Changing Practice From Dosing to Numbers
to
Survey-Proof Range Orders: An Update

AN AMERICAN SOCIETY FOR PAIN MANAGEMENT NURSING®
POSITION PAPER

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Conflict of Interest Statements

Ann Quinlan-Colwell:
- Speakers bureau non-branded education Mallinckrodt
- Book royalties Springer Publishing Co.
- And she doesn’t cook

No conflict of interest for this presentation
- Diana Rae
- Kathleen Brogio
- Debra Drew

...It was the Perfect Storm

- American Pain Society and 5th Vital Sign
- TJC Standards
- Well intentioned but misguided surveyors
- ISMP Guidelines for order sets
- Widespread prohibition of range orders in hospitals nationwide
Examples of Range orders replaced with Dosing to Numbers:

- Morphine 2 mg IV q 2 hrs prn for pain ratings 1-3 (or “mild pain”)
- Morphine 4 mg IV q 2 hrs prn for pain ratings 4-6 (or “moderate pain”)
- Morphine 6 mg IV q 2 hrs prn for pain ratings > 7-10 (or “severe pain”)

What’s so Bad about That???

Over simplifies the complexity of pain assessment
- Pain intensity ratings are completely subjective
- No research supports a specific opioid dose will relieve pain of a specific intensity
- Discourages nurses from exercising clinical judgment
- Jeopardizes patient safety

…and

Disregards ISMP recommendations for well designed order sets

- Have potential to reduce unnecessary calls for clarifications and questions.
- Include objective, organization-determined measures that vary based on degree of the presenting symptom.
- Exclude range orders without objective measures to determine correct dose.

…and also
Ignores other critical factors that influence opioid requirement

- Age
- Present intensity and comfort goal
- Sedation level and respiratory status
- Functional goal for next few hours
- Tolerance
- Response to prior opioid treatment
- Physical and psychiatric comorbidities
- Patient’s mood/distress
- Conversation with the patient

ASPMN® Position Statement

“The American Society for Pain Management Nursing® (ASPMN®) holds the position that the practice of prescribing doses of opioid analgesics based solely on a patient’s pain intensity should be prohibited because it disregards the relevance of other essential elements of assessment and may contribute to untoward patient outcomes, such as excessive sedation and respiratory depression, as a result of overmedication. Administering opioid analgesics based solely on pain intensity can also result in poor pain control from undermedication.”


Solution:

A well constructed range order supported in policy with objective measures

- **TJC standard** MM04.01.01
  The organization has a written policy that identifies the specific types of medication orders that it deems acceptable for use.
- **Range Orders:** Orders in which the dose or dosing interval varies over a prescribed range depending on the situation or patient’s status
Examples that have passed survey

- Oxycodone 5-15 mg PO q 4 hrs PRN
- Oxycodone 5-10 mg PO q 4 hrs PRN. Start with 5 mg and may increase to 10 mg if pain is unrelieved. Patient may refuse any dose. Hold if sedation level is greater than 2.
- Hydromorphone 0.2-0.5 mg IVP q 2 hrs PRN breakthrough pain from PO meds
- Morphine 2-4 mg IVP q 2 hrs PRN moderate to severe pain if enteral not tolerated or effective

Avoiding Therapeutic Duplication

- Require separate orders for drugs with multiple indications, e.g., one for APAP for fever and one for APAP for pain
- Require scheduled ATC nonopioid foundation unless contraindicated, e.g., APAP, NSAID, AE
- Allow only one option for PRN oral opioid range order. Prescriber must choose one opioid from among the options.

Avoiding Therapeutic Duplication (continued)

- Allow only one option for PRN IV opioid range order. Prescriber must choose one opioid from among the options.
- Include instructions that IV opioid can only be used for breakthrough pain or pain unrelieved by oral opioid
- Do not use two ranges within the same order: i.e., dose and time range.
  e.g., Morphine 2-4 mg IV q 2-3 hours PRN
Hospitals that Use Range Orders and Passed Surveys

- New Hanover Regional Medical Center, Wilmington, NC
- Tallahassee Memorial HealthCare, Tallahassee, FL
- Northwestern Medicine Central DuPage Hospital, Winfield, IL
- University of California San Francisco Medical Center, San Francisco, CA
- Blessing Hospital, Quincy, IL
- Unity Point Health – Meriter, Madison, WI
- Berkshire Medical Center, Pittsfield, MA
- CHI Franciscan Health System, Tacoma, WA
- William S. Middleton Memorial Veterans Hospital, Madison, WI
- University of Minnesota Medical Center, Minneapolis, MN
- University of Washington Medical Center, Seattle, WA

Survey of ASPMN® Members

- IRB approved study
- Purpose: To determine if ASPMN® position paper assisted clinicians in policy development and passing regulatory surveys
- Invitation to participate in survey extended via list serve and electronic newsletter
- Total membership= 981
- List serve membership= 693
- 142 members participated. Not all questions were answered by every participant.

Survey Question 1

In this survey “dosing to pain intensity” signifies when dosing is based upon either a number from zero to ten OR mild, moderate, or severe. At your institution are PRN analgesics dosed based upon:

- Numbers (zero to ten)
- Mild, moderate, severe
- Neither
- Something different
Q1: In this survey “dosing to pain intensity” signifies when dosing is based upon either a number from zero to ten OR mild moderate or severe. At your institution are PRN analgesics dosed based upon:

Answered: 120    Skipped: 22

- Numbers (zero to ten): 48.7%
- Mild moderate severe: 31.7%
- Neither: 9.2%
- Something different: 12.5%

Survey Question 2

If PRN analgesics are not prescribed dosed to pain intensity ratings, was the change made:

- Less or equal to 6 months ago: 4.2%
- More than 6 months ago, but less than one year ago: 5%
- Greater than one year ago but less than 2 years ago: 6.8%
- Greater than 2 years ago but less than 3 years ago: 4.2%
- Greater than 3 years ago: 4.2%
- Not applicable - did not change: 75%
Survey Question 3

Was the decision to discontinue dosing PRN analgesics to pain intensity ratings influenced by the American Society for Pain Management Nursing (ASPMN) position paper discouraging this practice?

- Yes
- No
- Not applicable - did not change
- Not applicable - I don't know about the ASPMN position paper

Q3: Was the decision to discontinue dosing PRN analgesics to pain intensity ratings influenced by the American Society for Pain Management Nursing® (ASPMN®) position paper discouraging this practice?

- Answered: 117  Skipped: 25
- 11.1%
- 14.5%
- 70.1%
- 7.5%

Survey Question 4

Was the decision to discontinue dosing PRN analgesics to pain intensity ratings influenced by the presentation at the September 2016 ASPMN® conference?

- Yes
- No
- Not applicable - did not change
- Not applicable - changed prior to ASPMN® presentation
- Did not attend session
Q4: Was the decision to discontinue dosing PRN analgesics to pain intensity ratings influenced by the presentation at the September 2016 ASPMN® conference?

- Answered: 120
- Skipped: 22

Survey Question 5

Which nursing barriers have you encountered in trying to make the change to discontinue dosing PRN analgesics to pain intensity ratings? (choose all that apply)

- Lack of understanding of legal consequences of inappropriate medication administration
- Standardized descriptions of pain intensity
- Lack of knowledge of spectrum of adverse opioid effects
- Lack of knowledge multimodal analgesia
- Other (please specify)
Survey Question 6

Which prescriber barriers have you encountered in trying to make the change to discontinue dosing PRN analgesics to pain intensity ratings? (choose all that apply)

- Variability in training/knowledge/practices of pain management
- Misconceptions related to assessment and management of pain
- Use of standardized order sets
- Other (please specify)
Q6: Which prescriber barriers have you encountered in trying to make the change to discontinue dosing PRN analgesics to pain intensity ratings? (choose all that apply)

- Answered: 114    Skipped: 28

   - 69.3%
   - 56.1%
   - 62.3%
   - 27.2%

Q6: OTHER prescriber barriers encountered in trying to make the change to discontinue dosing PRN analgesics to pain intensity ratings

Joint Commission

Education    Pain    Residents

Order    Decision

Examples of Responses

- Institutional use of EPIC & changes to order sets needs to go through multiple "channels" for approval/change.
- "Physicians not happy with increase calls to order medication correctly."
- "The attendings worried about residents having to attend to pain overnight without orders for higher strength opioids for prn pain intensity."
- "Residents need a little more education on this."
- "APPs, especially PAs who have inadequate training & are simply following the attending's preference."
- "Most physicians are not comfortable with range orders & are encouraged to use the descriptors, mild, moderate and severe when prescribing."
- "Providers wanting a simplistic practice such as order sets to fit everyone when in reality every patient needs individualized pain care plans."
Survey Question 7

What institutional barriers have you encountered in trying to make the change to discontinue dosing PRN analgesics to pain intensity ratings? (choose all that apply)

- Leadership lacks adequate knowledge related to advances in pain management and changes over time
- Leadership lacks adequate knowledge of development and implementation of safe pain management policies that will be accepted by regulators
- Policies that rely on pain severity rating are the cornerstone of pain assessment
- Lack of oversight of variability in pain management prescribing patterns
- Other (please specify)

Q7: What institutional barriers have you encountered in trying to make the change to discontinue dosing PRN analgesics to pain intensity ratings? (choose all that apply)

Answered: 112    Skipped: 30
46.4%  55.4%  49.1%  25%  42.9%  25%

Q7: OTHER institutional barriers you encountered in trying to make the change to discontinue dosing PRN analgesics to pain intensity ratings

Difficult Leadership
Joint Commission Surveyors
Assessment Orders Approach
Pain Institution Hospital
Prescribing
Scope of Practice Nursing
Examples of Responses

- "EMR"
- "We cannot make changes without Corporate's approval."
- "We are part of a large system, this merger took place in 2015. The approach the system took in relation to pain management orders was vastly different than my hospital. We have had to create workarounds to support the practice we had prior to the merger."
- "TJC consistently dings us on prn reasons for pain meds & continues to recommend we dose to pain score. We had multiple issues with therapeutic duplication so the hospital got on board with identifying other reasons for pain meds (not tolerating PO, pain not controlled by ___, 1st line, 2nd line, etc.)."
- "Confusing (Confusion?) related to comments made by Joint Commission surveyors (including Mock) and interpretation related to scope of practice, nurse practice act, and assessment."

Examples of Responses (continued)

- "Leadership worried that TJC surveyors are not aware that range orders are permissible."
- "Pharmacy refuses to change dosing to pain modifiers, such as mild, moderate, severe. They cite TJC as being the driving force behind nurses not having the scope of practice to choose medications/dosages from a range order."
- "Changes must be approved by multiple hospitals within the organization."
- "We were told we need a BON statement & we can't get our state BON to release one. We held out not using pain scores until our move to Epic, about 2 years ago."
- "Institution unwilling to make change as this dosing practice was just implemented in order to address joint commission identified deficiencies."

Survey Question 8

If your institution discontinued prescribing analgesic medications based upon pain intensity ratings, would you be willing to be interviewed to discuss your experience? If yes, contact Ann Quinlan-Colwell at ann.quinlan-colwell@nhrmc.org

- Yes
- No
- Not applicable
Q8: If your institution discontinued prescribing analgesic medications based upon pain intensity ratings, would you be willing to be interviewed to discuss your experience? If yes, contact Ann Quinlan-Colwell at ann.quinlan-colwell@nhrmc.org

Answered: 118    Skipped: 24

13.6%
12.7%
74.8%

Responding to Surveyor’s Questions

Q. How does a nurse know what dose to give within a given range?

A. E.g.
Our policy guides nurses to give the lowest dose in the range for the first dose. After the patient’s reaction to the lowest dose, the nurse reassesses patient status which guides the next clinical decision:
- Whether to give more medication within the allotted time interval
- Refrain from dosing again
- Collaborate with prescriber to modify the plan

Responding to Surveyor’s Questions

Q. How does a nurse implement a range order that does not specify intensity or descriptors?

A. E.g.
Nurses use more than the patient’s self report of pain intensity in a complete assessment. The patient’s perceived intensity is considered along with the patient’s functional status (e.g. sedation level). The nurse’s clinical decision to implement the order, or call for modification, also considers the patient’s response to previous doses, other medications, age, physical and psychiatric comorbidities, and tolerance to the medication.
Responding to Surveyor’s Questions

Q. How does a nurse know when a patient has moderate to severe pain?

A. E.g.
   Thorough assessment of a patient who can self report involves an interactive conversation and observation that includes:
   • Pain Intensity
   • The pain’s effect on functional status and sleep
   • Efficacy of previous intervention

   With complete assessment, the nurse makes a judgment that pain is more than mild and proceeds with treatment.

Responding to Surveyor’s Questions

Q. How does a nurse know when to give the next dose within a range order?

A. E.g.
   The institution has defined in policy that we endorse (insert “rolling clock” or “measure from time of first dose”) method.

   Note: Definition of terms must be clear and communicated to staff so that everyone shares a common understanding of when doses can be augmented or repeated.

Summary

USING A SIMPLE PAIN INTENSITY MEASURE TO ASSESS PAIN AND GUIDE DOSing OF OPIOIDS:

- OVER SIMPLIFIES THE COMPLEXITY OF PAIN ASSESSMENT
- JEOPARDIZES PATIENT SAFETY
- DISREGARDS ISMP RECOMMENDATIONS FOR WELL-DESIGNED ORDER SETS
- IgNORES OTHER CRITICAL FACTORS THAT INFLUENCE OPIOID REQUIREMENT
Let’s Talk

To access pdf of position paper:


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References
