all patients					
% of patients with cognitive and language deficit receiving targeted pain assessment	N = # of patients with cognitive and language deficit receiving targeted pain assessment D = # of all patients with diagnosed cognitive and/or language deficit					

Assessment

Measure	Numerator (N) Denominator (D)	Pre-Implementation Rate	3 Month Post - Implementation Rate	6 Month Post - Implementation Rate	9 Month Post - Implementation Rate	12 Month Post-Implementation Rate
% of patients with documented assessment by licensed nurse of a sufficiently detailed evaluation to characterize the pain	N = # of patients with documented assessment by licensed nurse of a sufficiently detailed evaluation to characterize the pain D = # of all patients with reported pain					
*% of patients with documentation showing that the practitioner performed laboratory, radiologic, and other diagnostic tests as appropriate	N = # of patients with documentation showing that the practitioner performed laboratory, radiologic, and other diagnostic tests as appropriate D = # of all patients with reported pain					
*% of patients with documentation by the practitioner that summarizes the characteristics and causes of the patient's pain	N = # of patients with documentation that summarizes the characteristics and causes of the patient's pain D = # of all patients with reported pain					
% of patients with documented assessment of the impact of pain on function and quality of life	N = # of patients with documented assessment of the impact of pain on function and quality of life D = # of all patients with reported pain					

Treatment

Measure	Numerator (N) Denominator (D)	Pre-Implementation Rate	3 Month Post - Implementation Rate	6 Month Post - Implementation Rate	9 Month Post - Implementation Rate	12 Month Post - Implementation Rate
% patients with documented person-centered inter-professional care plan for acute or chronic pain	N = # of patients with documented person-centered inter-professional care plan for acute or chronic pain D = # of all patients with reported pain					
% patients with established set goals for pain relief	N = # of patients with established set goals for pain relief D = # of all patients with reported pain					
*% patients with documented medication regimen with evidence of titration/adjustment in accordance with WHO step ladder	N = # of patients with documented medication regimen with evidence of titration/adjustment in accordance with WHO step ladder D = # of all patients receiving pain medication					
*% patients on pain medications with adjunctive (CAM, PT etc.) therapies to assist in pain relief	N = # of patients on pain medications with adjunctive therapies to assist in pain relief D = # of all patients receiving medications to treat pain					
*% patients on opioid medications receiving an appropriate constipation prevention regime	N = # of patients on opioid medications receiving an appropriate constipation prevention regime D = # of all patients on opioid medications					

Monitoring

Measure	Numerator (N) Denominator (D)	Pre-Implementation Rate	3 Month Post - Implementation Rate	6 Month Post - Implementation Rate	9 Month Post - Implementation Rate	12 Month Post - Implementation Rate
*% patients with periodic documented assessment of effectiveness of pain management by practitioner	N = # of patients with periodic documented assessment of effectiveness of pain management by practitioner D = # of all patients with reported pain					
% patients with periodic documented assessment by licensed nursing staff of effectiveness of pain management	N = # of patients with periodic documented assessment by licensed nursing staff of effectiveness of pain management D = # of all patients with reported pain					
% patients with periodic documented assessment by licensed nursing staff of effectiveness of pain management using same standardized tool pain originally assessed with	N = # of patients with periodic documented assessment by licensed nursing staff of effectiveness of pain management using same standardized tool pain originally assessed with D = # of all patients with reported pain					
*% patients with adjustments made to treatment plan by practitioner when pain management plan is not effective	N = # of patients with adjustments to treatment plan by practitioner when pain management is not effective D = # of all patients with non-effective pain management plans					

Clinical Outcome Measures

Measure	Numerator (N) Denominator (D)	Pre-Implementation Rate	3 Month Post - Implementation Rate	6 Month Post - Implementation Rate	9 Month Post - Implementation Rate	12 Month Post-Implementation Rate
% patients with Adverse Drug Reactions (ADRs) related to pain medications	N = # of patients with ADRs related to pain medications D = # of all patients receiving pain medication					
% patients with controlled ADRs to pain medications	N = # of patients with controlled ADRs to pain medications D = # of all patients receiving pain medication who had an ADR					
% patients with documented reduction of pain symptoms	N = # of patients with documented reduction of pain symptoms D = # of all patients with reported pain who received treatment					
% patients documented with achieving pain control goals after treatment	N = # of patients documented with achieving pain control goals after treatment D = # of all patients with reported pain who received treatment					
% patients with severe opioid-related constipation or fecal impaction	N = # of patients with severe opioid-related constipation or fecal impaction D = # of all patients receiving opioid treatment for pain					

Summary of Practitioner Responsibilities

Implementing the AMDA Pain Management Guideline

RECOGNITION / PROBLEM IDENTIFICATION
Identifying the presence of pain - Ask the nursing staff periodically whether your patients are having pain, especially if they have predisposing factors (for example, recent surgery, symptomatic osteoarthritis, peripheral neuropathy)
- On rounds, ask responsive patients about pain symptoms and observe less communicative patients for non-specific symptoms (restlessness, grimacing, fidgeting, etc.) that might represent pain
Characterizing the pain - Document key pain characteristics (i.e., location, frequency, intensity, and other important features)
ASSESSMENT / DIAGNOSIS / CAUSE IDENTIFICATION
Identifying causes of pain - In conjunction with nursing staff, look for or confirm cause(s) of pain OR explain why the individual should not be tested or evaluated OR explain why identifying causes would not change the treatment
TREATMENT / PROBLEM MANAGEMENT
Rationale for Treatment - Identify goals (correcting cause, controlling pain despite not being able to address causes, etc.) in relation to a patient's pain - If pertinent, explain why cause(s) of a patient's pain cannot or should not be treated.
Management of Pain - Select pain management approaches (including any medications) with the lowest feasible risk or likelihood of complications, based on the individual's condition, causes, risk factors, ability to cooperate, etc.
- If pain is not readily controlled, help identify other feasible options for pain management OR identify why continuing current approaches is warranted
Rationale for medication selection in presence of adverse drug reactions (ADR) or high ADR risk - If a higher-risk pain medication or a dose more likely to be associated with undesired side effects is used, explain why benefits outweigh significant risks, or why a lower-risk analgesic could not be used
MONITORING
Basis for continuing treatments - Periodically document status of pain
- Evaluate basis for continuing, changing, or discontinuing current pain management
Managing adverse drug reactions (ADRs) - Seek and manage significant ADRs related to pain medications by changing or stopping the medication(s) or doses OR explain why alternatives were not feasible

Frequently Asked Questions (FAQs)

Pain Management in the Long-Term Care Setting

How often should a facility assess all residents for the presence of pain, including residents who are not complaining of pain?

On admission or readmission of an individual to a facility, the nursing assessment should address the presence or absence of pain. At a minimum, individuals should be asked if they are having pain whenever vital signs are taken. Individuals should be assessed for pain whenever there is a significant change in condition (e.g., after a fall or other trauma) or at any time it is suspected that they are in pain. The monthly nursing assessment — or at least the quarterly care plan update — should include a summary reassessment regarding the presence or absence of pain in all individuals.

How often should a facility assess residents for the presence of pain based on non-specific symptoms, such as grimacing and restlessness, in an individual who cannot give a history?

When symptoms such as agitation or grimacing that may reflect pain are identified initially, a nurse should assess/evaluate the individual for pain (for example, by observing the individual's reaction to movement, palpation or treatment applied to various body areas). At some point, the practitioner should assess the patient and then document whether the individual may be experiencing pain or if the symptoms are due to something else. If it is concluded that the individual's non-specific symptoms are due to something else, that should be documented. If these non-specific symptoms continue, similar observations for possible pain should be made at least whenever vital signs are taken.

In these cases, an alternative to a numeric (such as 0-5 or 0-10) pain scale should be used to document pain. For those who are less reliably verbal, but still communicative, questioning the patient works reasonably well. For non verbal individuals, a behavioral scale is appropriate.

How can a facility distinguish whether non-specific symptoms such as grimacing, restlessness, or lethargy in someone who cannot give a history may represent pain?

Non-specific symptoms can result from other conditions or problems such as delirium or adverse drug reactions (ADRs). It is reasonable to rule out these other important causes, especially where a predisposing situation may exist. For example, individuals who have been on diuretics and recently have been ill may have delirium due to fluid and electrolyte imbalance. And it would not be desirable to empirically add more medications to the regimen of someone who already may be suffering an ADR from a medication they are taking currently. This assessment should be done by the practitioners as it is looking for a differential diagnosis and is beyond the scope-of-practice of the unit nurse.

After ruling out other causes of non-specific symptoms (or explaining why they cannot or should not be sought), then a careful nursing assessment should try to identify sources of pain. An increase in grimacing or restlessness while moving a joint or positioning an individual in a certain manner may provide information about the source of pain. If a symptom or behavior appears to reflect distress or to impair an individual's functional ability and no other reasonable explanation for the symptoms has been found, it is reasonable to try empirical pain management as a way to improve quality of life or functional status. A positive response suggests that pain may have caused the symptoms. However, keep in mind that narcotic analgesics may cause drowsiness or decreased responsiveness, so that a decrease in symptoms could also reflect sedation instead of, or in addition to, pain relief.

It is reasonable to begin a therapeutic trial with a lower-potency, lower-risk analgesic such as acetaminophen (for example, 650 mg q4h 8AM-8PM OR q4h PRN 8PM-8AM) and then to modify this approach as needed. If there is no relief with a trial of analgesics, the non-specific symptoms may be due to something else. Again, this will need an assessment by the practitioner.

In reviewing whether your facility's responses to such situations are adequate, consider that it may take time to reach the correct conclusion, especially when the symptoms are non-specific. Ultimately, if a practitioner decides — after a facility's reasonable effort to identify and characterize the situation — that non-specific symptoms are not due to pain, and if there is at least some subsequent periodic effort to monitor for changes in those symptoms, the facility should be considered to have made a reasonable effort. Drawing a different conclusion about the cause of symptoms after considering alternative explanations should not be considered an undue delay in addressing pain.

How can a facility demonstrate that it has satisfactorily tried to identify pain characteristics?

The facility should use a protocol for identifying and managing pain. Pain should be quantified and characterized using the approaches specified in the policy. Periodic monitoring should occur. The facility's quality improvement process should assess the effectiveness of these efforts, for example, by striving for as few individuals as possible in the facility with more than mild or intermittent pain. Since it is not always possible to reach the proper conclusion or to resolve pain totally or immediately, it is important to acknowledge a facility's efforts to follow appropriate processes.

What should a facility do when it is determined that the causes of pain cannot be identified or it would not make a significant difference if they were identified?

A facility should document a "good faith" effort to look for causes, recognizing that this is harder with less communicative individuals. It is important to evaluate common body areas that could cause pain, including head/neck, upper and lower abdomen, lower back and the joints of the hands, hips and knees (which can be assessed through passive or active range of motion).

If the nursing staff cannot readily identify a source of pain, the attending practitioner should determine whether a more thorough work-up might affect the patient's ultimate outcome or if the pain should be managed empirically. Document if the cause cannot be identified or is identified but cannot be treated, and treat the pain symptomatically. However, it is undesirable to simply treat pain symptomatically for an extended time without at least considering or commenting on a possible underlying cause.

How much or how long should a facility assess for pain to demonstrate that it is making a sufficient effort?

Ongoing or chronic pain warrants continuing vigilance, as does any chronic illness such as diabetes or hypertension. Every facility should try to identify and manage pain on an ongoing basis. As discussed above, documentation should reflect that ongoing effort. At least, it is desirable to keep trying if symptoms persist that might reflect pain, especially in those individuals with chronic or irreversible causes of pain, such as patients actively at the end-of-life or those with advanced arthritis.

How can a facility demonstrate that it has identified appropriate goals for individual pain management?

A facility should use an appropriate standardized assessment tool, identify "none to minimal" pain as the ultimate goal for each individual (unless determined to be unattainable and noting that complete relief of pain is often not achievable with diseases/conditions such as osteoarthritis, diabetic neuropathy, etc.), document periodically the extent of pain using the chosen measures, and then try to achieve that level of comfort.

The facility's quality improvement process should assess the effectiveness of these efforts, for example, by reviewing how many individuals in the facility have more than mild or intermittent pain. Additionally, monitor the use of analgesic drugs for appropriateness. For example, there should be little or no use of pentazocine or meperidine, while other analgesics should be used appropriately and safely.

How many alternatives must a facility try in order to demonstrate that it has made a good faith effort to control a person's pain?

While there is no right number, the facility should demonstrate continued efforts to try to control pain to the point where the individual finds it to be at an acceptable level. It is appropriate to use a step-wise approach, such as trying a medication listed at each level of the World Health Organization (WHO) ladder. Then, if appropriate, the practitioner might add a complementary therapy or try additional or different medications. Generally, it may take several days to a week of trying each option before deciding whether it is working. A facility that is making a good faith effort to try to find a satisfactory solution should not be considered to be moving "too slowly." However, a practitioner should help periodically adjust a pain management regimen based on the individual's responses.

What should a facility do for individuals who continually complain of vague or nonspecific pain despite multiple efforts to medicate, manage, etc.?

The facility should consider alternative causes of those symptoms such as depression, anxiety disorder, or a hysterical personality disorder with somatization. The attending practitioner can request a psychiatric consultation if unsure of the diagnosis. Ultimately, a facility that has done a reasonable assessment and tried multiple medical, functional, and psychosocial management options may have done all it can do. This may be true even if staff still identify frequent pain complaints from an individual without any clear relationship with how much or how often pain medications are given. Although a desirable goal, total pain relief is not always attainable. It is not necessary — and may be inappropriate — to continue adding multiple analgesics to the regimen indefinitely. For example, one or two analgesics plus an antidepressant or anti-anxiety agent may have to suffice. At some point, the practitioner may need to document a decision to limit an individual's pain management regimen in order to avoid significant complications.

When should a facility consider that possible side effects or complications from trying to treat the pain may outweigh the efforts to relieve the pain?

In trying to achieve a tolerable level of pain, some side effects may have to be tolerated.

While pain medications are comparatively safe, undesirable consequences such as adverse drug reactions (ADRs) can occur, especially in those patients who are taking other medications that can interact with pain medications or cause similar or additional side effects. Practitioners should watch for common, predictable side effects, such as constipation, anorexia, depression, lethargy, and confusion, especially in predisposed individuals. The use of narcotic analgesics may present problems in individuals with a pre-existing substance abuse problem.

The nursing staff and consultant pharmacist should be alert for possible significant side effects and alert the practitioner when they occur. The practitioner should help decide whether serious side effects may outweigh the efforts to relieve pain. It is important to judge side effects in relation to the goals for each individual patient. It may be necessary to adjust medications if medication side effects impair function and quality of life as much or more as the pain itself. For instance, substantial lethargy or anorexia may be insignificant side effects in a dying individual with pain but significant in someone with a recent hip fracture who is expected to improve.

A trial reduction or change of medications may be indicated. It is important to recognize and address the possibility of significant side effects that are having a negative impact on an individual's function or quality of life.

How, and how often, should a facility document or demonstrate follow-up monitoring of pain status?

The facility should use a pain monitoring and assessment protocol over time and should identify an appropriate monitoring frequency for each individual's situation. The appropriate frequency of follow-up depends on the causes, severity, and management of the pain.

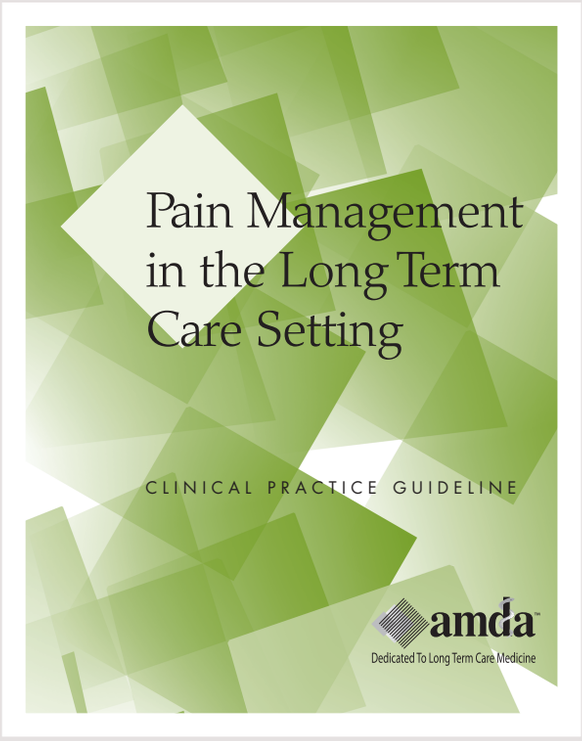
Generally, monitor more severe pain more frequently. For example, a terminally ill individual with severe pain secondary to metastatic cancer who requires regular doses of morphine for titration to an acceptable level of pain may require revaluation every one or two hours.

Periodically reassess anyone with a history of pain or who is receiving analgesics to determine whether pain is controlled. It may be necessary to monitor someone with moderate to severe pain or a recent worsening of pain several times daily or more often, at least until the pain is controlled and its effects on quality of life and function are minimized. Once pain is controlled and pain management is stabilized, reassess for pain when vital signs are taken or with any significant change in condition, and summarize the status of chronic pain approximately every 60-90 days. Review and reconsider current approaches if pain does not respond readily to the current treatment regimen or requires additional PRN medications.

AMDA Pain Management Clinical Practice Guideline (CPG)

SLIDE NOTES

For Medical Directors and Attending Practitioners



SLIDE 1: No Notes

SLIDE 2: No Notes

SLIDE 3: No Notes

SLIDE 4:

We recognize people who reside in post-acute/long-term care facilities are residents. However, throughout the guideline, the term patient(s), is used since we are addressing individuals within the context of treating a medical condition.

1. American Geriatrics Society (AGS) Panel on the Pharmacological Management of Persistent Pain in Older Persons. Pharmacological management of persistent pain in older persons. J Am Geriatr Soc 2009; 57: 1331-1346.

SLIDE 5:

- Media reports, government and public reaction, and occasional lawsuits regarding pain management have begun to put pressure on long-term care facilities and practitioners regarding pain management.
- The Centers for Medicare and Medicaid (CMS) kicked off a national initiative to improve the quality of care in nursing facilities called the Nursing Home Quality Initiative (NHQI). The prevalence of pain in nursing facility patients is one of several quality measures chosen for study in both chronic and post-acute patient populations. The NHQI website provides consumer and provider information regarding the quality of care in nursing homes. NHQI discusses quality measures that are shown at the Nursing Home Compare website (medicare.gov). This website allows consumers, providers, States and researchers to compare information on nursing homes.

2. Institute of Medicine. Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research. Washington, DC: The National Academies Press. 2011.

SLIDE 6:

1. American Geriatrics Society (AGS) Panel on the Pharmacological Management of Persistent Pain in Older Persons. Pharmacological management of persistent pain in older persons. J Am Geriatr Soc 2009; 57: 1331-1346.

3. Ferrell BA. Pain evaluation and management in the nursing home. Ann Intern Med 1995; 123:681-687.

4. AGS Panel on Persistent Pain in Older Persons. The management of persistent pain in older persons. J Am Geriatr Soc 2002; 50: S205-224.

SLIDE 7:

3. Ferrell BA. Pain evaluation and management in the nursing home. Ann Intern Med 1995; 123: 681–687.

5. Karp JF, Shega JW, Morone NE, Weiner DK. Advances in understanding the mechanisms and management of persistent pain in older adults. Br. J. Anaesth 2008; 101 (1): 111–120.

6. Crook J, Rideout E, Browne G. The prevalence of pain complaints in a general population. Pain 1984; 18: 299–314.

7. Fox PL, Raina P, Jadad AR. Prevalence and treatment of pain in older adults in nursing homes and other long-term care institutions: a systematic review. Can Med Assoc J 1999; 160: 329–333.

8. Scudds RJ, Ostbye T. Pain and pain-related interference with function in older Canadians: the Canadian Study of Health and Aging. Disabil Rehabil 2001; 23: 654–664.

9. Barkin RL, Barkin SJ, Barkin DS. Perception, assessment, treatment, and management of pain in the elderly. Clin Geriatr Med 2005; 21: 465-490, v.

SLIDE 8: No Notes

SLIDE 9:

1. American Geriatrics Society (AGS) Panel on the Pharmacological Management of Persistent Pain in Older Persons. Pharmacological management of persistent pain in older persons. J Am Geriatr Soc 2009; 57: 1331-1346.

SLIDE 10: No Notes

SLIDE 11: No Notes

SLIDE 12:

10. Reynolds KS, Hanson LC, DeVellis RF, et al. Disparities in pain management between cognitively intact and cognitively impaired nursing home residents. J Pain Symptom Manage 2008; 35: 388-396.

11. Fisher SE, Burgio LD, Thorn BE, Hardin JM. Obtaining self-report data from cognitively impaired elders: Methodological issues and clinical implications for nursing home pain assessment. Gerontologist 2006; 46: 81-88.

12. Zwakhalen SM, Koopmans RT, Geels PJ, et al. The prevalence of pain in nursing home residents with dementia measured using an observational pain scale. Eur J Pain 2009; 13: 89-93.

SLIDE 13: No Notes

SLIDE 14: No Notes

SLIDE 15: No Notes

SLIDE 16: No Notes

SLIDE 17:

13. Das SS. Grief and the imminent threat of non-being. Br J Psychiatry 1971; 118: 467-468.

14. Horowitz MJ. Stress-response syndromes: A review of posttraumatic and adjustment disorders. Hosp Community Psychiatry 1986; 37: 241-249.

15. Thobaben M. Clients' reaction to community violence: Posttraumatic stress disorder. Home Care Provid 1999; 4(5): 182-183.

SLIDE 18: No Notes

SLIDE 19: No Notes

SLIDE 20:

- Focusing on pain may lead us to interventions that not only reduce pain and suffering but directly affect the ability of a patient to walk, sleep, eat, think, socialize as well as impacting many other aspects of their life.
- When patients cannot sleep or exhibit problematic behavior, we may find pain has been the silent barrier for many of these patients trying to achieve a higher quality of life.
- Whether pain is managed in a hospital or a long-term facility, research has shown that it is generally under-recognized and under-treated.

3. Ferrell BA. Pain evaluation and management in the nursing home. Ann Intern Med 1995; 123: 681–687.

5. Karp JF, Shega JW, Morone NE, Weiner DK. Advances in understanding the mechanisms and management of persistent pain in older adults. Br. J. Anaesth 2008; 101 (1): 111–120.

6. Crook J, Rideout E, Browne G. The prevalence of pain complaints in a general population. Pain 1984; 18: 299–314.

7. Fox PL, Raina P, Jadad AR. Prevalence and treatment of pain in older adults in nursing homes and other long-term care institutions: a systematic review. Can Med Assoc J 1999; 160: 329–333.

8. Scudds RJ, Ostbye T. Pain and pain-related interference with function in older Canadians: the Canadian Study of Health and Aging. Disabil Rehabil 2001; 23: 654–664.

SLIDE 21: No Notes

SLIDE 22: No Notes

SLIDE 23: No Notes

SLIDE 24: No Notes

SLIDE 25: No Notes

SLIDE 26: No Notes

SLIDE 27:

- Racial, ethnic and gender bias held by both patients and caregivers may hinder patients from reporting pain and may reduce caregivers' sensitivity to the signs and symptoms of pain.

SLIDE 28: No Notes

SLIDE 29:

- Caregiving staff may not be skilled at assessing or evaluating pain or at using valid pain screening tools.
- Direct caregiving staff or supervisors may be unaware of the availability of pain assessment tools specifically for use with cognitively impaired patients and, therefore, may fail to recognize behaviors or language that suggest the presence of pain.
- Some LTC workers may believe that pain is a normal or an unavoidable factor in the aging process and, hence, may not take the initiative to assess or evaluate, address, or reduce pain in the patients they care for.
- The legal and regulatory requirements involved in prescribing Schedule II medications and other controlled substances may be perceived by the facility as a significant barrier to the implementation of pain management guidelines.

SLIDE 30: No Notes

SLIDE 31:

- If we have PRN pain medications routinely ordered for the patient we should be able to assess which PRN medication is most appropriate for the type of pain the patient is experiencing. We can carry out "Best Practice" by following the World Health Organization's (WHO) analgesic ladder that emphasizes the lowest dose of the least potent analgesic first. If pain control is not achieved then we can increase the dose or switch to a stronger analgesic until pain relief is achieved.
- A potential error may occur when the patient is admitted to the facility with medications prescribed while in the hospital before the patient's primary physician at the nursing home has reviewed the orders. Inappropriate medications may be on that admission order.
- Another potential error may occur when the patient's primary physician is unavailable. A physician on-call who is not familiar with the patient or may not have experience treating geriatric patients may be asked to write an order for a pain medication.

  Our patients are relying on us to be their advocates for appropriate care.

SLIDE 32:

- When a patient is in pain we may not be aware of the pain because the patient may not let us know. One of the more important parts of pain management is the screening and assessment of pain. The information gathered from the assessment of pain is essential to the treatment of pain. It may

be unnecessary and inappropriate to treat mild pain with medication that has been ordered for the patient but is prescribed for a moderate to severe pain.

SLIDE 33:

- The Three Step WHO Analgesic Ladder is suggested for use based on the premise that health care professionals should learn to use a few pain relieving drugs well. One can move a step up the ladder if there is no relief obtained after a drug is used in the recommended dosage and frequency. Only one drug from each of the groups should be used at the same time. Should a drug cease to be effective, a switch should be made to one that is definitely stronger if it is available. The side effects of both the analgesic and the adjuvant should be kept in mind and where required, drugs to counteract these efforts should be prescribed.

  Acetaminophen – How much is too much? Ask this question to your nurses. Post a chart somewhere or everywhere.

  - Max dosage is 3000mg/24hr. Dose every 4-6 hours. Can be toxic to liver. This drug is found in many different medications.

  Aspirin – What effects does aspirin have on the individual patient? Can cause gastric bleeding and abnormal platelet function.

  NSAIDs – What are they? Ibuprofen (Advil, Motrin, Nuprin). Can cause gastric bleeding, renal impairment, abnormal platelet function, constipation, confusion, headaches in older patients.

  Codeine – Often combined with aspirin or acetaminophen. No pain relief for 10% of population.

  Hydrocodone – In Lorcet, Lortab, Vicodin.

  Oxycodone – In Percocet, Percodan, Tyox, others.

  Tramadol – May precipitate seizures. May cause dizziness.

SLIDE 34:

- Reacting to pain has historically been the solitary duty of the patient's charge nurse.
- Pain management is the duty of all staff in the facility who care for the patient.

SLIDE 35: No Notes

SLIDE 36:

AMDA's guideline for pain management consists of four major areas:

1. **Recognition** of a person who is having pain or at risk for pain
2. **Assessment** of the person with pain to identify details and seek underlying causes and impact of the pain on the person's quality of life
3. **Treatment** of the person with pain issues
4. **Monitoring** of treatment

SLIDE 37:

Recognition of a person who is having pain:

- Evaluate the patient for pain upon admission, during periodic scheduled assessments, and whenever a change occurs in his or her condition (e.g., after a fall or other trauma or when a change occurs in the patient's behavior, daily routines, or mental status).
- The best indicator of the pain experience is the patient's own report. Assessment by the practitioner must include an assessment of pain intensity and the effect of pain on activities of daily living.

SLIDE 38:

16. CMS. Minimum Data Set, Version 3.0 (MDS 3.0). Baltimore, MD: Centers for Medicare and Medicaid Services. Available at: https://www.cms.gov/nursinghomequalityinits/. Accessed 12/2/11.

SLIDE 39:

- Key times to observe pain behaviors and to inquire about the presence and intensity of pain include during ambulation, bathing, dressing, meal time, recreational activities, therapy sessions, transfers, turning and repositioning, continence care, and wound care. It is also often helpful to ask family members how the patient historically has expressed pain or discomfort.
- In a review of the literature on pain in nursing homes, *Swafford et al (Swafford KL, Miller LL, Tsai PF, et al. Improving the process of pain care in nursing homes: A literature synthesis. J Am Geriatr Soc 2009; 57: 1080-1087.)* found that pain management improved in nursing homes that documented the use of a comprehensive pain assessment tool. Finding appropriate evidence-based tools can be challenging for many nursing homes.
- The American Geriatrics Society has published specific recommendations for pain assessment. *(AGS Panel on Persistent Pain in Older Persons. The management of persistent pain in older persons. J Am Geriatr Soc 2002; 50: S205-224.)*
- In addition, tools and resources for both cognitively impaired and cognitively intact patients that can be downloaded and customized to the facility are available from several sources online.
  - *Geriatricpain.org. Web site. Available at: http://www.geriatricpain.org. Accessed 12/2/11.*
  - *Med-Pass Inc. Pain evaluation form. Available at: http://www.med-pass.com/shopping/shopexd.asp?id=8193&MarketID=1300000&CategoryID=1321300. Last updated November 9, 2011.*
  - *PartnersAgainstPain.com. Pain management tools. Stamford, CT: Pudue Pharma, 2011. Available at: http://www.partnersagainstpain.com/hcp/pain-assessment/tools.aspx.*
- For consistency, the same assessment tool should be administered after an intervention to monitor the effectiveness of the pain intervention (e.g., 1 hour after a dose of a pain medication).

17. Cohen-Mansfield J, Lipson S. Pain in cognitively impaired nursing home residents: How well are physicians diagnosing it? J Am Geriatr Soc 2002; 50: 1039-1044.

SLIDE 40:

Source Table

- *Hurley AC, Volicer BJ, Hanrahan PA, et al. Assessment of discomfort in advanced Alzheimer patients. Res Nurs Health 1992; 15: 369-377.*
- *Horgas A, Miller L. Pain assessment in people with dementia. Am J Nurs 2008; 108: 62-70; quiz 71.*
- *Herr K, Bjoro K, Decker S. Tools for assessment of pain in nonverbal older adults with dementia: a state-of-the-science review. J Pain Symptom Manage 2006; 31: 170-192.*
- *Ingrid B, Marsella A. Factors influencing exercise participation by clients in long-term care. Perspectives 2008; 32: 5-11.*

SLIDE 41:

Appropriate members of the interdisciplinary team should

- Review the patient's known diagnoses or conditions and identify possible additional factors that may be causing or contributing to pain.
- Ask the patient to rate the intensity of his or her pain, using either a numerical score or a verbal or visual descriptor appropriate for and preferred by the patient.
- Ask about key characteristics of the pain (e.g., duration, frequency, location, onset, pattern, radiation) and for words that describe its qualities (e.g., aching, burning, throbbing).
- Use a specialized assessment tool for patients who cannot answer questions.

- Note the factors that make the pain better or worse.
- Identify recent exacerbations of persistent pain (Is there a pattern?).
- Assess or evaluate how pain is affecting the patient's mood and its impact on activities of daily living (ADLs), sleep, and selected quality-of-life measures (e.g., participation in hobbies, visiting with family).
- Determine whether the current level of pain relief is consistent with the patient's care goals. Some patients may prefer to tolerate a certain level of pain to avoid analgesic medications, medication side effects, or other interventions.
- Note the dosage and frequency of administration of all pain medications.
- Note all treatments that the patient is receiving for pain, including all nonpharmacologic and CAM therapies.
- Review the effectiveness of specific drugs and other treatments used in the past to treat pain.
- Discontinue the use of drugs or other treatments that are ineffective.

SLIDE 42:

- A good example of this point can be found when using the Wong-Baker Face Scale with cognitively impaired patients. Studies using the scale with cognitively impaired patients have found that as the cognition declines, the patient will pick the "happiest" face on the scale whether the patient has pain or not.

SLIDE 43: No Notes

SLIDE 44: No Notes

SLIDE 45:

- These pain scales have been validated for assessments on patients you have that may not be able to verbally express their pain.

SLIDE 46:

- Patients with acute injury should receive pain medication while awaiting diagnostic testing or transfer to the emergency department.
- A relevant study showed that morphine given to patients with acute abdominal pain did not adversely affect the ability to make an accurate diagnostic assessment. *(Thomas SH, Silen W, Cheema F, et al. Effects of morphine analgesia on diagnostic accuracy in emergency department patients with abdominal pain: A prospective, randomized trial. J Am Coll Surg 2003; 196: 18-31.)*

SLIDE 47:

- Assess the person with pain to identify details and seek underlying causes.

4. AGS Panel on Persistent Pain in Older Persons. The management of persistent pain in older persons. J Am Geriatr Soc 2002; 50: S205-224.

SLIDE 48: No Notes

SLIDE 49:

Second bullet note:

- In such circumstances, an evaluation of the effectiveness of appropriate comfort measures may suffice.

SLIDE 50:

First bullet notes: For example,

- Pain from a witnessed or unwitnessed fall could indicate an orthopedic injury.

- Headache pain with vision involvement could indicate temporal arteritis.
- Bone pain should raise suspicion of metastasis.
- Severe limb pain should raise suspicion of acute vascular events, such as arterial occlusion, embolus, thrombosis, or aneurysm, or neurologic compromise, such as radiculopathy or peripheral nerve entrapment.
- Pain in a unilateral dermatomal distribution, even before skin lesions are visible, should raise suspicion of herpes zoster.

SLIDE 51:

The medical history should include the following:

- The patient's existing diagnoses and conditions that may be causing or contributing to pain.
- Information from the patient's family or the interdisciplinary team that may suggest other diagnoses and conditions. For example, a report of weight loss prior to admission, especially in a patient with cognitive impairment, should prompt a thorough examination of the oral cavity for the presence of painful lesions.
- The patient's current medications. Consider asking the consultant pharmacist to review the medication regimen with particular attention to medications that may cause or exacerbate painful conditions. These could include opioid analgesics (abdominal pain); bisphosphonates (jaw, thigh, or hip pain); antiglaucoma medications (brow pain or headache); antidepressants and atypical antipsychotics (neuralgia, neuropathic pain, migraine, paresthesia); nonsteroidal anti-inflammatory drugs (NSAIDs, GI bleeding with pain and abdominal tenderness); antiretrovirals (neuropathy); and infusion and injectable medications (pain at the site of injection).
- Prior diagnostic evaluations, interventions, and treatments for pain.
- Beneficial and adverse effects of medications previously used to treat pain.

SLIDE 52:

For your reference, **Step 10:** Summarize the characteristics and causes of the patent's pain and assess the impact of pain on function and quality of life.

Step 8 notes:

- Consider consultation when the diagnoses or conditions contributing to pain are still not clear or if special skills are required for definitive treatment.
- For example, a dental consultation may be appropriate when oral or dental disease is suspected, or a consultant pharmacist may help to identify medications that could cause or exacerbate pain (e.g., NSAIDs and anticonvulsants such as divalproex sodium and lamotrigine).
- Additionally, a neurologist, orthopedist, physiatrist, or specialist in pain or palliative medicine may provide insights into the causes of pain and suggest treatment options.

SLIDE 53:

Step 10 notes: The practitioner and staff should collaborate on documenting a summary of the patient's situation that includes

- A description of the diagnoses and conditions contributing to the patient's pain or the reasons that the causes of the pain could not be established;
- A list of possible treatments for underlying diagnoses or conditions that are contributing to the patient's pain;
- Reasons for recommending the use or nonuse of identified treatment options, taking into account the patient's state of health, prognosis, and advance care directives, as well as the preferences of the patient and family or health care proxy; and
- Provision for access to family and friends, life review, quality life experiences, and completion of unfinished business at the end of life.

SLIDE 54:

Treatment

As a matter of course, all patients should be kept clean, dry, and comfortably positioned in bed or in a chair. Additional interventions include the following:

- Reassuring words and touch
- A back rub, hot or cold compresses, whirlpool bath, or shower (especially if such interventions have been helpful in the past)
- Repositioning
- Relaxation techniques as appropriate (e.g., aromatherapy, massage therapy)
- Comforting music
- The opportunity to talk to caregivers and others about pain, its causes and consequences, and the reasons for and expectations of the plan for treating the pain
- The services of a chaplain or other appropriate pastoral counselor
- Specialized equipment such as air-circulating beds
- Programs such as "Bathing Without a Battle" *(Barrick A, Rader J, Hoeffer B, et al., eds. Bathing Without a Battle: Person-Directed Care of Individuals with Dementia. 2nd ed. 2008. New York: Springer Publishing.)* to decrease the discomfort that ADLs may cause
- Pet therapy

SLIDE 55:

Step 11 notes: Factors influencing the choice of treatments include:

- The patient's underlying diagnoses or conditions that are causing or contributing to pain
- The causes, location, nature, and severity of the pain
- The patient's preferences and wishes as expressed directly, by a family member or other health care proxy, or in an advance directive
- The patient's goal for pain management with respect to what constitutes an acceptable pain level, an acceptable sedation level, and acceptable side effects
- Preferred route of medication administration
- The availability of experienced providers
- Possible adverse medication effects
- Costs to the patient
- Costs of medication acquisition

Step 12 notes: Goals for pain relief:

- For patients with persistent pain, primary goals often include not only reducing pain intensity but also achieving functional outcomes such as improving independence in ADLs, participating in activities, or optimizing cognition, mood, or sleep.
- Complete pain relief is uncommon, but even partial relief can improve function or quality of life.
- Offer a realistic outlook to patients, families and even staff.
- Review the goals of treatment and possible medication side effects.
- Explain that it may take time to find the optimal intervention, that is, the medications or other approaches which are most effective at relieving discomfort and have the most tolerable adverse effects.

SLIDE 56: No Notes

SLIDE 57: No Notes

SLIDE 58: No Notes

SLIDE 59: No Notes

SLIDE 60:

- Generally, start with a low to moderate dose of medication and titrate upward until an acceptable balance is achieved between pain relief and medication side effects. (For further discussion of the titration of opioid medications, see the section *Opioid Titration* in AMDA's *Pain Management in the Long-Term Care Setting Clinical Practice Guideline*, p26.) The half-life of the medication should be considered in determining the interval of dosing. Reassess the medication's effectiveness frequently and adjust the dosage to meet the patient's goals for pain relief.

1. American Geriatrics Society (AGS) Panel on the Pharmacological Management of Persistent Pain in Older Persons. Pharmacological management of persistent pain in older persons. J Am Geriatr Soc 2009; 57: 1331-1346.

SLIDE 61:

The WHO also recommends administering analgesic medications

- By mouth if possible
- Around the clock for continuous pain
- According to the pain relief ladder
- Tailored to the individual patient
- With attention to detail

SLIDE 62: No Notes

SLIDE 63:

- In patients with mild to moderate pain who do not have liver disease and do not consume alcohol, acetaminophen is the analgesic of first choice. Acetaminophen may be particularly useful in patients with generalized, nonspecific pain complaints; non-inflammatory musculoskeletal or joint pain; or uncomplicated headache. Unless pain is severe (7 or higher on a 0 to 10 scale), it may be reasonable to begin treatment with acetaminophen, which is likely to improve pain with few side effects. For mild to moderate persistent pain and less severe acute pain, start with a low dose and increase as needed to provide relief but not to exceed 3000 mg per day.
- If acetaminophen fails to provide adequate relief or if the patient has an acute inflammatory condition, the practitioner may consider prescribing an NSAID. For most LTC patients, NSAID treatment should be limited to 7 to 10 days. NSAIDs provide only modest superiority to acetaminophen in the treatment of osteoarthritis among patients with pain at rest, at night, or after activity. This increased efficacy is accompanied by an increased risk for adverse cardiovascular, GI, cognitive, and renal effects. *(Recommendations for use of selective and nonselective nonsteroidal antiinflammatory drugs: An American College of Rheumatology white paper. Arthritis Rheum 2008; 59: 1058-1073.)*

Source Table 5 – Slide 63-65:

- *American Geriatrics Society (AGS) Panel on the Pharmacological Management of Persistent Pain in Older Persons. Pharmacological management of persistent pain in older persons. J Am Geriatr Soc 2009; 57: 1331-1346.*
- *Elsevier/Gold Standard. Clinical Pharmacology [resource online]. Tampa, FL: Elsevier/Gold Standard, 2011. Available at: http://www.goldstandard.com/product/drug-reference-patienteducation/clinical-pharmacology/. Accessed 12/2/11.*
- *Graham DJ. COX-2 inhibitors, other NSAIDs, and cardiovascular risk: The seduction of common sense. JAMA 2006; 296: 1653-1656.*

SLIDE 64:

- Celecoxib is the only currently available selective cyclooxygenase-2 (COX-2) inhibitor; meloxicam is a preferential COX-2 inhibitor. All other available NSAIDs are nonselective, inhibiting both COX-1 and COX-2. Patients may benefit from a trial of different NSAIDs to achieve a satisfactory combination of symptom relief and tolerable adverse effects. The long-term use of full-dose, longer half-life, nonselective NSAIDs such as naproxen, oxaprozin, and piroxicam is generally not recommended in geriatric patients because of its potential to produce GI bleeding, renal failure, high blood pressure, and heart failure. *(Fick DM, Cooper JW, Wade WE, et al. Updating the Beers criteria for potentially inappropriate medication use in older adults: Results of a US consensus panel of experts. Arch Intern Med 2003; 163: 2716-2724.)*

SLIDE 65:

- Tramadol is a centrally acting analgesic that acts via the mu (μ) opioid receptor but may also affect pain by means of noradrenergic and serotonergic effects. Potentially effective for both nociceptive and neuropathic pain, tramadol may be the next agent to consider if pain is not relieved by acetaminophen or NSAIDs. It can be used either alone or in combination with acetaminophen or NSAIDs to manage moderate to moderately severe pain. Lower doses of tramadol in combination with acetaminophen may offer better pain relief than higher doses of tramadol alone. Tramadol's potential adverse effects include confusion, constipation, dizziness, gait disturbances, nausea, orthostatic hypotension, and sleepiness. Because it lowers the seizure threshold, tramadol can precipitate seizures in patients who have or are at risk for a seizure disorder.

SLIDE 66:

Source Table 6:

- *Recommendations for use of selective and nonselective nonsteroidal antiinflammatory drugs: An American College of Rheumatology white paper. Arthritis Rheum 2008; 59: 1058-1073.*

SLIDE 67: No Notes

SLIDE 68: No Notes

SLIDE 69:

Source Table 7 – Slides 69-71:

- *Moore RA, Derry S, McQuay HJ. Topical agents in the treatment of rheumatic pain. Rheum Dis Clin North Am 2008; 34: 415-432.*
- *Lin J, Zhang W, Jones A, Doherty M. Efficacy of topical non-steroidal anti-inflammatory drugs in the treatment of osteoarthritis: Meta-analysis of randomised controlled trials. BMJ (Clin Res ed) 2004; 329: 324.*
- *Galer BS, Gammaitoni AR, Oleka N, et al. Use of the lidocaine patch 5% in reducing intensity of various pain qualities reported by patients with low-back pain. Curr Med Res Opin 2004; 20 Suppl 2: S5-12.*
- *Galer BS, Sheldon E, Patel N, et al. Topical lidocaine patch 5% may target a novel underlying pain mechanism in osteoarthritis. Curr Med Res Opin 2004; 20: 1455-1458.*
- *Gammaitoni AR, Galer BS, Onawola R, et al. Lidocaine patch 5% and its positive impact on pain qualities in osteoarthritis: Results of a pilot 2-week, open-label study using the Neuropathic Pain Scale. Curr Med Res Opin 2004; 20 Suppl 2: S13-19.*

SLIDE 70:

- Topical NSAIDs have proven effective in the short term treatment of localized arthritic pain. When compared with oral NSAIDs, topical NSAIDs showed statistically similar rates of treatment success. Unlike oral NSAIDs, topical NSAIDs do not significantly increase the risk of GI events.
- Diclofenac is the only FDA-approved, commercially available topical NSAID. NSAID preparations containing ibuprofen, indomethacin, ketoprofen, naproxen, and others may be available from some compounding pharmacies.

SLIDE 71:

- Lidocaine patches are indicated for the relief of pain associated with post-herpetic neuralgia. The administration of topical lidocaine patches may present some challenges to nursing staff. Lidocaine patches should be applied directly to the most painful site or sites and only to intact skin. Before applying a patch, inspect the skin to ensure that the previous patches have been removed to prevent a systemic overdose of lidocaine. The pharmacist should notify the facility of drug interactions with some antiarrhythmic medications that may cause additive toxic effects. Sites of application and times of application and removal should be documented on the patient's medication administration record. Topical anesthetic preparations can also be useful for a variety of dermal and mucosal lesions.

SLIDE 72:

- Although evidence of long-term effectiveness for persistent noncancer pain in all age groups is lacking, controlled trials have established the efficacy of various opioids in the treatment of persistent pain associated with musculoskeletal conditions and in the management of several neuropathic pain conditions.
- Because the consequences of adverse events in the elderly can be serious, opioid analgesics should be chosen on the basis of safety and tolerability considerations *[Pergolizzi J, Boger RH, Budd K, et al. Opioids and the management of chronic severe pain in the elderly: Consensus statement of an International Expert Panel with focus on the six clinically most often used World Health Organization Step III opioids (buprenorphine, fentanyl, hydromorphone, methadone, morphine, oxycodone). Pain Pract 2008; 8: 287-313.]* and should be prescribed on a trial basis with clearly defined therapeutic goals.
- Long-term use of opioids for pain relief has not been shown to cause organ damage. (Krames ES. Rational use of opioids for nonmalignant pain*. J Pharm Care Pain Symp Control 1997; 5: 3-15.*)
- Addiction is unlikely to develop when opioids are appropriately prescribed to relieve acute or persistent pain; however, withdrawal symptoms, including diarrhea, abdominal cramps, chills, and increased pain, can be expected when regularly dosed opioids are stopped abruptly without tapering.

1. American Geriatrics Society (AGS) Panel on the Pharmacological Management of Persistent Pain in Older Persons. Pharmacological management of persistent pain in older persons. J Am Geriatr Soc 2009; 57: 1331-1346.

18. Portenoy RK. Opiate therapy for chronic noncancer pain: Can we get past the bias? Am Pain Soc Bull 1991; 1: 4-7.

SLIDE 73:

Adverse Effects

- In terms of fracture risk, long-acting opioids are preferable to short-acting opioids. *(Miller M, Sturmer T, Azrael D, et al. Opioid analgesics and the risk of fractures in older adults with arthritis. J Am Geriatr Soc 2011; 59: 430-438.)*
- Although the constipating effects of opioids persist throughout the course of treatment, patients develop tolerance to most of the other symptoms within a few days.
- To minimize adverse opioid effects, review the patient's entire medication regimen to determine whether other medications with adverse effects similar to those of opioids can be adjusted or eliminated.
- Respiratory depression is both the most-feared and the least-common adverse effect of opioid analgesics. Although a degree of concern about respiratory depression is appropriate, it does not warrant withholding opioid treatment from a patient with moderate or severe pain that is unresponsive to other medications. *(The use of opioids for the treatment of chronic pain. A consensus statement from the American Academy of Pain Medicine and the American Pain Society. Clin J Pain 1997; 13: 6-8.)*

SLIDE 74:

Morphine

- Several pure opioid agonists exist, but morphine is considered by most practitioners as the standard comparator for other opioids. Morphine is available in both immediate- and sustained release form, including once-daily dosing; it may be given orally, sublingually, rectally (off-label), topically (off-label), via inhalation (off-label), or parenterally.
- Because pure opioid agonists have no maximum effective dose (ceiling effect), the dose can be increased until the desired analgesic effect is obtained or until side effects become intolerable. Note that in patients with significant renal impairment, however, some morphine metabolites may cause neurotoxicity, especially myoclonus, and other adverse effects. In such patients, alternative opioid products should be used.

Beginning Opioid Therapy

- In patients who have not previously taken opioids, start with a low dose and titrate slowly. Begin by giving an immediate-release preparation. After establishing the daily dose needed to control the patient's pain, consider converting the daily dose to an equivalent dose of a sustained-release preparation given every 8 to 24 hours.
- Patients receiving scheduled doses of opioids may still need rescue doses of an immediate-release opioid for breakthrough pain. The patient can take about 10% to 15% of the total daily opioid dose every hour in a short-acting, immediate-release form as needed for breakthrough pain. *(Forman WB. Opioid analgesic drugs in the elderly. Clin Geriatr Med 1996; 12: 489-500; Bial A, Levine S. UNIPAC 3: Assessment and Treatment of Physical Pain Associated with Life-Limiting Illness. 2008. Glenview: American Academy of Hopsice and Palliative Medicine.)*
- If the patient routinely requires more than two to four rescue doses daily, increase the scheduled dosage accordingly. All patients starting an opioid should be placed on a scheduled bowel regimen to prevent constipation, unless a compelling reason (e.g., colostomy, chronic diarrhea) exists to avoid a laxative regimen.

Source Table 8:

- *American Geriatrics Society (AGS) Panel on the Pharmacological Management of Persistent Pain in Older Persons. Pharmacological management of persistent pain in older persons. J Am Geriatr Soc 2009; 57: 1331-1346.*
- *Equianalgesic dosing of opioids for pain management. Pharmacist's Letter/Prescriber's Letter 2010; 26(7): 260712.*
- *Compassion and Support. Equianalgesic Table for Adults. 2010. Available at: http://www.compassionandsupport.org/index.php/for_professionals/pain_management. Accessed 12/8/11.*

SLIDE 75:

Opioid Titration

- The optimal dose of an opioid is the dose that relieves a patient's pain sufficiently. Once it has been determined that an opioid is required to relieve a patient's pain, the practitioner may need to increase the dose or shorten the administration interval to optimize pain relief.
- The dosing interval used during the titration phase is different from that used once a steady state is reached. For example, immediate-release oral morphine has a duration of action of 3 to 4 hours, but its peak effect for both pain relief and respiratory depression occurs within 30 to 60 minutes.

- Consequently, one can safely give additional doses of oral morphine as often as every 30 to 60 minutes during upward titration until the pain relief goal is reached or adverse effects are noted.
- It is helpful to use a monitoring tool such as the Opioid Initiation and Titration Worksheet provided in Appendix 2 of the AMDA guideline to record notification parameters (e.g., when facility staff should notify the practitioner), pain control goals, level of pain control, and adverse opioid effects during the first 24 to 48 hours of opioid initiation or upward titration.

SLIDE 76:

Source Table 10:

- *Walsh D, Rivera NI, Davis MP, et al. Strategies for pain management: Cleveland Clinic foundation guidelines for opioid dosing for cancer pain. Support Cancer Ther 2004; 1: 157-164.*

SLIDE 77: No Notes

SLIDE 78: No Notes

SLIDE 79:

Practitioners must be aware of some unique aspects of medication use for neuropathic pain.

- First, most recommendations and guidelines for treatment are based on treatment trials for diabetic neuropathy or post-herpetic neuralgia. Until more specific data become available, practitioners must extrapolate this knowledge to treatment of other types of neuropathic pain.
- Second, many of the medications commonly used to treat neuropathic pain do not have FDA-approved indications for this use. Therefore, when proposing to use a medication that is not specifically FDA approved for the treatment of neuropathic pain, the patient or health care proxy party should be notified of this fact.
- When appropriate, informed consent should be sought and documented on the basis of facility policy, community practice standards, and applicable state regulations.

SLIDE 80: No Notes

SLIDE 81:

- Consider referral to a pain specialist for treatment with the capsaicin 8% dermal patch in patients with refractory pain from post-herpetic neuralgia. *[Irving GA, Backonja M, Rauck R, et al. NGX-4010, a Capsaicin 8% Dermal Patch, Administered Alone or in Combination With Systemic Neuropathic Pain Medications, Reduces Pain in Patients With Postherpetic Neuralgia. Clin J Pain 2011 Jul 12; Jones VM, Moore KA, Peterson DM. Capsaicin 8% topical patch (Qutenza)—A review of the evidence. J Pain Palliat Care Pharmacother 2011; 25: 32-41; Wallace M, Pappagallo M. Qutenza(R): A capsaicin 8% patch for the management of postherpetic neuralgia. Expert Rev Neurother 2011; 11: 15-27.]*
- The role of opioids in the treatment of neuropathic pain, although debated in the past, is now accepted more and more. The current data suggest that earlier incorporation of opioids may be beneficial. *[Pergolizzi J, Boger RH, Budd K, et al. Opioids and the management of chronic severe pain in the elderly: Consensus statement of an International Expert Panel with focus on the six clinically most often used World Health Organization Step III opioids (buprenorphine, fentanyl, hydromorphone, methadone, morphine, oxycodone). Pain Pract 2008; 8: 287-313.]*
- Methadone, although not FDA-approved in the treatment of neuropathic pain, may be particularly effective. Recent data also suggest that combining gabapentin or pregabalin with a TCA or duloxetine may be beneficial in refractory cases of neuropathic pain. *[Tanenberg RJ, Irving GA, Risser RC, et al. Duloxetine, pregabalin, and duloxetine plus gabapentin for diabetic peripheral neuropathic pain management in patients with inadequate pain response to gabapentin: An open-label, randomized, noninferiority comparison. Mayo Clinic Proc 2011; 86: 615-626.]*
- Some medications used to treat neuropathic pain are often called **adjuvant analgesics,** or simply **adjuvants**, because they augment the effects of traditional analgesics such as acetaminophen, NSAIDs, and opioids. For a table of selected adjuvant medications and typical dosages, see Appendix 5 in the AMDA *Pain Management in the Long-Term Care Setting Clinical Practice Guideline.*

Source Table 12:

- *Dworkin RH, O'Connor AB, Backonja M, et al. Pharmacologic management of neuropathic pain: Evidence-based recommendations. Pain 2007; 132: 237-251.*

SLIDE 82:

- Meperidine is not appropriate for persistent pain management in the LTC setting because of its potential for adverse CNS effects and accumulation of toxic metabolites. The organs of the body that process most medications are the kidneys and liver.
- The partial opioid agonists butorphanol, nalbuphine, and pentazocine, as well as fixed-dose agonist–antagonist combination products, are not recommended because they have analgesic ceiling effects, can be associated with dysphoria and hallucinations, and may precipitate withdrawal in opioid-dependent patients.
- Acute and chronic use of the NSAIDs indomethacin, meclofenamate, piroxicam, and tolmetin are not recommended because of the higher frequency of more-serious side effects, such as peptic ulceration and GI hemorrhage, than occur with other NSAIDs. CNS adverse effects such as agitation, confusion, and hallucinations may also occur at a higher frequency with these medications. *[Griffin MR, Piper JM, Daugherty JR, et al. Nonsteroidal anti-inflammatory drug use and increased risk for peptic ulcer disease in elderly persons. Ann Intern Med 1991; 114: 257-263; Committee on Safety of Medicines. CSM Update. Non-steroidal anti-inflammatory drugs and serious gastrointestinal adverse reactions–2. Br Med J (Clin Res ed) 1986; 292: 1190-1191; Fries JF, Williams CA, Bloch DA. The relative toxicity of nonsteroidal antiinflammatory drugs. Arthritis Rheum 1991; 34: 1353-1360.]* In general, long-term use of any NSAID has certain risks; when this course is being considered, it is important to weigh the risks and the benefits. *(Fick DM, Cooper JW, Wade WE, et al. Updating the Beers criteria for potentially inappropriate medication use in older adults: Results of a US consensus panel of experts. Arch Intern Med 2003; 163: 2716-2724.)*
- There is a list of "potential" inappropriate medications for the geriatric population, the "Beer's List". *[American Geriatrics Society 2012 Beers Criteria Update Expert Panel. J Am Geriatr Soc. American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. 2012 Apr;60(4):616-31. doi: 10.1111/j.1532-5415.2012.03923.x. Epub 2012 Feb 29. www.americangeriatrics.org/files/.../beers/2012BeersCriteria_JAGS.pdf]* It is helpful to have information regarding these potentially inappropriate medications available for practitioners who are unfamiliar with geriatric care, both post-acute and long-term. It is possible you may want to prescribe a medication which appears on the Beer's List as you believe the benefits of the medication outweigh the risks. However, be sure to document the rationale for prescribing in the medical record.

SLIDE 83:

- Opioid-induced bowel dysfunction should be considered whenever a patient receiving opioids experiences abdominal cramping or distention, bloating, constipation, hard stools, nausea, painful defecation, or vomiting. *(Thomas JR, Cooney GA, Slatkin NE. Palliative care and pain: New strategies for managing opioid bowel dysfunction. J Palliat Med 2008; 11 Suppl 1: S1-19; quiz S21-12.)*
- Opioids' constipating effects result from decreased intestinal secretion, increased fluid resorption, and slowing of peristalsis. Patients do not develop tolerance to these effects.
- Increasing dietary fiber intake may be reasonable in active patients with good oral intake of food and fluids, but it is likely to be counterproductive in patients with advanced disease and poor oral intake.
- Methylnaltrexone, an injectable opioid antagonist, may be beneficial for opioid-induced constipation that does not respond to laxatives. *(Thomas J, Karver S, Cooney GA, et al. Methylnaltrexone for opioid-induced constipation in advanced illness. New Engl J Med 2008; 358: 2332-2343.)*

SLIDE 84:

- **CAM** is defined as "a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine." *[National Center for Complementary and Alternative Medicine, National Institutes of Health (NCCAM). CAM Basics: What is CAM? NCCAM Pub. No. D347. Updated February 2007. Available at: http://nccam.nih.gov/health/whatiscam.]* It is beyond the scope of the AMDA guideline to review all possible types of CAM and the evidence supporting their use for the treatment of pain.
- According to recent studies, almost 30% of older Americans use CAM to treat their health problems. *[Arcury TA, Suerken CK, Grzywacz JG, et al. Complementary and alternative medicine use among older adults: Ethnic variation. Ethn Dis 2006; 16: 723-731.]* A patient, family member, or member of the interdisciplinary team may suggest CAM therapy or report on CAM therapies that have been helpful in the past.

19. *Dhanani NM, Caruso TJ, Carinci AJ. Complementary and alternative medicine for pain: An evidence-based review. Curr Pain Headache Rep 2011; 15: 39-46.*
20. *Corbin LW, Mellis BK, Beaty BL, Kutner JS. The use of complementary and alternative medicine therapies by patients with advanced cancer and pain in a hospice setting: A multicentered, descriptive study. J Palliat Med 2009; 12: 7-8.*

SLIDE 85:

- As with pharmacologic therapy, the goals of CAM therapy should be clear. Decisions about the continuation of a specific treatment should be based on a review of how well it has achieved the stated care goals.

SLIDE 86:

- During titration of treatment for acute pain, specify the intervals at which acute pain should be evaluated on the order sheet. At a minimum, reassess patients with acute pain daily until the pain is substantially controlled and a stable analgesic regimen has been established. Ideally, the effectiveness of an analgesic should be assessed at the time of its peak effect, usually 1 hour for oral opioids.
- Staff members should also assess or evaluate the degree of pain relief just before and after administration of analgesics.
- It is reasonable to assess pain as the fifth vital sign when collecting vital signs for other reasons. As a practitioner, you may order this as a monitoring requirement when writing an order for pain management.

SLIDE 87: No Notes

SLIDE 88:

- Because pain may fluctuate over time, use the same appropriate pain assessment tool you have been using to re-evaluate the patient and ensure the nursing staff is doing the same.

SLIDE 89:

- Nursing assistants and other direct caregivers, who spend the most time with patients from day to day, are well placed to monitor patients' pain. They should be encouraged to monitor for pain during ADLs and when providing personal care and to report patient statements or observed behaviors that indicate pain. Such reports should prompt timely re-evaluation by the nurses, who should then be reporting to you, the practitioner.

SLIDE 90:

- If a revision of the care plan is needed, prepare a revised care plan that recommends appropriate medications and complementary therapies. Explain the reasons for the proposed treatment changes to the patient and family or health care proxy.

- The timing of any medication reduction is a matter of clinical judgment. When adjusting the treatment, generally avoid adding multiple opioids; rather, use careful titration of a single scheduled, long-acting opioid with the availability of a short-acting opioid for breakthrough pain.
- Remember to concomitantly increase the dose of the short-acting opioid when the dose of the long-acting opioid is increased.
- Repeat **STEPS 14** and **15** (see Algorithm in the AMDA *Pain Management in the Long-Term Care Setting Clinical Practice Guideline)* as frequently as is appropriate for the patient.

SLIDE 91:

- In some patients, pain may relate to a somatoform disorder or may have a spiritual or existential component. When these conditions are suspected or when pain does not respond adequately to other, more conventional treatment strategies, psychiatric, psychological, or spiritual consultation may be of benefit and should be considered. Incorporate acceptable recommendations into the patient's care plan.
- If the consultant's recommendations are not carried out, document the reasons for this decision clearly in the patient's record.
- Ensure the interdisciplinary team is monitoring the patient's response to the course of treatment recommended by you.
- In extreme cases of uncontrolled physical pain, palliative sedation should be considered. Palliative sedation for existential suffering is considered controversial and should be addressed with great caution and preferably in consultation with a palliative care specialist.

SLIDE 92:

Do you want to know if your facility understands pain management or are they just reacting to a complaint of pain? Here are a few simple questions that will determine what is occurring in your facility.

1. How many PRN pain medications are given?
2. When are they given?
    - Check how many PRN pain medications are documented on the Medication Administration Record (MAR) as being administered, instead of routinely scheduled pain medications.
        - Look for a pattern or trend in the administration of these PRN medications.
        - This assessment may be a quick indicator showing whether staff are proactive in treating pain by assessing and routinely treating for pain or only reacting to pain when a patient complains of pain.
        - Another check can be done by observing if the same patients are getting PRN pain medications at the same time almost every day.
3. Does one nurse give out PRN pain medications while a different nurse gives no PRN pain medications for the same patients?
        - This observation may show that nurses may not be consistent in their understanding of how to assess for pain, behaviors for pain, or appropriate reasons for using pain medications.
        - Look to see how many PRN pain medications the evening charge nurse administers.
        - When the nurse reacts to a complaint of pain while attempting to do other required nursing duties it interrupts the routine which causes a delay and increased work.
        - Looking at trends or patterns with the PRN pain medications may help save extra work for the nurse and increase quality of life for the patient.

SLIDE 93:

- Patients, their families, health care advocates, and policy makers are concerned about untreated pain and expect adequate pain assessment and management.
- Pain can usually be effectively treated in the LTC setting.
- Medical directors and managers of LTC facilities should ensure that commitment to patient comfort permeates all aspects of the facility's operation.
- Education about pain assessment and treatment is an essential element of training and orientation programs for all employees and affiliated professionals in LTC facilities.

Bibliography

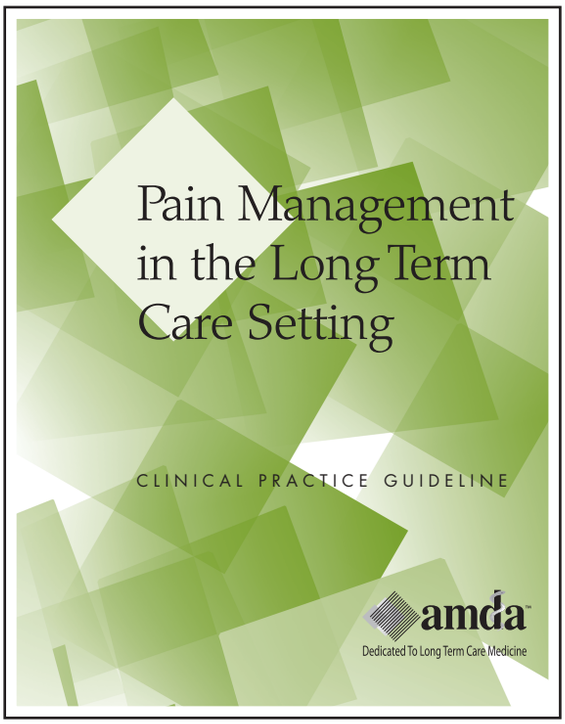
- American Cancer Society, "Cancer Facts & Figures 2012," page 2. http://www.cancer.org/acs/groups/content/@nho/documents/document/acspc-024113.pdf. Accessed April 13, 2012.
- American Medical Association. Code of Ethics. Opinion 2.201 – Sedation to Unconsciousness in End-of-Life Care. http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2201.page. Accessed June 29, 2012.
- Burckhardt CS, et al. *Guideline for the Management of Fibromyalgia Syndrome Pain in Adults and Children.* APS Clinical Practice Guideline Series. 2005; 4:vii-1.
- Centers for Disease Control and Prevention. "Arthritis: At a Glance 2011." http://www.cdc.gov/chronicdisease/resources/publications/AAG/arthritis.htm. Accessed June 29, 2012.
- Centers for Disease Control and Prevention. "Targeting Arthritis: Improving Quality of Life for More than 46 Million Americans." At a Glance 2012. http://www.cdc.gov/nccdphp/publications/aag/arthritis.htm. Accessed July 23, 2012.
- Chou, R. "Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society." *Ann Intern Med.* 2007; 147:478-291.
- Green CR, et al. "The unequal burden of pain: confronting racial and ethnic disparities in pain." *Pain Med.* 2003 Sep;4(3): 277-94.
- International Association for the Study of Pain. Declaration that Access to Pain Management is a Fundamental Human Right. September 2010. http://www.iasp pain.org/PainSummit/DeclarationOfMontreal.pdf. Accessed June 29, 2012.
- International Association for the Study of Pain, IASP Taxonomy, Pain Terms. 2011.
- Institute of Medicine. *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research.* Washington, DC: The National Academies Press. 2011.
- Martin B, Deyo R, Mirza S, Turner J, Comstock B, Hollingworth W, Sullivan S. "Expenditures and Health Status among Adults With Back and Neck Problems." *JAMA.* 2008;299(6):656-664.
- Maserejian NN, Link CL, Lutfey KL, et al. "Disparities in physicians' interpretations of heart disease symptoms by patient gender: results of a video vignette factorial experiment." *J Womens Health.* 2009;18(10):1661-7.
- Mattsson JY, Forsner M, Arman M. "Uncovering pain in critically ill non-verbal children: nurses' clinical experiences in the pediatric intensive care unit." *J Child Health Care.* 2011 Sep;15(3):187-98.
- Medline Plus. Back Pain. http://www.nlm.nih.gov/medlineplus/backpain.html. Accessed April 13, 2012.
- National Center for Health Statistics. Health, United States, 2006 With Chartbook on Trends in the Health of Americans. Hyattsville, MD.
- National Center for Health Statistics. Health, United States, 2011: With Special Feature on Socioeconomic Status and Health. Hyattsville, MD. 2012.

- National Headache Foundation. Migraine Facts. http://www.headaches.org/press/NHF_Press_Kits/Press_Kits_-_Migraine_Facts. Accessed April 25, 2012.
- National Institute of Neurological Disorders and Stroke. Pain: Hope through Research. June 15, 2011.
- National Rural Health Association. What's Different About Rural Health Care? http://www.ruralhealthweb.org/go/left/about-rural-health/what-s-different-about-rural-health-care/what-s-different-about-ruralhealth-care. Accessed June 29, 2012.
- Stewart W, Ricci J, Chee E, Morganstein D, Lipton R. "Lost Productive Time and Cost Due to Common Pain Conditions in the US Workforce." *JAMA.* 2003;290:2443-2454.
- Tang NK, Wright KJ, Salkovskis PM. "Prevalence and correlates of clinical insomnia co-occurring with chronic back pain." *JSleep Res.* 2007 Mar;16(1):85-95.
- TMJ Association. TMJD Basics. http://tmj.org/site/content/tmjd-basics. Accessed June 12, 2012.
- WebMD. Back Pain Health Center: Chronic Back Pain and Sleep. http://www.webmd.com/back-pain/chronic-back-pain-sleep. Accessed June 29, 2012.
- Wolfe J, Grier HE, Klar N,et al. "Symptoms and suffering at the end of life in children with cancer." *N Engl J Med.* 2000;342:326-333.
- Zwakhalen et. al. "Pain in elderly people with severe dementia: A systematic review of behavioural pain assessment tools." *BMC Geriatrics.* 2006; 6:3.

AMDA Pain Management Clinical Practice Guideline (CPG)

SLIDE NOTES

For Licensed Nurses



SLIDE 1: No Notes

SLIDE 2: No Notes

SLIDE 3: No Notes

SLIDE 4: No Notes

SLIDE 5:

We recognize people who reside in post-acute/long-term care facilities are residents. However, throughout the guideline, the term patient(s), is used since we are addressing individuals within the context of treating a medical condition.

1. American Geriatrics Society (AGS) Panel on the Pharmacological Management of Persistent Pain in Older Persons. Pharmacological management of persistent pain in older persons. J Am Geriatr Soc 2009; 57: 1331-1346.

SLIDE 6:

- Media reports, government and public reaction, and occasional lawsuits regarding pain management have begun to put pressure on long-term care facilities and practitioners regarding pain management.
- The Centers for Medicare and Medicaid (CMS) kicked off a national initiative to improve the quality of care in nursing facilities called the Nursing Home Quality Initiative (NHQI). The prevalence of pain in nursing facility patients is one of several quality measures chosen for study in both chronic and post-acute patient populations. The NHQI website provides consumer and provider information regarding the quality of care in nursing homes. NHQI discusses quality measures which are shown at the Nursing Home Compare website (medicare.gov). This website allows consumers, providers, States and researchers to compare information on nursing homes.

2. Institute of Medicine. Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research. Washington, DC: The National Academies Press. 2011.

SLIDE 7:

1. American Geriatrics Society (AGS) Panel on the Pharmacological Management of Persistent Pain in Older Persons. Pharmacological management of persistent pain in older persons. J Am Geriatr Soc 2009; 57: 1331-1346.

3. Ferrell BA. Pain evaluation and management in the nursing home. Ann Intern Med 1995; 123:681-687.

4. AGS Panel on Persistent Pain in Older Persons. The management of persistent pain in older persons. J Am Geriatr Soc 2002; 50: S205-224.

SLIDE 8:

3. Ferrell BA. Pain evaluation and management in the nursing home. Ann Intern Med 1995; 123: 681–687.

5. Karp JF, Shega JW, Morone NE, Weiner DK. Advances in understanding the mechanisms and management of persistent pain in older adults. Br. J. Anaesth 2008; 101 (1): 111–120.

6. Crook J, Rideout E, Browne G. The prevalence of pain complaints in a general population. Pain 1984; 18: 299–314.

7. Fox PL, Raina P, Jadad AR. Prevalence and treatment of pain in older adults in nursing homes and other long-term care institutions: a systematic review. Can Med Assoc J 1999; 160: 329–333.

8. Scudds RJ, Ostbye T. Pain and pain-related interference with function in older Canadians: the Canadian Study of Health and Aging. Disabil Rehabil 2001; 23: 654–664.

9. Barkin RL, Barkin SJ, Barkin DS. Perception, assessment, treatment, and management of pain in the elderly. Clin Geriatr Med 2005; 21: 465-490, v.

SLIDE 9: No Notes

SLIDE 10: No Notes

SLIDE 11:

10. Reynolds KS, Hanson LC, DeVellis RF, et al. Disparities in pain management between cognitively intact and cognitively impaired nursing home residents. J Pain Symptom Manage 2008; 35: 388-396.

11. Fisher SE, Burgio LD, Thorn BE, Hardin JM. Obtaining self-report data from cognitively impaired elders: Methodological issues and clinical implications for nursing home pain assessment. Gerontologist 2006; 46: 81-88.

12. Zwakhalen SM, Koopmans RT, Geels PJ, et al. The prevalence of pain in nursing home residents with dementia measured using an observational pain scale. Eur J Pain 2009; 13: 89-93.

SLIDE 12: No Notes

SLIDE 13:

1. American Geriatrics Society (AGS) Panel on the Pharmacological Management of Persistent Pain in Older Persons. Pharmacological management of persistent pain in older persons. J Am Geriatr Soc 2009; 57: 1331-1346.

SLIDE 14: No Notes

SLIDE 15: No Notes

SLIDE 16: No Notes

SLIDE 17:

13. Das SS. Grief and the imminent threat of non-being. Br J Psychiatry 1971; 118: 467-468.

14. Horowitz MJ. Stress-response syndromes: A review of posttraumatic and adjustment disorders. Hosp Community Psychiatry 1986; 37: 241-249.

15. Thobaben M. Clients' reaction to community violence: Posttraumatic stress disorder. Home Care Provid 1999; 4(5): 182-183.

SLIDE 18: No Notes

SLIDE 19:

- Focusing on pain may lead us to interventions that not only reduce pain and suffering but directly affect the ability of a patient to walk, sleep, eat, think, socialize as well as impacting many other aspects of their life.
- When patients cannot sleep or exhibit problematic behavior, we may find pain has been the silent barrier for many of these patients trying to achieve a higher quality of life.
- Whether pain is managed in a hospital or a long-term facility, research has shown it is generally under-recognized and undertreated.

2. Ferrell BA. Pain evaluation and management in the nursing home. Ann Intern Med 1995; 123: 681–687.

5. Karp JF, Shega JW, Morone NE, Weiner DK. Advances in understanding the mechanisms and management of persistent pain in older adults. Br. J. Anaesth 2008; 101 (1): 111–120.

6. Crook J, Rideout E, Browne G. The prevalence of pain complaints in a general population. Pain 1984; 18: 299–314.

7. Fox PL, Raina P, Jadad AR. Prevalence and treatment of pain in older adults in nursing homes and other long-term care institutions: a systematic review. Can Med Assoc J 1999; 160: 329–333.

8. Scudds RJ, Ostbye T. Pain and pain-related interference with function in older Canadians: the Canadian Study of Health and Aging. Disabil Rehabil 2001; 23: 654–664.

SLIDE 20:

Ask yourself if you are the reason the person with dementia lashes out to defend themselves. Are you using correct interventions specific for the person with dementia?

SLIDE 21: No Notes

SLIDE 22: No Notes

SLIDE 23: No Notes

SLIDE 24: No Notes

SLIDE 25: No Notes

SLIDE 26:

- Racial, ethnic, and gender bias held by both patients and caregivers may hinder patients from reporting pain and may reduce caregivers' sensitivity to the signs and symptoms of pain.

SLIDE 27: No Notes

SLIDE 28:

- Caregiving staff may not be skilled at assessing or evaluating pain or at using valid pain screening tools.
- Direct caregiving staff or supervisors may be unaware of the availability of pain assessment tools specifically for use with cognitively impaired patients and, therefore, may fail to recognize behaviors or language that suggest the presence of pain.
- Some LTC workers may believe that pain is a normal or an unavoidable factor in the aging process and, hence, may not take the initiative to assess or evaluate, address, or reduce pain in the patients they care for.
- The legal and regulatory requirements involved in prescribing Schedule II medications and other controlled substances may be perceived by the facility as a significant barrier to the implementation of pain management guidelines.

SLIDE 29: No Notes

SLIDE 30:

- Our population of elderly patients requires us to know how their bodies react to medications. At this stage in their life, drug absorption and the length of time the drug is effective will be different from when their bodies were younger. As part of an interdisciplinary team assigned to their care, if we see an inappropriate medication ordered, we cannot say "but that's what the doctor ordered!" Communicating with the patient's physician about the potential side-effects from an inappropriate medication may give us the opportunity to establish a working relationship with the patient's physician. By being specific and knowledgeable in our assessment of the pain information we present to the physician we can become a valuable partner in the patient's care.

Additional SLIDE Notes:

If we have PRN pain medications routinely ordered for the patient we should be able to assess which PRN medication is most appropriate for the type of pain the patient is experiencing. We can carry out "Best Practice" by following the World Health Organization's (WHO) analgesic ladder that emphasizes the lowest dose of the least potent analgesic first. If pain control is not achieved then we can increase the dose or switch to a stronger analgesic until pain relief is achieved.

- A potential error may occur when the patient is admitted to the facility with medications prescribed while in the hospital before the patient's primary physician at the nursing home has reviewed the orders. Inappropriate medications may be on that admission order.

- Another potential error may occur when the patient's primary physician is unavailable. A physician on-call who is not familiar with the patient or may not have experience treating geriatric patients may be asked to write an order for a pain medication.

Our patients are relying on us to be their advocates for appropriate care.

SLIDE 31:

- When a patient is in pain we may not be aware of the pain because the patient may not let us know. One of the more important aspects of pain management is the screening and assessment of pain. The information gathered from the assessment of pain is essential to the treatment of pain. It may be unnecessary and inappropriate to treat mild pain with a medication that has been ordered for the patient but is prescribed for moderate to severe pain.

SLIDE 32:

- Pain management is the duty of all staff in the facility who care for the patient.

SLIDE 33: No Notes

SLIDE 34:

AMDA's guideline for pain management consists of four major areas:

1. **Recognition** of a person who is having pain or at risk for pain
2. **Assessment** of the person with pain to identify details and seek underlying causes and impact of the pain on the person's quality of life
3. **Treatment** or management of the pain
4. **Monitoring** of the treatment plan

SLIDE 35:

- Staff who are educated in pain management realize the importance of completing a Pain Screen and are more likely to consistently complete the screening.
- An **EVALUATION** of the pain will lead to a more effective pain treatment by allowing the nurse to communicate to the practitioner exactly what is going on with the patient. This is done by describing the pain and how it affects the patient.
- A **CARE PLAN** allows the sharing of specific details for managing pain to be passed on to all day, evening, night, weekend, and temporary staff for implementation.
- Since up to 83% of nursing home patients have chronic pain, the **CONSISTENT** use and **ACTION** of these steps for pain management is a difficult barrier most facilities face.
- Without regular **RE-EVALUATION**, a pain management program is unable to identify how the patient is actually being managed.

  Our assumption that appropriate care is being given would, therefore, be based only on guesses.

SLIDE 36:

Recognition of a person who is having pain:

- Evaluate the patient for pain upon admission, during periodic scheduled assessments, and whenever a change occurs in his or her condition (e.g., after a fall or other trauma or when a change occurs in the patient's behavior, daily routines, or mental status).
- The best indicator of the pain experience is the patient's own report. The nurse must include an assessment of the pain intensity and the effect of pain on activities of daily living.

SLIDE 37:

16. CMS. Minimum Data Set, Version 3.0 (MDS 3.0). Baltimore, MD: Centers for Medicare and Medicaid Services. Available at: https://www.cms.gov/nursinghome qualityinits/. Accessed 12/2/11.

SLIDE 38:

- Key times to observe pain behaviors and to inquire about the presence and intensity of pain include during ambulation, bathing, dressing, meal time, recreational activities, therapy sessions, transfers, turning and repositioning, continence care, and wound care. It is also often helpful to ask family members how the patient historically has expressed pain or discomfort.
- In a review of the literature on pain in nursing homes, *Swafford et al (Swafford KL, Miller LL, Tsai PF, et al. Improving the process of pain care in nursing homes: A literature synthesis. J Am Geriatr Soc 2009; 57: 1080-1087.)* found that pain management improved in nursing homes that documented the use of a comprehensive pain assessment tool. Finding appropriate evidence-based tools can be challenging for many nursing homes.
- The American Geriatrics Society has published specific recommendations for pain assessment. *(AGS Panel on Persistent Pain in Older Persons. The management of persistent pain in older persons. J Am Geriatr Soc 2002; 50: S205-224.)*
- In addition, tools and resources for both cognitively impaired and cognitively intact patients that can be downloaded and customized to the facility are available from several sources online.
    - *Geriatricpain.org. Web site. Available at: http://www.geriatricpain.org. Accessed 12/2/11.*
    - *Med-Pass Inc. Pain evaluation form. Available at: http://www.med-pass.com/shopping/shopexd.asp?id=8193&MarketID=1300000&CategoryID=1321300. Last updated November 9, 2011.*
    - *PartnersAgainstPain.com. Pain management tools. Stamford, CT: Pudue Pharma, 2011. Available at: http://www.partnersagainstpain.com/hcp/pain-assessment/tools.aspx.*
- For consistency, the same assessment tool should be administered after an intervention to monitor the effectiveness of the pain intervention (e.g., 1 hour after a dose of a pain medication).

17. Cohen-Mansfield J, Lipson S. Pain in cognitively impaired nursing home residents: How well are physicians diagnosing it? J Am Geriatr Soc 2002; 50: 1039-1044.

SLIDE 39: No Notes

SLIDE 40:

Source Table 3:

- *Hurley AC, Volicer BJ, Hanrahan PA, et al. Assessment of discomfort in advanced Alzheimer patients. Res Nurs Health 1992; 15: 369-377.*
- *Horgas A, Miller L. Pain assessment in people with dementia. Am J Nurs 2008; 108: 62-70; quiz 71.*
- *Herr K, Bjoro K, Decker S. Tools for assessment of pain in nonverbal older adults with dementia: a state-of-the-science review. J Pain Symptom Manage 2006; 31: 170-192.*
- *Ingrid B, Marsella A. Factors influencing exercise participation by clients in long-term care. Perspectives 2008; 32: 5-11.*

SLIDE 41:

Appropriate members of the interdisciplinary team should

- Review the patient's known diagnoses or conditions and identify possible additional factors that may be causing or contributing to pain
- Ask the patient to rate the intensity of his or her pain, using either a numerical score or a verbal or visual descriptor appropriate for and preferred by the patient
- Ask about key characteristics of the pain (e.g., duration, frequency, location, onset, pattern, radiation) and for words that describe its qualities (e.g., aching, burning, throbbing)
- Use a specialized assessment tool for patients who cannot answer questions

- Note the factors that make the pain better or worse
- Identify recent exacerbations of persistent pain (is there a pattern?)
- Assess or evaluate how pain is affecting the patient's mood and its impact on activities of daily living (ADLs), sleep, and selected quality-of-life measures (e.g., participation in hobbies, visiting with family)
- Determine whether the current level of pain relief is consistent with the patient's care goals. Some patients may prefer to tolerate a certain level of pain to avoid analgesic medications, medication side effects, or other interventions
- Note the dosage and frequency of administration of all pain medications
- Note all treatments that the patient is receiving for pain, including all nonpharmacologic and CAM therapies
- Review the effectiveness of specific drugs and other treatments used in the past to treat pain
- Discontinue the use of drugs or other treatments that are ineffective

SLIDE 42:

- A good example of this point can be found when using the Wong-Baker Face Scale with cognitively impaired patients. Studies using the scale with cognitively impaired patients have found that as the cognition declines, the patient will pick the "happiest" face on the scale whether the patient has pain or not.

SLIDE 43:

There are many pain scales available; the nurses should let the practitioner know what scales are being used.

SLIDE 44: No Notes

SLIDE 45:

It may be helpful to ask the patient's

- How their pain feels at its worst?
- How the pain feels most of the time?
- How the pain feels at its least?
- How the pain changes with treatment?

Try to assign a number from 0 (zero) to 10 (ten) to the pain level. If no pain, use a 0.

As the numbers get higher, they indicate pain that is getting worse. A 10 means the pain is as bad as it can be.

SLIDE 46: No Notes

SLIDE 47: No Notes

SLIDE 48:

Pain Scale for non-verbal patients.

SLIDE 49: No Notes

SLIDE 50:

- These pain scales have been validated and are used to make assessments of patients who may not be able to verbally express their pain.

SLIDE 51:

- Patients with acute injury should receive pain medication while awaiting diagnostic testing or transfer to the emergency department.

- A relevant study showed that morphine given to patients with acute abdominal pain did not adversely affect the ability to make an accurate diagnostic assessment. *(Thomas SH, Silen W, Cheema F, et al. Effects of morphine analgesia on diagnostic accuracy in emergency department patients with abdominal pain: A prospective, randomized trial. J Am Coll Surg 2003; 196: 18-31.)*

SLIDE 52:

- Assess the person with pain to identify details and seek underlying causes.

4. AGS Panel on Persistent Pain in Older Persons. The management of persistent pain in older persons. J Am Geriatr Soc 2002; 50: S205-224.

SLIDE 53: No Notes

SLIDE 54:

The medical history should include the following:

- The patient's existing diagnoses and conditions that may be causing or contributing to pain.
- Information from the patient's family or the interdisciplinary team that may suggest other diagnoses and conditions. For example, a report of weight loss prior to admission, especially in a patient with cognitive impairment, should prompt a thorough examination of the oral cavity for the presence of painful lesions.
- The patient's current medications. Consider asking the consultant pharmacist to review the medication regimen with particular attention to medications that may cause or exacerbate painful conditions. These could include opioid analgesics (abdominal pain); bisphosphonates (jaw, thigh, or hip pain); antiglaucoma medications (brow pain or headache); antidepressants and atypical antipsychotics (neuralgia, neuropathic pain, migraine, paresthesia); nonsteroidal anti-inflammatory drugs (NSAIDs, GI bleeding with pain and abdominal tenderness); antiretrovirals (neuropathy); and infusion and injectable medications (pain at the site of injection).
- Prior diagnostic evaluations, interventions, and treatments for pain.
- Beneficial and adverse effects of medications previously used to treat pain.

SLIDE 55:

- For your reference, **Step 10:** Summarize the characteristics and causes of the patent's pain and assess the impact of pain on function and quality of life.

Step 8 notes:

- Consider consultation when the diagnoses or conditions contributing to pain are still not clear or if special skills are required for definitive treatment.
- For example, a dental consultation may be appropriate when oral or dental disease is suspected, or a consultant pharmacist may help to identify medications that could cause or exacerbate pain (e.g., NSAIDs and anticonvulsants such as divalproex sodium and lamotrigine).
- Additionally, a neurologist, orthopedist, physiatrist, or specialist in pain or palliative medicine may provide insights into the causes of pain and suggest treatment options.

SLIDE 56:

Step 10 notes: The practitioner and staff should collaborate on documenting a summary of the patient's situation that includes:

- A description of the diagnoses and conditions contributing to the patient's pain or the reasons the causes of the pain could not be established
- A list of possible treatments for underlying diagnoses or conditions contributing to the patient's pain
- Reasons for recommending the use or nonuse of identified treatment options, taking into account the patient's state of health, prognosis, and advance care directives, as well as the preferences of the patient and family or health care proxy

- Provision for access to family and friends, life review, quality life experiences, and completion of unfinished business at the end of life

SLIDE 57:

Treatment

As a matter of course, all patients should be kept clean, dry, and comfortably positioned in bed or in a chair. Additional interventions include the following:

- Reassuring words and touch
- A back rub, hot or cold compresses, whirlpool bath, or shower (especially if such interventions have been helpful in the past)
- Simple exercises or passive range of motion
- Repositioning
- Relaxation techniques as appropriate (e.g., aromatherapy, massage therapy)
- Comforting music
- The opportunity to talk to caregivers and others about pain, its causes and consequences, and the reasons for and expectations of the plan for treating the pain
- The services of a chaplain or other appropriate pastoral counselor
- Specialized equipment such as air-circulating beds
- Programs such as "Bathing Without a Battle" *(Barrick A, Rader J, Hoeffer B, et al., eds. Bathing Without a Battle: Person-Directed Care of Individuals with Dementia. 2nd ed. 2008. New York: Springer Publishing.)* to decrease the discomfort that ADLs may cause
- Pet therapy

SLIDE 58:

STEP 11 notes: Factors influencing the choice of treatments include:

- The patient's underlying diagnoses or conditions that are causing or contributing to pain
- The causes, location, nature, and severity of the pain
- The patient's preferences and wishes as expressed directly, by a family member or other health care proxy, or in an advance directive
- The patient's goal for pain management with respect to what constitutes an acceptable pain level, an acceptable sedation level, and acceptable side effects
- Preferred route of medication administration
- The availability of experienced providers
- Possible adverse medication effects
- Costs to the patient
- Costs of medication acquisition

STEP 12 notes: Goals for pain relief:

- For patients with persistent pain, primary goals often include not only reducing pain intensity but also achieving functional outcomes such as improving independence in ADLs, participating in activities, or optimizing cognition, mood, or sleep.
- Complete pain relief is uncommon, but even partial relief can improve function or quality of life.
- Offer a realistic outlook to patients, families and even staff.
- Review the goals of treatment and possible medication side effects.
- Explain that it may take time to find the optimal intervention, that is, the medications or other approaches which are most effective at relieving discomfort and that have the most tolerable adverse effects.

SLIDE 59: No Notes

SLIDE 60: No Notes

SLIDE 61: No Notes

SLIDE 62:

- Generally, start with a low to moderate dose of medication and titrate upward until an acceptable balance is achieved between pain relief and medication side effects. (For further discussion of the titration of opioid medications, see the section *Opioid Titration* in AMDA's *Pain Management in the Long-Term Care Setting Clinical Practice Guideline*, p26.) The half-life of the medication should be considered in determining the interval of dosing. Reassess the medication's effectiveness frequently and adjust the dosage to meet the patient's goals for pain relief.

1. American Geriatrics Society (AGS) Panel on the Pharmacological Management of Persistent Pain in Older Persons. Pharmacological management of persistent pain in older persons. J Am Geriatr Soc 2009; 57: 1331-1346.

SLIDE 63:

The WHO also recommends administering analgesic medications

- By mouth if possible
- Around the clock for continuous pain
- According to the pain relief ladder
- Tailored to the individual patient
- With attention to detail

SLIDE 64:

- For nurses who want to learn more regarding Non-Opioid and Opioid Analgesics, please see p16-34 in AMDA's *Pain Management in the Long-Term Care Setting Clinical Practice Guideline.*

SLIDE 65:

Adverse Effects

- In terms of fracture risk, long-acting opioids are preferable to short-acting opioids. *(Miller M, Sturmer T, Azrael D, et al. Opioid analgesics and the risk of fractures in older adults with arthritis. J Am Geriatr Soc 2011; 59: 430-438.)*
- Although the constipating effects of opioids persist throughout the course of treatment, patients develop tolerance to most of the other symptoms within a few days.
- To minimize adverse opioid effects, review the patient's entire medication regimen to determine whether other medications with adverse effects similar to those of opioids can be adjusted or eliminated.
- Respiratory depression is both the most-feared and the least-common adverse effect of opioid analgesics. Although a degree of concern about respiratory depression is appropriate, it does not warrant withholding opioid treatment from a patient with moderate or severe pain that is unresponsive to other medications. *(The use of opioids for the treatment of chronic pain. A consensus statement from the American Academy of Pain Medicine and the American Pain Society. Clin J Pain 1997; 13: 6-8.)*

SLIDE 66:

- Meperidine is not appropriate for persistent pain management in the LTC setting because of its potential for adverse CNS effects and accumulation of toxic metabolites. The organs of the body that process most medications are the kidneys and the liver. When we are older, these organs don't process medications as well as when we were younger.
- The partial opioid agonists butorphanol, nalbuphine, and pentazocine, as well as fixed-dose agonist–antagonist combination products, are not recommended because they have analgesic ceiling

effects, can be associated with dysphoria and hallucinations, and may precipitate withdrawal in opioid-dependent patients.

- Acute and chronic use of the NSAIDs indomethacin, meclofenamate, piroxicam, and tolmetin are not recommended because of the higher frequency of more serious side effects, such as peptic ulceration and GI hemorrhage, which occur more than with other NSAIDs. CNS adverse effects such as agitation, confusion, and hallucinations may also occur at a higher frequency with these medications. *[Griffin MR, Piper JM, Daugherty JR, et al. Nonsteroidal anti-inflammatory drug use and increased risk for peptic ulcer disease in elderly persons. Ann Intern Med 1991; 114: 257-263; Committee on Safety of Medicines. CSM Update. Non-steroidal anti-inflammatory drugs and serious gastrointestinal adverse reactions–2. Br Med J (Clin Res ed) 1986; 292: 1190-1191; Fries JF, Williams CA, Bloch DA. The relative toxicity of nonsteroidal antiinflammatory drugs. Arthritis Rheum 1991; 34: 1353-1360.]* In general, long-term use of any NSAID has certain risks; when this course is being considered, it is important to weigh the risks and the benefits. *(Fick DM, Cooper JW, Wade WE, et al. Updating the Beers criteria for potentially inappropriate medication use in older adults: Results of a US consensus panel of experts. Arch Intern Med 2003; 163: 2716-2724.)*
- There is a list of "potential" inappropriate medications for the geriatric population called the "Beer's List" that we can reference. *[American Geriatrics Society 2012 Beers Criteria Update Expert Panel. J Am Geriatr Soc. American Geriatrics Society Updated Beers Criteria for for Potentially Inappropriate Medication Use in Older Adults. 2012 Apr;60(4):616-31. 10.1111/j.1532-5415.2012.03923.x. Epub 2012 Feb 29. www.americangeriatrics.org/files/.../beers/2012BeersCriteria_JAGS.pdf]* It is helpful to have information on these potentially inappropriate medications available for practitioners to read who are unfamiliar with geriatric care and long-term care. It is possible that the patient's practitioners may want to prescribe a medication that is on the Beer's List because he or she feels the benefits of the medication out-weigh the risks. However, check to make sure they have documented the rationale for prescribing in the medical record.
    - It is then our responsibility to care plan to monitor for the possible adverse effects so that all staff will be aware of potential problems to watch out for with the patient. For example, if the medication makes the patient dizzy, then "assistance with ambulation" while on the medication may be necessary to add to the care plan.

SLIDE 67:

- **CAM** is defined as "a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine." *[National Center for Complementary and Alternative Medicine, National Institutes of Health (NCCAM). CAM Basics: What is CAM? NCCAM Pub. No. D347. Updated February 2007. Available at: http://nccam.nih.gov/health/whatiscam.]* It is beyond the scope of the AMDA guideline to review all possible types of CAM and the evidence supporting their use for the treatment of pain.
- According to recent studies, almost 30% of older Americans use CAM to treat their health problems. *[Arcury TA, Suerken CK, Grzywacz JG, et al. Complementary and alternative medicine use among older adults: Ethnic variation. Ethn Dis 2006; 16: 723-731.]* A patient, family member or member of the interdisciplinary team may suggest CAM therapy or report on CAM therapies that have been helpful in the past.

18. *Dhanani NM, Caruso TJ, Carinci AJ. Complementary and alternative medicine for pain: An evidence-based review. Curr Pain Headache Rep 2011; 15: 39-46.*

19. *Corbin LW, Mellis BK, Beaty BL, Kutner JS. The use of complementary and alternative medicine therapies by patients with advanced cancer and pain in a hospice setting: A multicentered, descriptive study. J Palliat Med 2009; 12: 7-8.*

SLIDE 68:

- As with pharmacologic therapy, the goals of CAM therapy should be clear. Decisions about the continuation of a specific treatment should be based on a review of how well it has achieved the stated care goals.

SLIDE 69:

- During titration of treatment for acute pain, specify the intervals at which acute pain should be evaluated on the order sheet. At a minimum, reassess patients with acute pain daily until the pain is substantially controlled and a stable analgesic regimen has been established. Ideally, the effectiveness of an analgesic should be assessed at the time of its peak effect, usually 1 hour for oral opioids.
- Staff members should also assess or evaluate the degree of pain relief just before and after administration of analgesics.
- It is reasonable to assess pain as the fifth vital sign when collecting vital signs for other reasons. A practitioner may order this as a monitoring requirement when writing an order for pain management.

SLIDE 70: No Notes

SLIDE 71:

- Since pain may fluctuate over time, use the same appropriate pain assessment tool you have been using to re-evaluate the patient.

SLIDE 72:

- Nursing assistants and other direct caregivers, who spend the most time with patients from day to day, are well placed to monitor patients' pain. They should be encouraged to monitor for pain during ADLs and when providing personal care and to report patient statements or observed behaviors that indicate pain. Such reports should prompt timely re-evaluation by the nurses, who should then be reporting to the practitioner.

SLIDE 73:

- If a revision of the care plan is needed, prepare a revised care plan that recommends appropriate medications and complementary therapies. Explain the reasons for the proposed treatment changes to the patient and family or health care proxy.
- The timing of any medication reduction is a matter of clinical judgment. When the practitioner is adjusting the treatment, they will generally avoid adding multiple opioids; rather, they will carefully titrate a single scheduled, long-acting opioid with a short-acting opioid for breakthrough pain.
- The practitioner will most likely concomitantly increase the dose of the short-acting opioid when the dose of the long-acting opioid is increased.
- Repeat **Steps 14** and **15** (see Algorithm in the AMDA *Pain Management in the Long-Term Care Setting Clinical Practice Guideline)* as frequently as is appropriate for the patient.

SLIDE 74:

- In some patients, pain may relate to a somatoform disorder (a mental disorder in which patients experience pain that can't be traced to any physical cause) or may have a spiritual or existential component. When these conditions are suspected or when pain does not respond adequately to other, more conventional treatment strategies, psychiatric, psychological, or spiritual consultation may be of benefit and should be considered. The practitioner will then incorporate acceptable recommendations into the patient's care plan.
- If the consultant's recommendations are not carried out, the practitioner should document the reasons for this decision clearly in the patient's record. If this is missing, the nurse should call the practitioner and let them know.
- Ensure the interdisciplinary team is monitoring the patient's response to the course of treatment recommended by the practitioner.
- In extreme cases of uncontrolled physical pain, palliative sedation should be considered. Palliative sedation for existential suffering is considered controversial and should be addressed with great caution and preferably in consultation with a palliative care specialist.

SLIDE 75:

Do you want to know if your facility understands pain management or are they just reacting to a complaint of pain? Here are a few simple questions that will determine what is occurring in your facility.

1. How many PRN pain medications are given?
2. When are they given?
    - Check how many PRN pain medications are documented on the Medication Administration Record (MAR) as being administered, instead of routinely scheduled pain medications.
    - Look for a pattern or trend in the administration of these PRN medications.
    - This assessment may be a quick indicator showing whether Staff is proactive in treating pain by assessing and routinely treating for pain or only reacting to pain when a patient complains of pain.
    - Another check can be done by observing if the same patients are getting PRN pain medications at the same time almost every day.
3. Does one nurse give out PRN pain medications while a different nurse gives no PRN pain medications for the same patients?
    - This observation may show that nurses may not be consistent in their understanding of how to assess for pain, behaviors for pain, or appropriate reasons for using pain medications.
    - Look to see how many PRN pain medications the evening nurse administers.
    - When the nurse reacts to a patient complaint of pain while attempting to do other required nursing duties it interrupts the routine which causes a delay and increased work.
    - Looking at trends or patterns with the PRN pain medications may help save extra work for the nurse and increase quality of life for the patient.

SLIDE 76:

- Patients, their families, health care advocates, and policy makers are concerned about untreated pain and expect adequate pain assessment and management.
- Pain can usually be effectively treated in the LTC setting.
- Medical directors and managers of LTC facilities should ensure that commitment to patient comfort permeates all aspects of the facility's operation.
- Education regarding pain assessment and treatment is an essential element of training and orientation programs for all employees and affiliated professionals in LTC facilities.

Bibliography

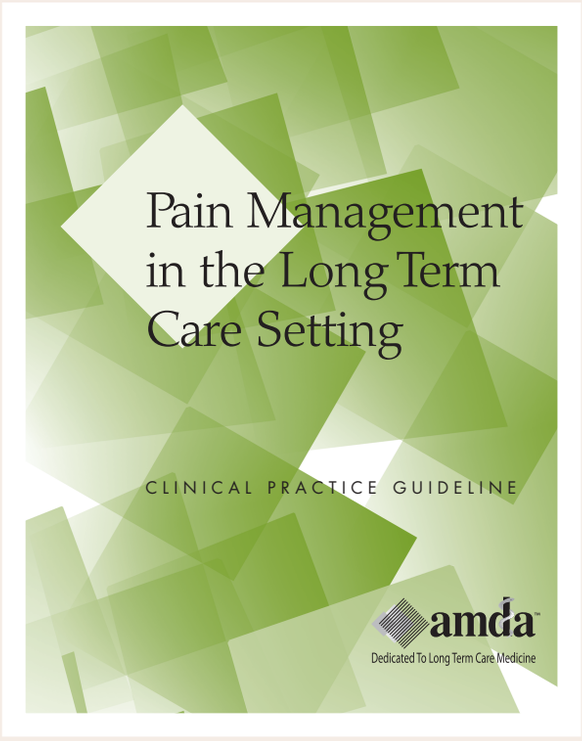
- American Cancer Society, "Cancer Facts & Figures 2012," page 2. http://www.cancer.org/acs/groups/content/@nho/documents/document/acspc-024113.pdf. Accessed April 13, 2012.
- American Medical Association. Code of Ethics. Opinion 2.201 – Sedation to Unconsciousness in End-of-Life Care. http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2201.page. Accessed June 29, 2012.
- Burckhardt CS, et al. *Guideline for the Management of Fibromyalgia Syndrome Pain in Adults and Children.* APS Clinical Practice Guideline Series. 2005; 4:vii-1.
- Centers for Disease Control and Prevention. "Arthritis: At a Glance 2011." http://www.cdc.gov/chronicdisease/resources/publications/AAG/arthritis.htm. Accessed June 29, 2012.
- Centers for Disease Control and Prevention. "Targeting Arthritis: Improving Quality of Life for More than 46 Million Americans." At a Glance 2012. http://www.cdc.gov/nccdphp/publications/aag/arthritis.htm. Accessed July 23, 2012.
- Chou, R. "Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society." *Ann Intern Med.* 2007; 147:478-291.
- Green CR, et al. "The unequal burden of pain: confronting racial and ethnic disparities in pain." *Pain Med.* 2003 Sep;4(3): 277-94.
- International Association for the Study of Pain. Declaration that Access to Pain Management is a Fundamental Human Right. September 2010. http://www.iasp pain.org/PainSummit/DeclarationOfMontreal.pdf. Accessed June 29, 2012.
- International Association for the Study of Pain, IASP Taxonomy, Pain Terms. 2011.
- Institute of Medicine. Relieving Pain in America: *A Blueprint for Transforming Prevention, Care, Education, and Research.* Washington, DC: The National Academies Press. 2011.
- Martin B, Deyo R, Mirza S, Turner J, Comstock B, Hollingworth W, Sullivan S. "Expenditures and Health Status among Adults With Back and Neck Problems." JAMA. 2008;299(6):656-664.
- Maserejian NN, Link CL, Lutfey KL, et al. "Disparities in physicians' interpretations of heart disease symptoms by patient gender: results of a video vignette factorial experiment." *J Womens Health.* 2009;18(10):1661-7.
- Mattsson JY, Forsner M, Arman M. "Uncovering pain in critically ill non-verbal children: nurses' clinical experiences in the pediatric intensive care unit." *J Child Health Care.* 2011 Sep;15(3):187-98.
- Medline Plus. Back Pain. http://www.nlm.nih.gov/medlineplus/backpain.html. Accessed April 13, 2012.
- National Center for Health Statistics. Health, United States, 2006 With Chartbook on Trends in the Health of Americans. Hyattsville, MD.
- National Center for Health Statistics. Health, United States, 2011: With Special Feature on Socioeconomic Status and Health. Hyattsville, MD. 2012.

- National Headache Foundation. Migraine Facts. http://www.headaches.org/press/NHF _Press_ Kits/Press_Kits_-_Migraine_Facts. Accessed April 25, 2012.
- National Institute of Neurological Disorders and Stroke. Pain: Hope through Research. June 15, 2011.
- National Rural Health Association. What's Different About Rural Health Care? http://www.ruralhealthweb.org/go/left/about-rural-health/what-s-different-about-rural-health-care/what-s-different-about-ruralhealth-care. Accessed June 29, 2012.
- Stewart W, Ricci J, Chee E, Morganstein D, Lipton R. "Lost Productive Time and Cost Due to Common Pain Conditions in the US Workforce." *JAMA.* 2003;290:2443-2454.
- Tang NK, Wright KJ, Salkovskis PM. "Prevalence and correlates of clinical insomnia co-occurring with chronic back pain." *JSleep Res.* 2007 Mar;16(1):85-95.
- TMJ Association. TMJD Basics. http://tmj.org/site/content/tmjd-basics. Accessed June 12, 2012.
- WebMD. Back Pain Health Center: Chronic Back Pain and Sleep. http://www.webmd.com/back-pain/chronic-back-pain-sleep. Accessed June 29, 2012.
- Wolfe J, Grier HE, Klar N,et al. "Symptoms and suffering at the end of life in children with cancer." *N Engl J Med.* 2000;342:326-333.
- Zwakhalen et. al. "Pain in elderly people with severe dementia: A systematic review of behavioural pain assessment tools." *BMC Geriatrics.* 2006; 6:3.

AMDA Pain Management Clinical Practice Guideline (CPG)

SLIDE NOTES

For Certified Nursing Assistants



SLIDE 1: No Notes

SLIDE 2: No Notes

SLIDE 3: No Notes

SLIDE 4: No Notes

SLIDE 5:

We recognize people who reside in post-acute/long-term care facilities are residents. However, throughout the guideline the term, patient(s), is used because we are addressing individuals within the context of treating a medical condition.

1. American Geriatrics Society (AGS) Panel on the Pharmacological Management of Persistent Pain in Older Persons. Pharmacological management of persistent pain in older persons. J Am Geriatr Soc 2009; 57: 1331-1346.

SLIDE 6:

- Media reports, government and public reaction, and occasional lawsuits regarding pain management have begun to put pressure on long-term care facilities and practitioners regarding pain management.
- The Centers for Medicare and Medicaid (CMS) kicked off a national initiative to improve the quality of care in nursing facilities called the Nursing Home Quality Initiative (NHQI). The prevalence of pain in nursing facility patients is one of several quality measures chosen for study in both chronic and post-acute patient populations. The NHQI website provides consumer and provider information regarding the quality of care in nursing homes. NHQI discusses quality measures that are shown at the Nursing Home Compare website (medicare.gov). This website allows consumers, providers, States and researchers to compare information on nursing homes.

2. Institute of Medicine. Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research. Washington, DC: The National Academies Press. 2011.

SLIDE 7:

1. American Geriatrics Society (AGS) Panel on the Pharmacological Management of Persistent Pain in Older Persons. Pharmacological management of persistent pain in older persons. J Am Geriatr Soc 2009; 57: 1331-1346.

3. Ferrell BA. Pain evaluation and management in the nursing home. Ann Intern Med 1995; 123:681-687.

4. AGS Panel on Persistent Pain in Older Persons. The management of persistent pain in older persons. J Am Geriatr Soc 2002; 50: S205-224.

SLIDE 8:

3. Ferrell BA. Pain evaluation and management in the nursing home. Ann Intern Med 1995; 123: 681–687.

5. Karp JF, Shega JW, Morone NE, Weiner DK. Advances in understanding the mechanisms and management of persistent pain in older adults. Br. J. Anaesth 2008; 101 (1): 111–120.

6. Crook J, Rideout E, Browne G. The prevalence of pain complaints in a general population. Pain 1984; 18: 299–314.

7. Fox PL, Raina P, Jadad AR. Prevalence and treatment of pain in older adults in nursing homes and other long-term care institutions: a systematic review. Can Med Assoc J 1999; 160: 329–333.

8. Scudds RJ, Ostbye T. Pain and pain-related interference with function in older Canadians: the Canadian Study of Health and Aging. Disabil Rehabil 2001; 23: 654–664.

9. Barkin RL, Barkin SJ, Barkin DS. Perception, assessment, treatment, and management of pain in the elderly. Clin Geriatr Med 2005; 21: 465-490, v.

SLIDE 9:

- Pain is not meant by the body to be tolerated. The body uses pain to let us know something is not right and needs our attention.
- Pain is a personal experience. It is subjective.

SLIDE 10:

1. American Geriatrics Society (AGS) Panel on the Pharmacological Management of Persistent Pain in Older Persons. Pharmacological management of persistent pain in older persons. J Am Geriatr Soc 2009; 57: 1331-1346.

SLIDE 11: No Notes

SLIDE 12: No Notes

SLIDE 13:

The Joint Commission (TJC) is a professional body. It is an independent, not-for-profit organization that accredits and certifies more than 20,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.

TJC continuously strives to improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.

http://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx

SLIDE 14: No Notes

SLIDE 15:

- Sometimes a patient may kick, bite, scratch, spit etc., if they are hurting and they don't have the words to tell you they hurt, such as patients with dementia. This is why it is important to note mood and behavior changes that occur when you are assisting a patient in moving.

SLIDE 16: No Notes

SLIDE 17:

Here are some examples of how a patient may show that they are in pain.

1. **Pain words:** burning, itching, throbbing, "That hurts!," "Ouch!," cursing, "Stop that!"
2. **Rubbing:** massaging affected area
3. **Pain noises:** moans, groans, grunts, cries, gasps, sighs
4. **Bracing:** rigidity, holding, guarding (especially during movement), frequent shifting
5. **Pain faces:** furrowed brow, grimaces, winces
6. **Restlessness:** rocking, inability to stay still
7. **Changes from typical behavior:** for example, usually restless patient is quiet; usually quiet patient is restless; changes in appetite

Believe a patient who has dementia when they say they are in pain! If a patient with dementia says he or she is not in pain, but you see the above PAIN BEHAVIORS, report them to the nurse.

Table 3 Sources:

- *Hurley AC, Volicer BJ, Hanrahan PA, et al. Assessment of discomfort in advanced Alzheimer patients. Res Nurs Health 1992; 15: 369-377.*
- *Horgas A, Miller L. Pain assessment in people with dementia. Am J Nurs 2008; 108: 62-70; quiz 71.*
- *Herr K, Bjoro K, Decker S. Tools for assessment of pain in nonverbal older adults with dementia: a state-of-the-science review. J Pain Symptom Manage 2006; 31: 170-192.*
- *Ingrid B, Marsella A. Factors influencing exercise participation by clients in long-term care. Perspectives 2008; 32: 5-11.*

SLIDE 18:

- Untreated, or under treated pain can result in other problems for the patients. These include: the decrease in enjoyment of recreational activities, decreased mobility, decreased socialization, anxiety, sleep disturbances, impaired posture, and more.

SLIDE 19: No Notes

SLIDE 20:

- Some patients will not acknowledge their pain by telling staff that they have pain. But, listening to the patient may reveal that the patient is "not up to par, or a little under the weather or just not comfortable." Many other phases may tell staff that the patient is in pain. There are some patients who have a closer relationship with the nursing assistant, maintenance person or housekeeping person than their charge nurse. The patient may be more willing to say to them how they feel. If the nursing staff responds to information about the patient from other staff, a team approach to managing pain can help improve the care of the patient.

SLIDE 21: No Notes

SLIDE 22: No Notes

SLIDE 23:

The following strategies might help when speaking to a patient in pain

1. Ask yes/no questions – this will help the patient to provide information to you without taxing them.
2. Use the word pain or other simple words to help the patient identify what is happening with them.
3. Point to areas thought to be painful when asking questions – this will help to identify areas that may be painful.

SLIDE 24:

Discussion: Can you give me some examples of how you would know a patient is in pain?

SLIDE 25:

Pain can be a difficult thing to assess and treat and this can happen for many reasons.

1. Sometimes older people may not report pain – older people do not report pain because they do not want to be a burden which makes some seniors less likely to report pain – they may also have sensory and/or cognitive impairments that make it more difficult for them to communicate the sensations that they are feeling.
2. At times nurses and caregivers may not inquire to see if pain is something that is impacting on a patient. It is important to remember that pain is a real experience for the patients and that there can be something done to reduce this happening.
3. Some pain assessment scales have been found to be too difficult for older people to use.

SLIDE 26:

Read the above SLIDE out loud…

- Most pain medication takes about 45 minutes to 1 hour to work…please preplan for the patient to have their pain medication before you begin assisting in ADL care.

SLIDE 27:

When transferring or walking with a patient who may be in pain REMEMBER TO….

- Ensure the patient is wearing proper footwear and is set up properly for transfer
- If you think transferring and walking is causing the patient pain, ask a licensed nurse to request an OT/PT evaluation for transfer and walking strategies

SLIDE 28:

- Pain management is the duty of all the staff in the facility who care for the patient.

SLIDE 29: No Notes

SLIDE 30: No Notes

SLIDE 31: No Notes

SLIDE 32:

- Pain is an important issue with patients and their families. But, unless the patient asks for a pain pill, we often don't think about managing pain.
- Many nurses have stories of how effective pain management brought comfort and heartfelt thankfulness from the patient and their family members. Nurses need to hear these success stories in order to understand the importance of assisting their patients with pain management. Once success is achieved, it will help improve the life of the patient and help the staff feel job satisfaction. Staff retention is not a problem in a facility where everyone feels that they are part of the success. With pain management the success is the reduction of pain and suffering.

SLIDE 33:

- Patients, their families, health care advocates, and policy makers are concerned about untreated pain and expect adequate pain assessment and management.
- Pain can usually be effectively treated in the LTC setting.
- Medical directors and managers of LTC facilities should ensure that commitment to patient comfort spreads through all aspects of the facility's operation.
- Education about pain assessment and treatment is an essential element of training and orientation programs for all employees and affiliated professionals in LTC facilities.

Bibliography

- American Cancer Society, "Cancer Facts & Figures 2012," page 2. http://www.cancer.org/acs/groups/content/@nho/documents/document/acspc-024113.pdf. Accessed April 13, 2012.
- American Medical Association. Code of Ethics. Opinion 2.201 – Sedation to Unconsciousness in End-of-Life Care. http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2201.page. Accessed June 29, 2012.
- Burckhardt CS, et al. *Guideline for the Management of Fibromyalgia Syndrome Pain in Adults and Children.* APS Clinical Practice Guideline Series. 2005; 4:vii-1.
- Centers for Disease Control and Prevention. "Arthritis: At a Glance 2011." http://www.cdc.gov/chronicdisease/resources/publications/AAG/arthritis.htm. Accessed June 29, 2012.
- Centers for Disease Control and Prevention. "Targeting Arthritis: Improving Quality of Life for More than 46 Million Americans." At a Glance 2012. http://www.cdc.gov/nccdphp/publications/aag/arthritis.htm. Accessed July 23, 2012.
- Chou, R. "Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society." *Ann Intern Med.* 2007; 147:478-291.
- Green CR, et al. "The unequal burden of pain: confronting racial and ethnic disparities in pain." *Pain Med.* 2003 Sep;4(3): 277-94.
- International Association for the Study of Pain. Declaration that Access to Pain Management is a Fundamental Human Right. September 2010. http://www.iasp pain.org/PainSummit/DeclarationOfMontreal.pdf. Accessed June 29, 2012.
- International Association for the Study of Pain, IASP Taxonomy, Pain Terms. 2011.
- Institute of Medicine. Relieving Pain in America: *A Blueprint for Transforming Prevention, Care, Education, and Research.* Washington, DC: The National Academies Press. 2011.
- Martin B, Deyo R, Mirza S, Turner J, Comstock B, Hollingworth W, Sullivan S. "Expenditures and Health Status among Adults With Back and Neck Problems." JAMA. 2008;299(6):656-664.
- Maserejian NN, Link CL, Lutfey KL, et al. "Disparities in physicians' interpretations of heart disease symptoms by patient gender: results of a video vignette factorial experiment." *J Womens Health.* 2009;18(10):1661-7.
- Mattsson JY, Forsner M, Arman M. "Uncovering pain in critically ill non-verbal children: nurses' clinical experiences in the pediatric intensive care unit." *J Child Health Care.* 2011 Sep;15(3):187-98.
- Medline Plus. Back Pain. http://www.nlm.nih.gov/medlineplus/backpain.html. Accessed April 13, 2012.
- National Center for Health Statistics. Health, United States, 2006 With Chartbook on Trends in the Health of Americans. Hyattsville, MD.
- National Center for Health Statistics. Health, United States, 2011: With Special Feature on Socioeconomic Status and Health. Hyattsville, MD. 2012.
- National Headache Foundation. Migraine Facts. http://www.headaches.org/press/NHF _Press_Kits/Press_Kits_-_Migraine_Facts. Accessed April 25, 2012.

- National Institute of Neurological Disorders and Stroke. Pain: Hope through Research. June 15, 2011.
- National Rural Health Association. What's Different About Rural Health Care? http://www.ruralhealthweb.org/go/left/about-rural-health/what-s-different-about-rural-health-care/what-s-different-about-ruralhealth-care. Accessed June 29, 2012.
- Stewart W, Ricci J, Chee E, Morganstein D, Lipton R. "Lost Productive Time and Cost Due to Common Pain Conditions in the US Workforce." *JAMA.* 2003;290:2443-2454.
- Tang NK, Wright KJ, Salkovskis PM. "Prevalence and correlates of clinical insomnia co-occurring with chronic back pain." *JSleep Res.* 2007 Mar;16(1):85-95.
- TMJ Association. TMJD Basics. http://tmj.org/site/content/tmjd-basics. Accessed June 12, 2012.
- WebMD. Back Pain Health Center: Chronic Back Pain and Sleep. http://www.webmd.com/back-pain/chronic-back-pain-sleep. Accessed June 29, 2012.
- Wolfe J, Grier HE, Klar N,et al. "Symptoms and suffering at the end of life in children with cancer." *N Engl J Med.* 2000;342:326-333.
- Zwakhalen et. al. "Pain in elderly people with severe dementia: A systematic review of behavioural pain assessment tools." *BMC Geriatrics.* 2006; 6:3.

Risk Evaluation and Mitigation Strategy (REMS) for Extended-Release and Long-Acting Opioids

Introduction for the FDA Blueprint for Prescriber Education for Extended-Release and Long-Acting Opioid Analgesics

In April 2011, FDA announced the elements of a Risk Evaluation and Mitigation Strategy (REMS) to ensure that the benefits of extended-release and long-acting (ER/LA) opioid analgesics outweigh the risks. The REMS supports national efforts to address the prescription drug abuse epidemic.
As part of the REMS, all ER/LA opioid analgesic companies must provide:

- Education for prescribers of these medications, which will be provided through accredited continuing education (CE) activities supported by independent educational grants from ER/LA opioid analgesic companies.
- Information that prescribers can use when counseling patients about the risks and benefits of ER/LA opioid analgesic use.

FDA developed core messages to be communicated to prescribers in the Blueprint for Prescriber Education (FDA Blueprint), published the draft FDA Blueprint for public comment, and considered the public comments when finalizing the FDA Blueprint. This final FDA Blueprint contains the core educational messages. It is approved as part of the ER/LA Opioid Analgesic REMS and will remain posted on the FDA website for use by CE providers to develop the actual CE activity. A list of all REMS-compliant CE activities that are supported by independent educational grants from the ER/LA opioid analgesic companies to accredited CE providers will be posted at www.ER-LA-opioidREMS.com as that information becomes available.

The CE activities provided under the FDA Blueprint will focus on the safe prescribing of ER/LA opioid analgesics and consist of a core content of about three hours. The content is directed to prescribers of ER/LA opioid analgesics, but also may be relevant for other health care professionals (e.g., pharmacists). The course work is not intended to be exhaustive nor a substitute for a more comprehensive pain management course.

Accrediting bodies and CE providers will ensure that the CE activities developed under this REMS will be in compliance with the standards for CE of the Accreditation Council for Continuing Medical Education (ACCME)[1,2] or another CE accrediting body as appropriate to the prescribers' medical specialty or health care profession.

For additional information from FDA, including more detailed Questions and Answers about the REMS for ER/LA Opioid Analgesics, see http://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm163647.htm.

Why Prescriber Education is Important

Health care professionals who prescribe extended-release (ER) and long-acting (LA) opioid analgesics (hereafter referred to as ER/LA opioid analgesics) are in a key position to balance the benefits of prescribing ER/LA opioid analgesics to treat pain against the risks of serious adverse outcomes including addiction, unintentional overdose, and death. Opioid misuse and abuse, resulting in injury and death, has emerged as a major public health problem.

---

[1] Accreditation Council for Continuing Medical Education. 2012. *Accreditation Requirements. Criteria for CME Providers–Accreditation Criteria.* http://www.accme.org/requirements/accreditation-requirements-cme-providers/accreditation-criteria. Accessed on March 30, 2012.

[2] Accreditation Council for Continuing Medical Education. 2012. *Accreditation Requirements. Criteria for CME Providers–Standards for Commercial Support*. http://www.accme.org/requirements/accreditation-requirements-cme-providers/standards-for-commercial-support. Accessed on March 30, 2012.

- Based on the 2010 National Survey on Drug Use and Health, public health experts estimate more than 35 million Americans age 12 and older used an opioid analgesic for non-medical use some time in their life – an increase from about 30 million in 2002.[3]

- In 2009, there were nearly 343,000 emergency department visits involving nonmedical use of opioid analgesics.[4]

- In 2008, nearly 36,500 Americans died from drug poisonings, and of these, nearly 14,800 deaths involved opioid analgesics.[5]

- Improper use of any opioid can result in serious side effects including overdose and death, and this risk can be greater with ER/LA opioid analgesics.

Appropriate prescribing practices and patient education are important steps to help address this public health problem. Health care professionals who prescribe ER/LA opioid analgesics have a responsibility to help ensure the safe and effective use of these drug products.

The expected results of the prescriber education in these REMS are that the prescribers will:
a. Understand how to assess patients for treatment with ER/LA opioid analgesics.
b. Be familiar with how to initiate therapy, modify dose, and discontinue use of ER/ LA opioid analgesics.
c. Be knowledgeable about how to manage ongoing therapy with ER/LA opioid analgesics .
d. Know how to counsel patients and caregivers about the safe use of ER/LA opioid analgesics, including proper storage and disposal.
e. Be familiar with general and product-specific drug information concerning ER/LA opioid analgesics.

I. Assessing Patients for Treatment with ER/LA Opioid Analgesic Therapy

a. Prescribers should consider risks involved with ER/LA opioid analgesics and balance these against potential benefits. Risks include:

   i. Overdose with ER/LA formulations, as most dosage units contain more opioid than immediate-release formulations.
   ii. Abuse by patient or household contacts.
   iii. Misuse and addiction.
   iv. Physical dependence and tolerance.
   v. Interactions with other medications and substances (See table in Section VI for specific information).
   vi. Inadvertent exposure by household contacts, especially children.

---

[3] Substance Abuse and Mental Health Services Administration. 2011. *Results from the 2010 National Survey on Drug Use and Health: Detailed Table*, Table 7.1.a. Rockville, MD. http://www.samhsa.gov/data/NSDUH/2k10NSDUH/tabs/Sect7peTabs1to45.htm#Tab7.1A. Accessed on March 30, 2012.

[4] Substance Abuse and Mental Health Services Administration. 2011. *Drug Abuse Warning Network, 2009: National Estimates of Drug-Related Emergency Department Visits*, Table 19. Rockville, MD. http://www.samhsa.gov/data/2k11/DAWN/2k9DAWNED/HTML/DAWN2k9ED.htm#Tab19. Accessed on March 30, 2012

[5] Warner M, Chen LH, Makuc DM, Anderson RN, and Miniño AM. 2011. Drug Poisoning Deaths in the United States, 1980–2008, in U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, *NCHS Data Brief*, *No 81*. December 2011. Hyattsville, MD. http://www.cdc.gov/nchs/data/databriefs/db81.pdf. Accessed on March 30, 2012.

b. Prescribers should assess each patient's risk of abuse, including substance use and psychiatric history. Prescribers should:

   i. Obtain a complete history and conduct a complete physical examination, including assessment of family history of substance abuse and psychiatric disorders, as well as special considerations for the elderly and children.
      - A history of substance abuse does not prohibit treatment with ER/LA opioid analgesics but may require additional monitoring and expert consultation.
   ii. Be knowledgeable about risk factors for opioid abuse.
   iii. Understand and appropriately use screening tools for addiction or abuse to help assess potential risks associated with chronic opioid therapy and to help manage patients using ER/LA opioid analgesics (e.g., structured interview tools).
   iv. Adequately document all patient interactions and treatment plans.

c. Prescribers should understand when to appropriately refer high risk patients to pain management specialists.

d. Prescribers should understand opioid tolerance criteria as defined in the product labeling.
   - Prescribers should know which products and which doses are indicated for use only in opioid tolerant patients. (See table in Section VI for specific information).

II. Initiating Therapy, Modifying Dosing, and Discontinuing Use of ER/LA Opioid Analgesics

a. Prescribers should have awareness of federal and state regulations on opioid prescribing.

b. Prescribers should be aware that:
   i. Dose selection is critical, particularly when initiating therapy in opioid non-tolerant patients.
   ii. Some ER/LA opioid analgesics are only appropriate for opioid-tolerant patients.
   iii. Dosage should be individualized in every case.
   iv. Titration should be based on efficacy and tolerability.

c. Prescribers should be knowledgeable about when and how to supplement pain management with immediate-release analgesics, opioids and non-opioids.

d. Prescribers should be knowledgeable about converting patients from immediate-release to ER/LA opioid products and from one ER/LA opioid product to another ER/LA opioid product.

e. Prescribers should understand the concept of incomplete cross-tolerance when converting patients from one opioid to another.

f. Prescribers should understand the concepts and limitations of equianalgesic dosing and follow patients closely during all periods of dose adjustments.

g. Prescribers should understand the warning signs and symptoms of significant respiratory depression from opioids.

h. Prescribers should understand that tapering the opioid dose is necessary to safely discontinue treatment with ER/LA opioid analgesics when therapy is no longer needed.

III. Managing Therapy with ER/LA Opioid Analgesics

a. Prescribers should establish analgesic and functional goals for therapy and periodically evaluate pain control, functional outcomes, side-effect frequency and intensity, and health-related quality of life.

b. Prescribers should be aware of the existence of Patient Prescriber Agreements (PPAs).
   i. PPAs are documents signed by both prescriber and patient at the time an opioid is prescribed.
   ii. PPAs can help ensure patients and caregivers understand the goals of treatment, the risks, and how to use the medications safely.
   iii. PPAs can include commitments to return for follow-up visits, to comply with appropriate monitoring (such as random drug testing), and to safeguard the medication.

c. Prescribers should monitor patient adherence to the treatment plan, especially with regard to misuse and abuse by:
   i. Recognizing, documenting, and addressing aberrant drug-related behavior.
   ii. Utilizing state Prescription Drug Monitoring Programs, where practical, to identify behaviors that may represent abuse.
   iii. Understanding the utility and interpretation of drug testing (e.g., screening and confirmatory tests), and using it as indicated.
   iv. Screening and referring for substance abuse treatment as indicated.
   v. Performing medication reconciliation as indicated.

d. Prescribers should understand how to anticipate and manage adverse events associated with ER/LA opioid analgesics.

e. Prescribers treating patients with ER/LA opioid analgesics should periodically assess benefits and side effects of these drugs, and the continued need for opioid analgesics.

f. Prescribers should understand the need for reevaluation of patient's underlying medical condition if the clinical presentation changes over time.

g. Prescribers should be familiar with referral sources for the treatment of abuse or addiction that may arise from the use of ER/LA opioid analgesics.

IV. Counseling Patients and Caregivers about the Safe Use of ER/LA Opioid Analgesics

a. Prescribers should use the Patient Counseling Document as part of the discussion when prescribing opioid analgesics.

b. Prescribers should explain product-specific information about the prescribed ER/LA opioid analgesic.

c. Prescribers should explain how to take the ER/LA opioid analgesic as prescribed.

d. Prescribers should explain the importance of adherence to dosing regimen, how to handle missed doses, and to contact their prescriber should pain not be controlled.

e. Prescribers should inform patients and caregivers to read the specific ER/LA opioid analgesic Medication Guide they receive from the pharmacy.

f. Prescribers should warn patients that under no circumstances should an oral ER/LA opioid analgesic be broken, chewed or crushed, and patches should not be cut or torn prior to use, as this may lead to rapid release of the ER/LA opioid analgesic causing overdose and **death. When a patient cannot swallow a capsule whole, prescribers should refer to the product labeling to determine if it is appropriate to sprinkle the contents of a capsule on applesauce or administer via a feeding tube.**

g. Prescribers should caution patients that the us e of other CNS depressants such as a sedative-hypnotics and anxiolytics, alcohol, or illegal drugs with ER/LA opioid analgesics can cause overdose and death. Patients should be instructed to only use other CNS depressants, including other opioids, under the instruction of their prescriber.

h. Prescribers should instruct patients to tell all of their doctors about all medications they are taking.

i. Prescribers should warn patients not to abruptly discontinue or reduce their ER/LA opioid analgesic and discuss how to safely taper the dose when discontinuing.

j. Prescribers should caution patients that ER/LA opioid analgesics can cause serious side effects that can lead to death. Prescribers should counsel patients and caregivers on the risk factors, signs, and symptoms of overdose and opioid-induced respiratory depression, gastrointestinal obstruction, and allergic reactions.

k. Prescribers should counsel patients and caregivers on the most common side effects of ER/LA opioid analgesics, and about the risk of falls, working with heavy machinery, and driving.

l. Patients should call their prescriber for information about managing side effects.

m. Prescribers should explain that sharing ER/LA opioid analgesics with others may cause them to have serious side effects including death, and that selling or giving away ER/LA opioid analgesics is against the law.

n. Prescribers should counsel patients to store their ER/LA opioid analgesic in a safe and secure place away from children, family members, household visitors, and pets.

o. Prescribers should warn patients that ER/LA opioid analgesics must be protected from theft.

p. Prescribers should counsel patients to dispose of any ER/LA opioid analgesics when no longer needed and to read the product-specific disposal information included with the ER/LA opioid analgesic product.

q. Prescribers should counsel patients and caregivers to inform them about side effects.

r. Adverse events should be reported to the FDA at 1-800-FDA-1088 or via http://www.fda.gov/downloads/Safety/MedWatch/HowToReport/DownloadForms/UCM082725.pdf.

V. General Drug Information for ER/LA Opioid Analgesic Products

Prescribers should be knowledgeable about general characteristics, toxicities, and drug interactions for ER/LA opioid analgesic products. For example,

a. ER/LA opioid analgesic products are scheduled under the Controlled Substances Act and can be misused and abused.

b. Respiratory depression is the most important serious adverse effect of opioids as it can be immediately life-threatening.

c. Constipation is the most common long-term side effect and should be anticipated.

d. Drug-drug interaction profiles vary among the products. Knowledge of particular opioid-drug interactions, and the underlying pharmacokinetic and pharmacodynamic mechanisms, allows for the safer administration of opioid analgesics.
   i. Central nervous system depressants (alcohol, sedatives, hypnotics, tranquilizers, tricyclic antidepressants) can have a potentiating effect on the sedation and respiratory depression caused by opioids.
   ii. Some ER opioid formulations may rapidly release opioid (dose dump) when exposed to alcohol. Some drug levels may increase without dose dumping when exposed to alcohol. See individual product labeling.
   iii. Using opioids with monoamine oxidase inhibitors (MAOIs) may result in possible increase in respiratory depression. Using certain opioids with MAOIs may cause serotonin syndrome.
   iv. Opioids can reduce the efficacy of diuretics by inducing the release of antidiuretic hormone (ADH).
   v. Some opioids (methadone, buprenorphine) can prolong the QTc interval.
   vi. Concomitant drugs that act as inhibitors or inducers of various cytochrome P450 enzymes can result in higher or lower than expected blood levels of some opioids. (See table in Section VI for specific information).

e. Tolerance to sedating and respiratory-depressant effects of opioids is critical to the safe use of certain products, certain dosage unit strengths, or certain doses of some products.
   i. Patients must be opioid tolerant before using any strength of
      - Transdermal fentanyl, or
      - ER hydromorphone.
   i. For other ER products, patients must be opioid tolerant before using
      - Certain strengths, or
      - Certain daily doses.
   ii. See table in Section VI for specific information.

f. ER/LA opioid analgesic tablets must be swallowed whole. ER/LA opioid analgesic capsules should be swallowed intact or when necessary, the pellets from some capsules can be sprinkled on applesauce and swallowed without chewing.

g. For transdermal products, external heat, fever, and exertion can increase absorption of the opioid, leading to fatal overdose. Transdermal products with metal foil backings are not safe for use in MRIs.

VI. Specific Drug Information for ER/LA Opioid Analgesic Products

Prescribers should be knowledgeable about specific characteristics of the ER/LA opioid analgesic products they prescribe, including the drug substance, formulation, strength, dosing interval, key instructions, specific information about conversion between products where available, specific drug interactions, use in opioid-tolerant patients, product-specific safety concerns, and relative potency to morphine. The attached table is a reference. For detailed information, prescribers can refer to prescribing information available online via DailyMed at www.dailymed.nlm.nih.gov or Drugs@FDA at www.fda.gov/drugsatfda.

Drug Information Common to the Class of Extended-Release and Long-Acting Opioid Analgesics (ER/LA opioid analgesics)

Avinza (morphine sulfate ER capsules) **Dolophine** (methadone HCl tablets) **Embeda** (morphine sulfate ER-naltrexone capsules) **Kadian** (morphine sulfate ER capsules) **Nucynta ER** (tapentadol HCl ER tablets) **OxyContin** (oxycodone HCl CR tablets)	**Butrans** (buprenorphine transdermal system) **Duragesic** (fentanyl transdermal system) **Exalgo** (hydromorphone HCl ER tablets) **MS Contin** (morphine sulfate CR tablets) **Opana ER** (oxymorphone HCl ER tablets)
Dosing Interval	• Refer to individual product information.
Key Instructions	• Individually titrate to a dose that provides adequate analgesia and minimizes adverse reactions. • The times required to reach steady-state plasma concentrations are product specific; refer to product information for titration interval. • Continually reevaluate to assess the maintenance of pain control and the emergence of adverse reactions. • During chronic therapy, especially for non-cancer-related pain, periodically reassess the continued need for opioids. • If pain increases, attempt to identify the source, while adjusting the dose. • When an ER/LA opioid analgesic is no longer required, gradually titrate downward to prevent signs and symptoms of withdrawal in the physically-dependent patient. **Do not abruptly discontinue these products.** • Limitations of usage: ■ Not for use as an as-needed analgesic. ■ Not for mild pain or pain not expected to persist for an extended duration. ■ Not for use in treating acute pain. • Solid oral dosage forms: ■ Swallow tablets and capsules whole: crushing, chewing, breaking, cutting or dissolving may result in rapid release and absorption of a potentially fatal dose of opioid. ■ Some capsules can be opened and pellets sprinkled on applesauce for patients who can reliably swallow without chewing and used immediately. See individual product information. ■ Exposure of some products to alcoholic beverages or medications containing alcohol may result in the rapid release and absorption of a potentially fatal dose of opioid. ■ Dispose of unused product by flushing down the toilet. • Transdermal dosage forms: ■ Avoid exposure to external heat. Patients with fever must be monitored for signs or symptoms of increased opioid exposure. ■ Location of application must be rotated. ■ Prepare skin by clipping, not shaving hair, and washing area only with water. • See individual product information for the following: ■ Dosage reduction for hepatic or renal impairment.

continued

CONTINUED

Drug Information Common to the Class of Extended-Release and Long-Acting Opioid Analgesics (ER/LA opioid analgesics)

Drug Interactions Common to the Class	• Concurrent use with other central nervous system depressants (sedatives, hypnotics, general anesthetics, antiemetics, phenothiazines, other tranquilizers, and alcohol) can increase the risk of respiratory depression, hypotension, profound sedation, or coma. Reduce the initial dose of one or both agents. • Partial agonists and mixed agonist/antagonist analgesics (i.e., buprenorphine, pentazocine, nalbuphine and butorphanol) may reduce the analgesic effect or precipitate withdrawal symptoms. Avoid concurrent use. • Opioids may enhance the neuromuscular blocking action of skeletal muscle relaxants and produce an increased degree of respiratory depression. • Concurrent use with anticholinergic medication increases the risk of urinary retention and severe constipation, which may lead to paralytic ileus.
Use in Opioid-Tolerant Patients	• See individual product information for which products: ■ Have strengths or total daily doses only for use in opioid-tolerant patients. ■ Are only for use in opioid-tolerant patients at all strengths.
Contraindications	• Significant respiratory depression • Acute or severe asthma in an unmonitored setting or in the absence of resuscitative equipment • Known or suspected paralytic ileus • Hypersensitivity (e.g., anaphylaxis) See individual product information for additional contraindications.
Relative Potency To Oral Morphine	**These are intended as general guides.** • Follow conversion instructions in individual product information. • Incomplete cross-tolerance and inter-patient variability require the use of conservative dosing when converting from one opioid to another - halve the calculated comparable dose and titrate the new opioid as needed.

Specific Drug Information for Extended-Release and Long-Acting Opioid Analgesics (ER/LA opioid analgesics)

Avinza	Morphine Sulfate ER Capsules, 30 mg, 45 mg, 60 mg, 75 mg, 90 mg, and 120 mg
Dosing Interval	Once a day
Key Instructions	• Initial dose in opioid non-tolerant patients is 30 mg. • Titrate using a minimum of 3-day intervals. • Swallow capsule whole (do not chew, crush, or dissolve). • May open capsule and sprinkle pellets on applesauce for patients who can reliably swallow without chewing; use immediately. • Maximum daily dose: 1600 mg due to risk of serious renal toxicity by excipient, fumaric acid.
Specific Drug Interactions	• Alcoholic beverages or medications containing alcohol may result in the rapid release and absorption of a potentially fatal dose of morphine. • PGP inhibitors (e.g. quinidine) may increase the absorption/exposure of morphine sulfate by about two-fold.
Use in Opioid-Tolerant Patients	90 mg and 120 mg capsules are for use in opioid-tolerant patients only.
Product-Specific Safety Concerns	None
Butrans	Buprenorphine Transdermal System, 5 mcg/hr, 10 mcg/hr, 20 mcg/hr
Dosing Interval	One transdermal system every 7 days
Key Instructions	• Initial dose in opioid non-tolerant patients when converting from less than 30 mg morphine equivalents, and in mild to moderate hepatic impairment - 5 mcg/hr dose. • When converting from 30 mg to 80 mg morphine equivalents - first taper to 30 mg morphine equivalent, then initiate with 10 mcg/hr dose. • Titrate after a minimum of 72 hours prior to dose adjustment. • Maximum dose: 20 mcg/hr due to risk of QTc prolongation. • Application ■ Apply only to sites indicated in the Full Prescribing Information. ■ Apply to intact/non-irritated skin. ■ Skin may be prepped by clipping hair, washing site with water only ■ Rotate site of application a minimum of 3 weeks before reapplying to the same site. ■ Do not cut. • Avoid exposure to heat. • Dispose of used/unused patches by folding the adhesive side together and flushing down the toilet.
Specific Drug Interactions	• CYP3A4 Inhibitors may increase buprenorphine levels. • CYP3A4 Inducers may decrease buprenorphine levels. • Benzodiazepines may increase respiratory depression. • Class IA and III antiarrythmics, other potentially arrhythmogenic agents, may increase risk for QTc prolongation and torsade de pointe.
Use in Opioid-Tolerant Patients	Butrans 10 mcg/hr and 20 mcg/hr transdermal systems are for use in opioid-tolerant patients only.

continued

CONTINUED
Specific Drug Information for Extended-Release and Long-Acting Opioid Analgesics (ER/LA opioid analgesics)

Drug-Specific Safety Concerns	• QTc prolongation and torsade de pointe. • Hepatotoxicity • Application site skin reactions
Relative Potency To Oral Morphine	Equipotency to oral morphine has not been established.
Dolophine	Methadone Hydrochloride Tablets, 5 mg and 10 mg
Dosing Interval	Every 8 to 12 hours
Key Instructions	• Initial dose in opioid non-tolerant patients: 2.5 to 10 mg • Conversion of opioid-tolerant patients using equianalgesic tables can result in overdose and death. Use low doses according to the table in the full prescribing information. • High inter-patient variability in absorption, metabolism, and relative analgesic potency. • Opioid detoxification or maintenance treatment shall only be provided in a federally certified opioid (addiction) treatment program (Code of Federal Regulations, Title 42, Sec 8).
Specific Drug Interactions	• Pharmacokinetic drug-drug interactions with methadone are complex. ■ CYP 450 inducers may increase methadone levels. ■ CYP 450 inhibitors may decrease methadone levels. ■ Anti-retroviral agents have mixed effects on methadone levels. • Potentially arrhythmogenic agents may increase risk for QTc prolongation and torsade de pointe. • Benzodiazepines may increase respiratory depression
Use in Opioid-Tolerant Patients	Refer to full prescribing information.
Product-Specific Safety Concerns	• QTc prolongation and torsade de pointe. • Peak respiratory depression occurs later and persists longer than analgesic effect. • Clearance may increase during pregnancy. • False positive urine drug screens possible.
Relative Potency To Oral Morphine	Varies depending on patient's prior opioid experience.
Duragesic	Fentanyl Transdermal System, 12, 25, 50, 75, and 100 mcg/hr
Dosing Interval	Every 72 hours (3 days)

continued

CONTINUED

Specific Drug Information for Extended-Release and Long-Acting Opioid Analgesics (ER/LA opioid analgesics)

Key Instructions	• Use product specific information for dose conversion from prior opioid • Use 50% of the dose in mild or moderate hepatic or renal impairment, avoid use in severe hepatic or renal impairment • Application ■ Apply to intact/non-irritated/non-irradiated skin on a flat surface. ■ Skin may be prepped by clipping hair, washing site with water only ■ Rotate site of application. ■ Titrate using no less than 72 hour intervals. ■ Do not cut. • Avoid exposure to heat. • Avoid accidental contact when holding or caring for children. • Dispose of used/unused patches by folding the adhesive side together and flushing down the toilet. **Specific contraindications:** • Patients who are not opioid-tolerant. • Management of acute or intermittent pain, or in patients who require opioid analgesia for a short period of time. • Management of post-operative pain, including use after out-patient or day surgery. • Management of mild pain.
Specific Drug Interactions	• CYP3A4 inhibitors may increase fentanyl exposure. • CYP3A4 inducers may decrease fentanyl exposure.
Use in Opioid-Tolerant Patients	All doses of Duragesic are indicated for use in opioid-tolerant patients only.
Product-Specific Safety Concerns	• Accidental exposure due to secondary exposure to unwashed/unclothed application site. • Increased drug exposure with increased core body temperature or fever. • Bradycardia • Application site skin reactions
Relative Potency To Oral Morphine	See individual product information for conversion recommendations from prior opioid
Embeda	Morphine Sulfate ER-Naltrexone Capsules, 20 mg/0.8 mg, 30 mg/ 1.2 mg, 50 mg/2 mg, 60 mg/2.4 mg, 80 mg/3.2 mg, 100 mg/4 mg
Dosing Interval	Once a day or every 12 hours
Key Instructions	• Initial dose as first opioid: 20 mg/0.8 mg. • Titrate using a minimum of 3-day intervals. • Swallow capsules whole (do not chew, crush, or dissolve) • Crushing or chewing will release morphine, possibly resulting in fatal overdose, and naltrexone, possibly resulting in withdrawal symptoms. • May open capsule and sprinkle pellets on applesauce for patients who can reliably swallow without chewing, use immediately.
Specific Drug Interactions	• Alcoholic beverages or medications containing alcohol may result in the rapid release and absorption of a potentially fatal dose of morphine. • PGP inhibitors (e.g. quinidine) may increase the absorption/exposure of morphine sulfate by about two-fold.

continued

CONTINUED

Specific Drug Information for Extended-Release and Long-Acting Opioid Analgesics (ER/LA opioid analgesics)

Use in Opioid-Tolerant Patients	Embeda 100 mg/4 mg capsule is for use in opioid-tolerant patients only.
Product-Specific Safety Concerns	None
Exalgo	Hydromorphone Hydrochloride Extended-Release Tablets, 8 mg, 12 mg or 16 mg
Dosing Interval	Once a day
Key Instructions	• Use the conversion ratios in the individual product information. • Start patients with moderate hepatic impairment on 25% dose that would be prescribed for a patient with normal hepatic function. • Start patients with moderate renal impairment on 50%, and patients with severe renal impairment on 25% of the dose that would be prescribed for a patient with normal renal function. • Titrate using a minimum of 3 to 4 day intervals. • Swallow tablets whole (do not chew, crush, or dissolve). • Do not use in patients with sulfa allergy–contains sodium metabisulfite.
Specific Drug Interactions	None
Use in Opioid-Tolerant Patients	All doses of Exalgo are indicated for opioid-tolerant patients only.
Drug-Specific Adverse Reactions	Allergic manifestations to sulfa component.
Relative Potency To Oral Morphine	Approximately 5:1 oral morphine to hydromorphone oral dose ratio, use conversion recommendations in the individual product information.
Kadian	Morphine Sulfate Extended-Release Capsules, 10 mg, 20mg, 30 mg, 50 mg, 60 mg, 80 mg, 100 mg, and 200 mg
Dosing Interval	Once a day or every 12 hours
Key Instructions	• Product information recommends not using as first opioid. • Titrate using a minimum of 2-day intervals. • Swallow capsules whole (do not chew, crush, or dissolve). • May open capsule and sprinkle pellets on applesauce for patients who can reliably swallow without chewing, use immediately.
Specific Drug Interactions	• Alcoholic beverages or medications containing alcohol may result in the rapid release and absorption of a potentially fatal dose of morphine. • PGP inhibitors (e.g. quinidine) may increase the absorption/exposure of morphine sulfate by about two-fold.
Use in Opioid-Tolerant Patients	Kadian 100 mg and 200 mg capsules are for use in opioid-tolerant patients.
Product-Specific Safety Concerns	None

continued

CONTINUED

Specific Drug Information for Extended-Release and Long-Acting Opioid Analgesics (ER/LA opioid analgesics)

MS Contin	Morphine Sulfate Controlled-release Tablets, 15 mg, 30 mg, 60 mg, 100 mg, and 200 mg
Dosing Interval	Every 8 hours or every 12 hours
Key Instructions	• Product information recommends not using as first opioid. • Titrate using a minimum of 2-day intervals. • Swallow tablets whole (do not chew, crush, or dissolve).
Specific Drug Interactions	PGP inhibitors (e.g. quinidine) may increase the absorption/exposure of morphine sulfate by about two-fold.
Use in Opioid-Tolerant Patients	MS Contin 100 mg and 200 mg tablet strengths are for use in opioid-tolerant patients only.
Product-Specific Safety Concerns	None
Nucynta ER	Tapentadol Extended-Release Tablets, 50 mg, 100mg, 150 mg, 200 mg, and 250 mg
Dosing Interval	Every 12 hours
Key Instructions	• Use 50 mg every 12 hours as initial dose in opioid nontolerant patients • Titrate by 50 mg increments using a minimum of 3-day intervals. • Maximum total daily dose is 500 mg • Swallow tablets whole (do not chew, crush, or dissolve). • Take one tablet at a time and with enough water to ensure complete swallowing immediately after placing in the mouth. • Dose once daily in moderate hepatic impairment with 100 mg per day maximum • Avoid use in severe hepatic and renal impairment.
Specific Drug Interactions	• Alcoholic beverages or medications containing alcohol may result in the rapid release and absorption of a potentially fatal dose of tapentadol. • Contraindicated in patients taking MAOIs.
Use in Opioid-Tolerant Patients	No product-specific considerations.
Product-Specific Safety Concerns	• Risk of serotonin syndrome • Angioedema
Relative Potency To Oral Morphine	Equipotency to oral morphine has not been established.

continued

CONTINUED

Specific Drug Information for Extended-Release and Long-Acting Opioid Analgesics (ER/LA opioid analgesics)

Opana ER	Oxymorphone Hydrochloride ER Tablets, 5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg, 30 mg, and 40 mg
Dosing Interval	Every 12h dosing, some may benefit from asymmetric (different dose given in AM than in PM) dosing.
Key Instructions	• Use 5 mg every 12 hours as initial dose in opioid non-tolerant patients and patients with mild hepatic impairment and renal impairment (creatinine clearance < 50 mL/min) and patients over 65 years of age • Swallow tablets whole (do not chew, crush, or dissolve). • Take one tablet at a time, with enough water to ensure complete swallowing immediately after placing in the mouth. • Titrate using a minimum of 2-day intervals. • Contraindicated in moderate and severe hepatic impairment.
Specific Drug Interactions	• Alcoholic beverages or medications containing alcohol may result in the absorption of a potentially fatal dose of oxymorphone.
Use in Opioid-Tolerant Patients	No product specific considerations.
Product-Specific Safety Concerns	None
Relative Potency To Oral Morphine	Approximately 3:1 oral morphine to oxymorphone oral dose ratio
OxyContin	• Oxycodone Hydrochloride • Controlled-release Tablets, 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 60 mg, and 80 mg
Dosing Interval	• Every 12 hours
Key Instructions	• Opioid-naïve patients: initiate treatment with 10 mg every 12 hours. • Titrate using a minimum of 1 to 2 day intervals. • Hepatic impairment: start with one third to one half the usual dosage • Renal impairment (creatinine clearance <60 mL/min): start with one half the usual dosage. • Consider use of other analgesics in patients who have difficulty swallowing or have underlying GI disorders that may predispose them to obstruction. Swallow tablets whole (do not chew, crush, or dissolve). • Take one tablet at a time, with enough water to ensure complete swallowing immediately after placing in the mouth.
Specific Drug Interactions	• CYP3A4 inhibitors may increase oxycodone exposure. • CYP3A4 inducers may decrease oxycodone exposure.
Use in Opioid-Tolerant Patients	• Single dose greater than 40 mg or total daily dose greater than 80 mg are for use in opioid-tolerant patients only.
Product-Specific Safety Concerns	• Choking, gagging, regurgitation, tablets stuck in the throat, difficulty swallowing the tablet. • Contraindicated in patients with gastrointestinal obstruction.
Relative Potency To Oral Morphine	Approximately 2:1 oral morphine to oxycodone oral dose ratio.
For detailed information, refer to prescribing information available online via DailyMed at www.dailymed.nlm.nih.gov or Drugs@FDA at www.fda.gov/drugsatfda.	

Pain: Tools & Web Links

The following tools and resources for pain management are broken down by category: Assessment, Communication with Practitioners, Medication Guides, Other Pain Tools, and References. Materials are listed alphabetically within category and all are accessible online via the links provided.

ASSESSMENT:

Initial Pain Assessment Tool

http://www.partnersagainstpain.com/printouts/A7012AF4.pdf

Source: Partners Against Pain

Comprehensive Pain Assessment Form (Cognitively Impaired)*

http://www.geriatricpain.org/Content/Assessment/Impaired/Pages/Recommendations.aspx

Source: Geriatric Pain

MDS 3.0 pain items

http://www.geriatricpain.org/Content/MDS/Documents/MDS%203%200%20Section%20J.pdf

Source: Geriatric Pain

Pain Audit for Residents with Cognitive Impairment/Dementia From Genesis ElderCare

http://www2.edc.org/lastacts/archives/archivesMarch02/painaudit.doc
Pain audit chart developed for use over a three-day period by nursing staff, to determine whether patients' pain is being adequately controlled.

Source: Educational Development Center

Pain Scale in 18 Languages

http://www.partnersagainstpain.com/printouts/Multilingual_Pain_Scale.pdf
Shows the pain scale and translations into a total of 18 languages: English, Chinese, French, German, Greek, Hawaiian, Hebrew, Ilocano, Italian, Japanese, Korean, Pakistani, Polish, Russian, Samoan, Spanish, Tagalog, Tongan, and Vietnamese.

Source: Partners Against Pain

Wong/Baker FACES scale

http://partnersagainstpain.com/printouts/A7012AS6.pdf

Source: Partners Against Pain

MEDICATION GUIDES:

*Algorithms for Pain Management**

Mild: http://www2.edc.org/lastacts/archives/archivesJan01/mildpain.pdf
Moderate: http://www2.edc.org/lastacts/archives/archivesJan01/moderatepain.pdf
Severe: http://www2.edc.org/lastacts/archives/archivesJan01/severepain.pdf
Three pain algorithms for mild, moderate, and severe pain, as determined by administration of a pain scale test, with flow diagrams leading through the pain assessment and relief processes.

Source: Educational Development Center

AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults Printable Beers pocketguide

http://www.americangeriatrics.org/files/documents/beers/PrintableBeersPocketCard.pdf

Source: The American Geriatrics Society

PAIN MANAGEMENT TOOLS:

http://www.partnersagainstpain.com/hcp/pain-assessment/tools.aspx

These practice tools are available to help health care professionals diagnose and treat pain more effectively in their patients.

Source: Partners Against Pain

RESOURCES:

The following web sites were used as sources in compiling the list of links above. Please visit these sites for more information about pain topics.

American Academy of Pain Medicine – www.painmed.org

American Academy of Pain Management – www.aapainmanage.org

American Board of Pain Medicine – www.abpm.org

American Chronic Pain Association – www.theacpa.org

American Geriatrics Society – www.americangeriatrics.org
The management of persistent pain: Resources for older adults and caregivers. –
http://www.healthinaging.org/aging-and-health-a-to-z/topic:pain-management

Includes:
- Patient education forum, with frequently asked questions (FAQs) on the assessment and management of pain
- A pain diary tool to describe and keep track of pain experiences (in .pdf format*)
- A medication and supplement diary tool to record use of all pain medications (in .pdf format*)
- A guide to safe use of pain medications among older adults
- An assessment tool for persons with dementia (in .pdf format*)
- A comprehensive online guide for caregivers, including a chapter on pain management problem-solving

These topics are based on the clinical practice guidelines developed by the American Geriatrics Society (AGS) for the management of persistent pain in older adults

American Health Care Association – www.ahca.org

American Pain Society – www.ampainsoc.org

American Society of Consultant Pharmacists – www.ascp.com

Includes:

- Statement on pain recognition and assessment in older adults
  https://www.ascp.com/articles/policy-statements
- Guidelines for pain recognition and assessment in older adults
  https://www.ascp.com/sites/default/files/ASCP-PA-NewChangesGui-PainRecognition.pdf
- Clinical reference cards for pain recognition and assessment in older adults (for sale)
  http://www.med-pass.com/assessing-pain-in-the-elderly-reference-card-10-pack.html
- Also lists of journal article references, online resources and continuing education, and pain, palliative care, and hospice organizations

Cancer Care – www.cancercare.org

Case Management Resource Guide – www.cmrg.com

Educational Development Center – http://www2.edc.org/lastacts/pain.asp

Includes useful tools from innovations in end-of-life care

- Pain Audit for Residents with Cognitive Impairment/Dementia From Genesis ElderCare
- Pain Algorithms
- Pain Flow Sheets
- Pain Management Guidelines

EPEC (Education for Physicians of End of Life Care) – www.epec.net

Healthlink: Medical College of Wisconsin – www.healthlink.mcw.edu

National Hospice and Palliative Care Organization – http://www.nhpco.org/

Partners Against Pain – http://www.partnersagainstpain.com/

- Pain scale in 18 languages - for patients who are not native English speakers, one of the 18 translations may be the best way to accurately assess pain.
  http://www.partnersagainstpain.com/printouts/Multilingual_Pain_Scale.pdf
  http://www.partnersagainstpain.com/hcp/pain-assessment/tools.aspx

- Includes:
  - Opioid Therapy Documentation Kit
  - 18 instruments used to assess quality of life (QOL) in people with acute, chronic, and/or cancer pain

Appendix 1

Appendix reprinted from Registered Nurses' Association of Ontario. (2012). Toolkit: Implementation of best practice guidelines *(2nd ed.). Toronto, ON: Registered Nurses' Association of Ontario.*

Appendix 3.1 – Facilitators and Barriers: Questions to Guide You

These charts are a resource to help raise questions for the planning team as you plan for implementation. The answers to these questions will help you devise strategies to help overcome barriers and will be essential in assuring successful outcomes.

Evidence-related factors

Ensuring you have the best evidence for your clients, setting and staff will provide a solid basis for proceeding. Faith in the evidence and the ability to convince others that it is the right thing to do and the right time to do it will help in minimizing or removing barriers and facilitating your implementation

Barriers/Facilitators		Questions to consider
Accessibility	Awareness of where and how to access relevant guidelines	How might you display the guideline/recommendations to catch attention in your workplace? Posters? Bedside charts? Newsletters? Meeting rooms?
Understandability/ Complexity	Level of understanding and how to implement it in practice	Are the recommendations clear and easy to understand? If not, how might you make them so? Provide real-world examples, relevant to your setting Who has used it in your hospital? In a similar setting elsewhere? Who is the end user of the recommendations? Tailor education to their needs in a respectful and interactive way. (using principles of adult characteristics *) Are there RNAO Best Practice Champions on this team(s) that could be enlisted to help?
Ease of implementation	Ease of implementation of guideline into current practice environment	Who in your organization is looked up to, either in formal in leadership or on your team? How might you engage those people to help promote using the evidence? How can the implementation flow into current work to make it ease into practice? Does it need to be broken into steps?

Believability	Quality of the evidence on which the guideline is based	How can you communicate the evidence to assure that what you are using is well founded? Has been successful elsewhere? How can you provide for time to discuss and bring forward any disagreements openly? How can you be open to opposition, provide discussion and if valid concerns, find consensus? Where could you run a pilot to either show success or provide learning on how to improve implementation?
Compatibility	Compatibility with what is already known, believed and done	What examples can you provide where the guideline fits with current thinking, beliefs, and values? For your client population? For the care providers? For the organization? How can I involve those who will be using the guideline in the implementation process? Can they be on the committee? Can they help with development of a tool? Could they provide feedback at certain points in the planning? Can they be part of a pilot?
Timing	Number of guidelines available	What other guidelines or other implementations are being planned during the timeframe you plan to implement? If there are others, is there any opportunity to combine efforts, or is an adjustment or delay needed to avoid over taxing staff?

Target audience related factors		
Barriers/Facilitators		**Questions to consider**
Health-Care Providers		
Attitudes	Attitudes towards research use in practice	What have their previous experiences been with evidence based changes in practice? What went well? What didn't go well? What can you learn from those stories to modify your approach? Has there been a positive experience within your facility/ organization that you can use to highlight?
Knowledge/Skills	Level of knowledge and skill	Who will need education? What level of education will be required? (i.e. client education is recommended to be at Gr.6 level). Do you need to educate on all recommendations? Are some recommendations already current practice? Can you focus on only those that need changing?
Comfort/confidence	Level of comfort and confidence	How can you provide a supportive environment? Are you comfortable dealing with concerns and disagreement? How will you provide positive feedback where appropriate?
Time	Time to read and implement guidelines	How can you provide time needed for the team members to read and implement the guideline? How can you reach those on shifts or those on leaves? When could you schedule sessions to reach as many members as possible?
Motivation to change	Belief in ability to bring about change	Has there been a successful change in the past? What factors helped in that success? How can you provide encouragement at all stages of the implementation? What would be an incentive in your workplace? Does the team respond well to case studies? To opportunities to highlight their area to the rest of the organization? To snacks with education?
Buy-in	Belief that guideline will make a difference	How can you show the difference between current practice and the recommendations? Would a chart help? Would a visual depiction of the current outcomes versus possible outcomes work?
Patient/Client related factors		
Knowledge	Knowledge of guideline recommendations	How will you provide client education? Are your materials accessible? (literacy level, multiple media, available to those with disabilities) Who will assure they are available at implementation and into the future? Where will they learn best? (during hospitalization, at home, in clinic)?

Access	Access to required resources	What resources are needed for clients when implementing? Will they need more labs? Supplies? Additional care? Will any current resources no longer be needed? How will you communicate to the areas/ organizations affected?
Team		
Opinions of others	Degree of consensus between / within professions	Is senior leadership openly supportive of this implementation? If not, how can you enlist their support? Can they role model the change needed? Who on the team is not directly involved in the implementation, but should be kept involved in the plans? How can you engage them in discussion and take into account their feedback?
Expectations	Clarity of expectations	How will you plan and communicate the implementation so that everyone is clear on what is changing, how it will change and their role in the change?
Exchange of information processes (i.e., communication)	Opportunities to exchange information	How is education delivered currently? How is it communicated? How well does it work? If it works well, could the education needed for implementation use this format? Do they learn well with in-services? Self-learning? Online learning? Is there funding for attending a workshop or conference? Has the health-care team been exposed to evidence-based practice? If not, could some education about research be provided? Would a journal club work in this setting? Are they able to access resources to help with clinical appraisal of research? For example, are librarian resources available? Could you link with academic partners?
Cohesiveness	Ability of team to work together	Does the team work well together? Does the team have a history of collaboration? If not, how might you build some skills doing small implementations? How might you access and use team-building activities to support the change in practice?

Resource Related Factors		
Barriers/Facilitators		**Questions to consider**
Human resources	Presence of adequate staff	How can you ensure there will be extra staff to allow for education sessions? Will additional staff be needed for those on the planning committee? During implementation? During evaluation? Do you have leadership support for needed staffing?
Financial resources	Availability of financial resources necessary to implement the guideline	What will the cost be to implement? Have you costed out not just supplies and educational materials, but also replacement costs for staffing? What will be on the ongoing costs of equipment or documentation materials? Where could you look for funding other than the operational budget? Foundations? Fundraising? Professional organizations? Government?
Time as a resource	Ensure that target audience have enough time to engage in implementation efforts	What else is going on in the unit or facility that might demand your time, and the time of those changing their practice or the leadership? How much time will be needed for the planning stage? Education stage? Evaluation? Have you built a realistic timeline (most projects take longer than expected)?
Physical resources (e.g., equipment and supplies) (3)	Access to required equipment and supplies	Do you need access to computers for education/implementation? Are they available? What supplies are needed? Who will order and put in place for implementation and ongoing? Is capital equipment needed? What is the process and timeline for getting what is needed?
Space	Adequacy of physical facilities for implementation	Where will learning take place? Do people need to get away from the clinical area to focus? Is the room big enough for the groups? Is the room equipped with necessary tables/chairs, LCD/laptop/screen, flipcharts, etc.?

Organization-related factors		
Barriers/Facilitators		**Questions to consider**
Leadership	Presence of effective leaders	Are they visible and accessible to the team members when they have concerns? Do you have leader support for team member time, educational activities and the acquisition of needed equipment and supplies?
Scope of practice	Assure guideline recommendations are consistent with relevant staff's scope of practice	Is this within staffs' scope of practice? Would a medical directive be required? Is this implementation supported by the relevant professional associations? How might you engage professional associations/unions in selecting and implementing? Do they have policies or materials that support the recommendations?
Existing policy and procedures	Fit with existing policies and procedures	What policies currently in place might support the recommendations? What will need to be changed to reflect the new practices? Are these corporate? Profession specific? Unit/clinic specific? Who owns these and needs to be involved?
Change agents/ Opinion leaders	Presence of effective change agents/opinion leaders	Do senior nurses role model positive clinical leadership? Who on this team might you target to help champion this implementation? Is someone passionate about these recommendations, this patient population, the potential outcomes that can be achieved?
Workload	Manageable workload	Does the complexity of clients impact the implementation of these recommendations? Will implementation add or decrease workload? Will the complexity of the client's condition impact measurement of outcomes?
Concurrent projects (changes)	Concurrent projects (may act as a barrier or a facilitator)	What other change projects are happening during the time frame of implementation? Too many changes at once can overwhelm a team.
Priorities	Concurrent with organizational priorities	What are the corporate priorities? Does this implementation complement the strategic goals? How can you engage stakeholders early in the guideline selection and implementation process? How can you educate senior leadership to show why the new guideline should be a priority?
Organizational approval processes	Speed at which administrative/organizational process works	Who has to approve the project? The financing?
		What is the turn-around time for decisions in the organization? How far ahead do you need to be planning?

Appendix 2

Appendix reprinted from Registered Nurses' Association of Ontario. (2012). Toolkit: Implementation of best practice guidelines *(2nd ed.). Toronto, ON: Registered Nurses' Association of Ontario.*

Action Plan Template:

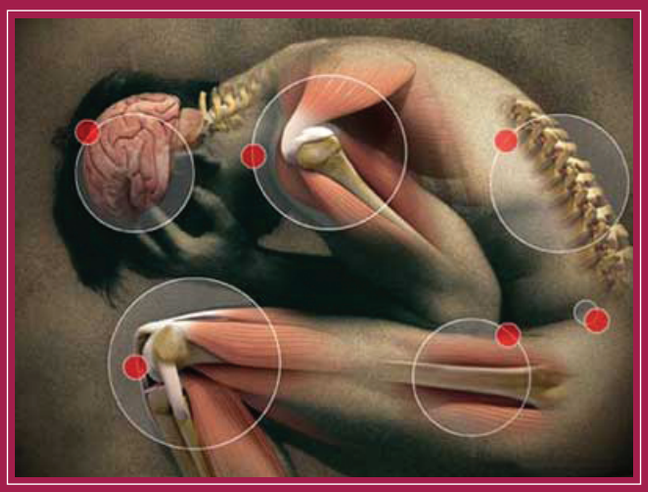
Instructions: Use this template to develop your implementation action plan. You will need to complete the columns and identify specific activities under each of the major activities identified in the template.

#	Activity	Target Date	Person responsible	Outcome/ deliverables	Progress
1.	Identification of project lead, champions and/or the group who will lead the identification and implementation of a BPG: a) Identify skill and role requirements b) Communicate/recruit interested individual or group c) Secure participation of project lead d) Ensure project lead has clear mandate and resources required to start the planning process				
2.	Identification of a BPG: a) Identify stakeholders who will participate in the identification, assessment and selection of a BPG b) Access the AGREE II instrument c) Ensure understanding and knowledge about the use of the AGREE II instrument d) Search and retrieve all available BPGs in the topic area of interest to the organization e) Conduct the appraisal exercise f) Present the data to the group involved in the appraisal exercise. Decide on a BPG based on its quality and content g) Communicate the decision to relevant stakeholders.				
3.	Identification, analysis and engagement of stakeholders: a) Define scope of implementation— extent of implementation b) dentify stakeholders— use team approach to identify. c) Using team, collect data about the stakeholders–use template provided. d) Organize the data and analyze— again use a team approach— strive for consensus. e) Determine strategies that will be used to influence, support and engage stakeholders in different capacities. f) Update the action plan based on strategies identified.				

#	Activity	Target Date	Person responsible	Outcome/ deliverables	Progress
4.	Insertion of stakeholder strategies and actions once identified.				
5.	Completion of environmental readiness assessment.				
6.	Identification and planning of specific implementation strategies: a) Identify the barriers and facilitators from the environmental assessment. b) Involve your relevant stakeholders, choose intervention strategies. Choose interventions based on available information, effectiveness, and fit with the organization and its members.				
7.	Update of action plan, based on implementation strategies identified.				
8.	Development of plan for evaluation: a) Identify available sources of evaluation support—expertise, data collection, etc. (may want to start with your Quality Council) b) Develop evaluation plan. c) Operationalize the plan.				
9.	Update of action plan based on results of the evaluation plan.				
10.	Identification of resources required for implementation: a) Use budget worksheets provided on the diskette. b) Involve implementation team and relevant stakeholders to ensure support for the completed budget. c) Develop strong argument for the budget. d) Identify ways to obtain funding from non-operational sources first – e.g. revenue streams, partnerships with specific vendors, etc. (Consider any conflict of interest) e) Present budget and sources of revenue to the responsible organizational management level.				
11	Identification of monitoring processes.				
12.	Plan for celebration, marking milestones.				

Notes


CD attaches here



AMDA – Dedicated to Long Term Care Medicine™
11000 Broken Land Parkway - Suite 400
Columbia, MD 21044
Main: 410-740-9743
Fax: 410-740-4572
Website: www.amda.com

amda™
Dedicated To Long Term Care Medicine