

2010 ASPMN National Conference
**Optimizing the Treatment of
Pain in Patients with Acute
Presentations**

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Some History...



- Focus – Pain in the ED
- Partnering with national organizations
 - ASPMN
 - ENA – Emergency Nurses Association
- Official board approvals: August + December, 2006

Additional Collaboration

- Support from additional organizations
 - APS – American Pain Society
 - ACEP – American College of Emergency Physicians

First Conference Call: **March, 2007!**

Initial Goals

- Explore best practices
- Explore current research base, educational materials and resources available
- Initial request – send any ED pain protocols to share with group



Common ED Pain Issues

- Diverse patient groups
- Lack of standardized pain assessment and reassessment protocols
- How to reimburse ED's based on quality measures
- Broad belief that there are high volumes of "addicted" patients seeking meds

- Many still believe pediatric patients don't have pain
- Some ED's encourage NOT using opioids in any circumstance
- Lack of knowledge with treating cancer and end of life pain in the ED



**Group Consensus:
Develop Position Statement**

- Revised goal of group
- Incorporate current research into ED practices
- Demonstrate partnering of four national pain organizations

**Draft Position Statement
Fall, 2007**

- Approved by ASPMN Board of Directors
- Approved by ENA Board of Directors



Next many months...

- Revised format
- Tweak content
- Look for approval from APS and ACEP





Oops....some new challenges

- APS and ACEP issues
- Need better established membership
- Need Board of Directors approval for members and goals

NOW WHAT????

- Disband group?
- Only go with ASPMN + ENA
- Start over?
- Pick up and move forward?

Revised Plans

- Formal letters to APS and ACEP Board of Directors – August, 2008
- Reformat position statement in conjunction with various organizational requirements
- Remove use of 'Emergency Department' and broaden to include additional healthcare settings

Lessons learned along the way...

- Establish clear membership responsibilities from onset
- Re-visit this aspect as needed throughout meetings
- Ask designated members to bring group position statements – note format and criteria

Where do we stand TODAY???



Ok, we have the
Position Paper....
now what??

Future directions....

- Where the Task Force is headed....
- Ideas for future projects or focus
- Interest in joining the Task Force

Thank You!

**ADVOCATE
FOR PAIN
CONTROL !!**



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References and Suggested Readings

- American College of Emergency Physicians (ACEP). Mission and Vision Statement, 2003. Retrieved December 26, 2007 from www.acep.org
- American Nurses Association (ANA). (2001). Code of Ethics for Nurses with Interpretive Statements. Washington, D.C., American Nurses Association.
- American Nurses Association (ANA). (1995). Nursing's Social Policy Statement. Washington, D.C., American Nurses Association.
- American Pain Society (APS) (2004). APS Strategic Plan. Retrieved December 26, 2007 from ampainsoc.org
- American Society for Pain Management Nursing (ASPMN). (2007). Mission Statement & Goals. Retrieved December 26, 2007, from www.aspmn.org
- American Society for Pain Management Nursing (ASPMN). (2002). Core Curriculum for Pain Management Nursing. Lenexa, KS, American Society for Pain Management Nursing.
- Emergency Nurses Association (ENA). (1999). Standards of Emergency Nursing Practice. (4th ed) Des Plaines, IL. Author.
- Hwang U, Richardson L, Sonuyi T, Morrison R (2006). The effect of emergency department crowding on the management of pain in older adults with hip fracture. *Journal of the American Geriatric Society*. 54, 2, 270-275.

References and Suggested Readings

- Joint Commission on Accreditation of Healthcare Organizations. (2000). Pain assessment and management: An organizational approach. Oakbrook Terrace, IL: Author.
- Pletcher, MJ, Kertesz SG, Kohn MA, Gonzales, R. (2008). Trends in opioid prescribing by race/ethnicity for patients seeking care in US Emergency Departments. *Journal of the American Medical Association*. 299, 1, 70-78.
- Rupp T, Delaney K (2004) Inadequate analgesia in emergency medicine. *Annals of Emergency Medicine*. 43, 4, 494-503.
- Tamayo-Sarver J, Hinze S, Cydulka R, Baker D (2003) Racial and ethnic disparities in emergency department analgesic prescription. *American Journal of Public Health*. 93, 12, 2067-2074
- Todd K (2001) Influence of ethnicity on emergency department pain management. *Emergency Medicine*. 13, 3, 274-278.
- Todd K, Deaton D, D'Adamo A, & Goe L (2000) Ethnicity and analgesic practice. *Annals of Emergency Medicine*. 35, 1, 11-16.
- Todd K, Ducharme J, Choiniere M, Crandall CS, Fosnocht, DE, Homel P, & Tanabe P (2007). Pain in the emergency department -Results of the Pain and Emergency Medicine Initiative (PEMI) multicenter study. *Journal of Pain*, 8,6, 460-466.
- Todd K, Samaroo N, Hoffman J (1993). Ethnicity as a risk factor for inadequate emergency department analgesia. *Journal of the American Medical Association*. 269, 12, 1537-1539.
- Weissman DE, Haddox JD. Opioid pseudoaddiction--an iatrogenic syndrome. *Pain*. Mar 1989;36(3):363-366.

Optimizing the Treatment of Pain in Patients with Acute Presentations



Position Statement

The American Society for Pain Management Nursing (ASPMN) and the Emergency Nurses Association (ENA) in collaboration with the American College of Emergency Physicians (ACEP) and the American Pain Society (APS) support efforts to improve pain management for patients in all healthcare settings. These organizations recognize the need for prompt, safe, and effective pain management.

Core Principles

The patients' self-report of pain is a critical component of a comprehensive pain assessment which includes clinical assessment and pain history and treatment. Pediatric patients, the elderly, and the cognitively impaired are patients at high risk of inadequate pain management.

1. Optimal pain treatment may be enhanced by acknowledging cultural differences in the expression of pain.
2. A comprehensive assessment, including the patients self-report of pain will allow clinicians to better evaluate the patient's experience. Improvement in function may be an important reference.
3. Evidence based assessment and management techniques should guide pain management whenever possible.
4. Pain categorization: acute; an acute exacerbation of a recurring painful condition; chronic/persistent, and cancer pain are of help in choosing appropriate interventions. In addition to contemporaneous pharmacologic intervention other pathways should be considered such as referral for long term pain management, case management or referral to social service for clinicians and/or centers available to provide long term pain management.
5. Analgesic management should begin as soon as possible when indicated. Diagnosis of the pain etiology should not delay administration of analgesics.
6. Providers must consider the special needs of patients with addictive disease to ensure adequate and safe delivery of analgesia.
7. Those individuals who appear to present with behaviors suggestive of addictive disease should be given a brief intervention and a referral for substance abuse treatment. Chronic repeat visits to non continuity of care providers can be addressed through social service interventions, care plans in conjunction with primary care physicians and analgesic contracts for emergency pain relief.
8. Aberrant behaviors do not equate with addictive disease and may indicate under-treatment of pain. Clinicians and nurses caring for patients experiencing acute and chronic pain may screen for addiction, bearing in mind that it is not the same as tolerance, physical dependence and pseudo-addiction. All patients should be treated appropriately for reports of pain, including those with addictive disease.
9. Health care settings should have appropriate pharmacologic agents and non-pharmacologic interventions readily available in their setting to promote optimal care.
10. The development and adoption of analgesic protocols are encouraged. Measurement of patient response to pain relief interventions from these protocols is required by accrediting agencies. Protocols should be physician/nurse developed and nurse initiated.
11. At the end of a healthcare visit, patients should receive instructions with an individualized pain treatment plan, including important medication specific safety considerations.
12. Nursing and physician leadership has been found to be an important component to promote best practice treatment and referral for patients with a report of pain.
13. Clinician education and resources support optimal pain management.
14. Research and education is encouraged to support wide-spread dissemination of evidence-based analgesic practices.

Summary

Management of pain in is an essential nursing and physician responsibility. This joint position statement describes recommendations for improving pain management in health care settings.

Appendix

Definitions

Tolerance: “Tolerance is a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug’s effects over time.”

Physical Dependence: “Physical dependence is a state of adaptation that often includes tolerance and is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.”

Addiction: “Addiction is a primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.”

Pseudoaddiction, is a related term and was defined in 1990 by Weissman. Patients with pseudoaddiction exhibit behaviors of addiction (frequently asking for more analgesics or higher doses) which resolve when pain is adequately treated. Patients are often coined as “drug-seeking.” The cause is inadequate analgesic management and the treatment for pseudoaddiction is adequate analgesic management. Pseudoaddiction results in a crisis of mistrust between the patient and staff and threatens the ability to provide analgesic management.

Pain Classifications

Acute: Duration of 0 to 7 days. The cause may be known or unknown. Acute pain usually occurs as part of a single and treatable event. Acute pain occurs as a result of traumatic injury, surgical procedure, or a medical disorder. It is often (not always) associated with autonomic nervous system responses (tachycardia, hypertension, diaphoresis). Acute pain decreases with time. Examples of diagnoses that are associated with acute pain include the following: fractured femur, appendicitis, burns, procedural pain.

Acute exacerbation of a recurring painful condition: Pain can occur over any duration of time. Pain is due to chronic organic nonmalignant pathology. Examples of diagnoses that include acute exacerbation of a recurring painful condition are the following: sickle cell pain episodes and migraine headache. There are pain free episodes between the exacerbations.

Chronic/persistent pain: Chronic (persistent) pain is pain that lasts longer than the expected time of healing. There is continuous pain or the pain recurs at intervals

for months or years. In some cases, there are acute exacerbations of chronic pain problems. The cause is often unknown. Examples of chronic/persistent pain include the following: low back pain, diabetic neuropathy, post herpetic neuralgia, multiple sclerosis, and phantom pain.

Cancer pain: Pain caused by “conditions that are potentially life-threatening.” The causes of cancer pain are: cancer itself, treatment of cancer and concurrent disease. Examples of cancer pain include the following: cancer of the pancreas, spinal cord compression caused by tumor infiltration, postsurgical pain associated with cancer treatment, post mastectomy syndrome.

Background

Pain is the most common reason for admission to the Emergency Department. Studies continue to show that pain is undertreated in the emergency department.¹

Additionally patients with pain may access care through the emergency department due to lack of access or pain relief from other care sites such as pain management, specialty and primary care practices.²⁻⁸

The nursing profession is committed to the provision of comfort and the prevention of suffering.⁹ The Emergency Nurses Association Scope of Practice uses Nursing’s Social Policy Statement¹⁰ as the framework for Emergency Nursing Practice. Included in the Emergency Nurses Association Scope of Practice is the collegial and collaborative interface of emergency nursing with other professional groups for the improvement of care.¹¹

The American Society for Pain Management Nursing’s mission is to advance and promote optimal nursing care for people affected by pain by promoting best nursing practice. This is accomplished through education, standards, advocacy, and research.¹²

The American College of Emergency Physicians promotes the highest quality of emergency care as described in its mission statement. Their vision statement describes their commitment to high quality patient care, teaching, leadership, research, and innovation.¹³

The American Pain Society supports efforts to increase the knowledge of pain and transform public policy and clinical practice to reduce pain-related suffering. One of its strategic goals is to continually improve the knowledge base of current and future professionals who care for persons in pain.¹⁴

The Joint Commission views pain management as an integral component of care and has expanded the scope of its pain management standards.¹⁵ The American Pain Society (APS) has endorsed these new standards. The standards apply to organizations involved in the direct provision of care.

The organizational commitment to pain management is represented by the Rights and Ethics Standard of JCAHO. This standard addresses the individual's right to involvement in all aspects of his/her care.¹⁵ This right is promoted by health care organizations by implementing "policies and procedures" that are compatible with their mission and resources, have diverse input, and guarantee communication across the organization. Structures within the organization are developed to provide individual and family involvement in their care. Individuals' involvement includes making decisions about management and treatment of their pain.¹⁵

Ethical Tenets

The ethical principles of beneficence (duty to benefit another) and non-maleficence (duty to do no harm) support the clinician's role in providing effective pain management and comfort to all patients including those who are at high risk of inadequate pain management (pediatric patients, elderly, and cognitively impaired).

Provision 4.1 of the ANA Code of Ethics states that the RN "retains accountability and responsibility for the quality of practice and for conformity with standards of care."⁹ These principles and provision oblige RNs to acquire the knowledge and expertise necessary for patient care in the Emergency Department.

The principle of justice (the equal or comparative treatment of individuals) obliges clinicians to provide quality pain management to all patients regardless of ethnicity or economic status.

References

1. Todd K, Ducharme J, Choiniere M, et al. Pain in the emergency department: Results of the Pain and Emergency Medicine Initiative (PEMI) multicenter study. *J Pain*. 2007; 8(6):460-466.
2. Hwang U, Richardson L, Sonuyi T, et al. The effect of emergency department crowding on the management of pain in older adults with hip fracture. *J Am Geriatr Soc*. 2006; 54(2):270-275.
3. Rupp T, Delaney K. Inadequate analgesia in emergency medicine. *Ann Emerg Med*. 2004;43(4):494-503.
4. Tamayo-Sarver J, Hinze S, Cydulka R, et al. Racial and ethnic disparities in emergency department analgesic prescription. *Am J Pub Health*. 2003;93(12):2067-2074.
5. Todd K. Influence of ethnicity on emergency department pain management. *Emerg Med*. 2001;13(3):274-278.
6. Todd K, Samaroo N, Hoffman J. Ethnicity as a risk factor for inadequate emergency department analgesia. *JAMA*. 1993; 269(12):1537-1539.
7. Todd K, Deaton D, D'Adamo A, et al. Ethnicity and analgesic practice. *Ann Emerg Med*. 2000; 35(1):11-16.
8. Pletcher MJ, Kertesz SG, Kohn MA, et al. Trends in opioid prescribing by race/ethnicity for patients seeking care in US Emergency Departments. *JAMA*. 2008;299(1):70-78.
9. American Nurses Association. Code of Ethics for Nurses with Interpretive Statements. Washington, DC, American Nurses Association. 2001.
10. American Nurses Association. Nursing's Social Policy Statement. Washington, DC, American Nurses Association. 1995.
11. Emergency Nurses Association. Standards of Emergency Nursing Practice. (4th ed) Des Plains, IL, Author. 1999.
12. American Society for Pain Management Nursing. Mission Statement & Goals 2007. Retrieved December 26, 2007, from www.aspmn.org.
13. American College of Emergency Physicians. Mission and Vision Statement, 2003. Retrieved December 26, 2007 from www.acep.org.
14. American Pain Society. APS Strategic Plan. 2004. Retrieved December 26, 2007 from ampainsoc.org
15. Joint Commission on Accreditation of Healthcare Organizations. Pain assessment and management: An organizational approach. Oakbrook Terrace, IL: 2000.

Suggested Reading

- American Society for Pain Management Nursing (ASPMN). (2002). Core Curriculum for Pain Management Nursing. Lenexa, KS, American Society for Pain Management Nursing.
- McCaffery M, Pasero C. Pain Clinical Manual, Second Edition. 1999. 462.
- McCaffery M. Medline abstract, *Pain Manage Nurs*. 2005;6(4):122-136.
- Weissman DE, Haddox JD. Opioid pseudoaddiction--an iatrogenic syndrome. *Pain*. 1989;36(3):363-366.