

Pain and End of Life Care

MUHA

Adult and Children's Hospitals

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Objectives

- Define pain
- Describe types of pain
- Differentiate between addiction, tolerance, and dependence
- List strategies to ensure effective pain management
- Identify Joint Commission pain standards
- Identify MUHA Policy C-64 as guidelines for pain management

Definition of Pain

- "An unpleasant sensory and emotional stimulus associated with actual or potential tissue damage or described in terms of such damage." (International Association for the study of Pain, 1979)
- "Pain is whatever the experiencing person says it is, existing whenever he/she says it does." (McCaffery 1968)

Basic Types of Pain

Acute: Relatively brief, pain that subsides as healing takes place.

- Defined onset, self-limiting, tells you something is wrong, serves a purpose

Chronic: Can persist for months, serves no purpose, no change in vital signs

- Malignant (cancer)
- Non-malignant (non-cancer)

Combination: Chronic with acute exacerbations

Basic physiology of pain

Nociceptive Pain:

- Results from ongoing activation of primary afferent neurons by noxious stimuli (intact nervous system)
- Somatic: Arises from bone, joint, muscle, skin, or connective tissue:
 - normally opioid sensitive
- Visceral: Arises from visceral organs, such as GI tract or pancreas.
 - normally opioid sensitive

Basic physiology of pain

Neuropathic:

- Abnormal processing of sensory input by peripheral or central nervous system (lesion or dysfunction)
- Proposed mechanism: peripheral nervous system damaged in some way
- Relatively opioid resistant
- Treatment should include *adjuvant analgesics*

Did you know?

- Pain is the most common reason individuals seek medical attention but only 1 in 4 receive proper treatment for their pain
- Unrelieved pain has adverse physical and psychological effects (APS, 1999)
- Over 75 million Americans suffer with pain each year (APS, 2000)
 - ⊕ Approximately 50 million Americans suffer with chronic pain each year
 - ⊕ About 25 million Americans have acute pain from injury or surgery

Myth busting: Addiction

- A psychological dependence; a pattern of compulsive drug use characterized by craving and the need to use a drug for effects other than pain relief.
- A psychological and behavioral syndrome with 3 distinguishing characteristics:
 - Loss of control over drug use
 - Compulsive drug use
 - *Continued use despite harm*

Physical Dependence

Dependence- An adaptive neuro-physiological response to the chronic presence of a drug

- Expect to occur after 2-3 days of repeated doses of an opioid

Withdrawal or Abstinence syndrome

- Is a manifestation of physical dependence.
- Occurs when drug is abruptly stopped or antagonist is given
- Not an indicator of addiction

Tolerance

A pharmacodynamic response at the neurophysiologic level to chronic drug administration

- Evidenced by reduction in response or effect to a given dose of a drug after repeated administration
- Occurs after 2-3 days of repeated dosing
- Tolerance to some of the effects of opioids is expected (sedation, respiratory depression)
- Not an indicator of addiction
 - Tolerance develops to the effects of many classes of drugs, e.g. Corticosteroids

Barriers

Health Care Professionals:

- Inadequate knowledge of pain management
- Poor pain assessment skills
- Concern over side effects such as respiratory depression
- Fear of Addiction/Tolerance

Patients

- Reluctance to report
- Reluctance to take pain medication
- Fear of addiction by patient or family member

Joint Commission (JC) Pain Standards

- The hospital addresses care at the end of life (RI.1.2.8.):
 - Hospital framework provides for: Managing pain aggressively and effectively
 - Effective pain management is appropriate for all patients, not just dying patients
- Patients have the right to appropriate assessment and management of pain (RI.1.2.9)



JC Pain Standards

- Pain is assessed in all patients (PE.1.4)
- Each patient is reassessed at points designated in hospital policy (PE.2)
- Reassessment occurs at regular intervals in the course of care (PE.2.1)
- Reassessment determines a patient's response to care (PE.2.2)
- Significant change in a patient's condition results in reassessment (PE.2.3)



JC Pain Standards

- Patients are educated about pain and managing pain as part of treatment, as appropriate (PF.3.4)
- The organization collects data to monitor its performance (PI.3.1)
 - The appropriateness and effectiveness of pain management



Question 1

Patients have the right to appropriate screening, assessment and management of pain.

True

or

False

Question 2

Physical dependence is an indication of addiction.

True

False

MUSC Policies: Related to Pain

- Pain Policy (C-64)
- Patient Controlled Analgesia (C-55)
 - Separate orders (Primary service may order)
 - Subcutaneous infusion
- Epidural Analgesia (C-54)
 - Separate orders (Anesthesia writes orders)
- Peripheral Nerve Block (C-111)
 - Separate orders (Anesthesia writes orders)

MUHA policy C-64

- Designates for all areas on campus (including ambulatory care and institute of psychiatry) the individual providers responsibilities for monitoring and documenting pain management activities for MUSC
- Direct reflection of JCAHO standards
- READ THE POLICY at least ONCE

MUHA policy C-64



Example: Responsibilities

- Guidelines for RN or Provider regarding pain management:
 - Admission and follow-up guidelines for pain assessment
 - Re-screen and re-assessment guidelines
 - Documentation standards
 - Educating patients on use of appropriate pain scale

- How CA/PCT can collaborate with providers
 - Alert providers when patient reports pain

MUHA Pain Policy: C-64

Example: Definitions



- **Pain Score:** The report of a patient
- **Pain Screening:** A systematic and guided (supervised) approach to collecting health care information or data from a patient. Does not involve interpretation of information or data except to report abnormal findings to a RN or provider.
 - Re-screening implies that initial education of appropriate pain scales has occurred and is a follow-up to the initial screening.

MUHA Pain Policy: C-64

Definitions continued

- **Pain Assessment:** The systematic interpretation of health care information from a patient that is the foundation for creating a plan of care.
 - Screening and health care data maybe collected by designated employees trained in screening and data collection procedures. *However,*
- Interpretation of the data (assessment) **MUST** be completed by RN or provider. RN or Provider must complete a pain assessment for all reported pain sites if applicable to the visit

MUHA Pain Policy: C-64

Example: Trigger for Pain Assessment

- The patient's self-report of pain is the single most reliable indicator of pain (AHCPR, 1992, Jacox, et al., 1994)
- Triggers for Assessment:
 - Adults > 0 out of 10
 - Children > 0 out of 10
 - Nurseries \geq 8 out of 16
- And/or is considered significant by the patient (greater than personal relief goal)
- And/or interferes with patient healing or activities of daily living

MUHA:Pain Policy C-64

Documentation

- 1 hour post-intervention re-screen, score and assessment and related documentation applies to all pain interventions, EXCEPT ATC (around the clock) dosing
- Routine vital signs (minimum q8h for pain) covers the screening for ATC pain medications, just as routine vital signs cover the screening for ATC meds for blood pressure

MUHA:Pain Policy C-64

Example: Dose Range Guidelines

- Dose Range Guidelines
 - Dose range OK (2-6 mg of Morphine)
 - Time range NOT OK (q4-6 hours)
 - Correct = 2-6 mg Morphine q 4 hours
- Dose amount is based on documented patient pain score and assessment
- If less than maximum dose given, an additional dose may be given that does not exceed the maximum dose ordered within the time frame ordered for pain.

Question 3

According to MUSC Pain policy C-64, all patients will have an initial pain score and screening completed by a designated employees and if indicated, an assessment completed and documented by the RN or provider.

True

False

Question 4

RN or providers will educate patient and their families about pain screening and management.

True

False

Question 5

According to MUSC Pain policy C-64, a pain score is re-screened and documented at specific intervals that are dependent on the characteristics of the patient population.

True

False

Question 6

According to MUSC Pain policy C-64, a pain screen must be completed and documented within **2** hours after an intervention for pain is completed.

True

False

Question 7

According to MUSC Pain policy C-64, the RN performs a pain assessment for adult and pediatric patients who have a pain score >0 , greater than or equal to 8 in for patients in the nursery, pain that is considered significant to patient, or pain that interferes with healing or activities of daily living.

- True
- False

Question 8

Pain **assessments** (not screens) can be delegated by RN to assistive personnel.

True

False

Range Orders

- The maximum pain medication dose in the range order should be at least 2 times but no more than 4 times the minimum dose in the range (e.g. 2-8 mg Morphine)
- Prior to the administration of a pain medication with a dose range, the nurse will assess the patient for pain and document the findings of physical assessment parameters (e.g. vital signs), degree of discomfort, location of pain, and level of pain utilizing the appropriate scale

Range Orders

- Any subsequent dose should be administered from the time the *first* dose was given
-
- No more than the maximum amount ordered can be administered within any ordered time frame
- e.g. Percocet 1-2 tabs PO q 4 hours PRN. If you administer 1 tab at 1200 and 1 tab at 1300, you could administer 1 tab at 1600 or wait and administer 2 tabs at 1700

MUHA policy C-64

Example: Appendices

- Appendix A: Policy Quick Reference Guide - Inpatient
- Appendix B: Policy Quick Reference Guide - Ambulatory Care
- Appendix C: Algorithm for Pain Screening and Assessment
- Appendix D: Pain Assessment Scales – Pediatrics
- Appendix E: Pain Assessment Scales – Adult
- Appendix F: MUSC Pain Services
- Appendix G: Guidelines for Non-pharmacological Interventions
- Appendix H: Guidelines for Pharmacological Interventions
- Appendix I: Guidelines for Management of Opioid Side Effects
- Appendix J: Opioid Sedation Scale (OSS)
- Appendix K: Guidelines for Analgesic Trial
- Appendix L: Guidelines for IV Opioid Range Orders

End of Life Care at MUSC

Objectives

- Discuss JC end of life regulation
- Describe scope of palliative care and role to improve end of life care at MUSC
- State how to contact palliative care services at MUSC
- Recognize the role of the interdisciplinary team in providing end of life care

JC Regulations: End of Life

- Patients have the right to refuse care, treatment and services in accordance with the law and regulation (RI 2.70)
- The organization addresses the wishes of patients related to end-of-life decisions (RI 2.80)
- Comfort and dignity are optimized during end-of-life care (PC 8.70)

Palliative Care

- Interdisciplinary care that aims to relieve suffering and improve quality of life for patients with advanced illness and their families.
- Offered simultaneously with all other appropriate medical treatment.

(2003: Center to Advance Palliative Care, Meier, MD)

Palliative Care's Place in the Course of Illness

Life Prolonging Therapy



Death

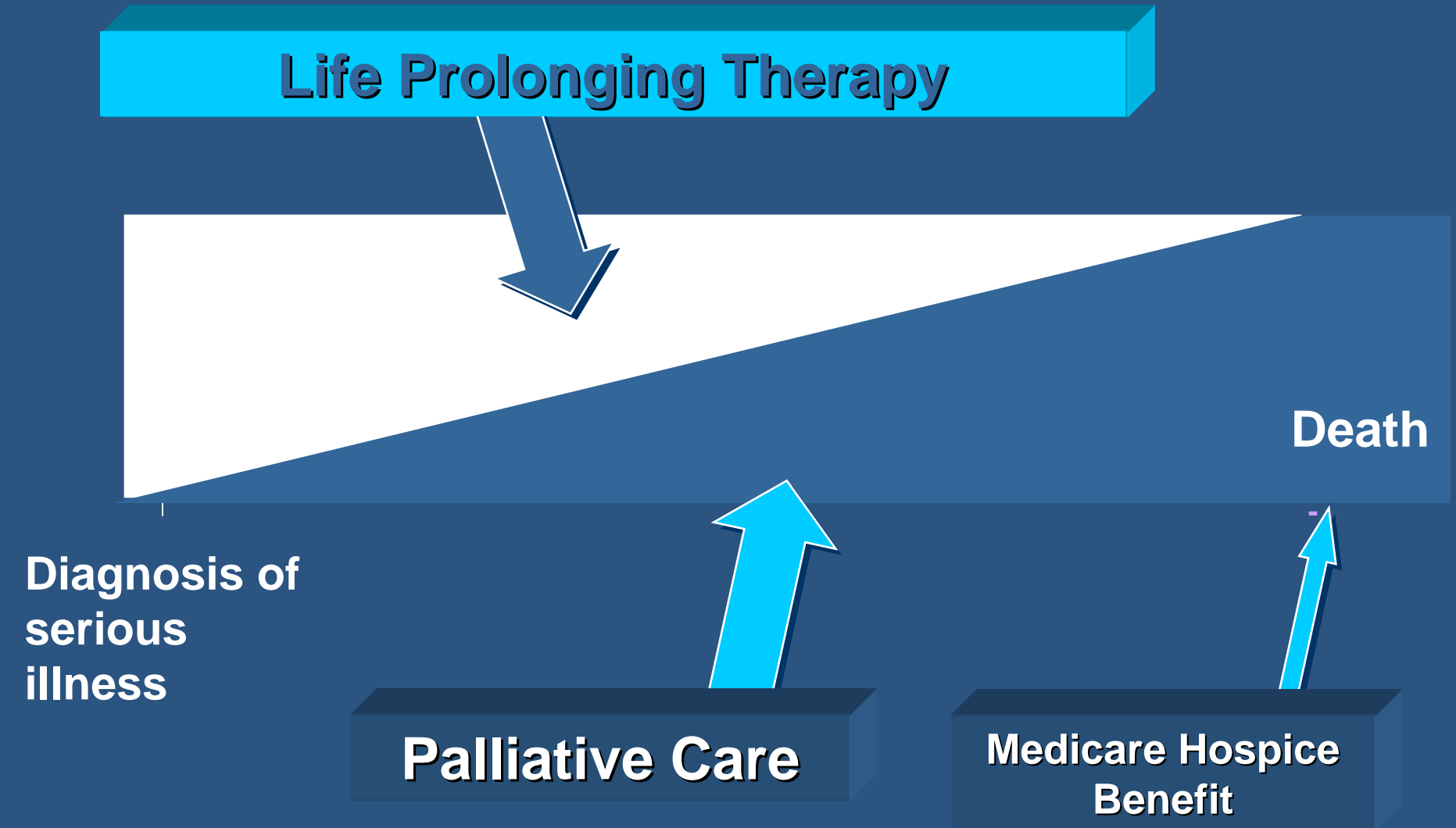
**Diagnosis of
serious
illness**



Palliative Care



**Medicare Hospice
Benefit**



Principles of Palliative Care

- Affirms life, regards dying as a normal process.
- Neither hastens nor postpones death
- Focus is on treatment that enhances comfort, alleviates symptoms and improves quality of life
- Dying is a process, not an illness
- Patient and family are unit center of care
- Holistic approach to care: focus on physical, psychological, social and spiritual needs

What Do Patients with a Serious Illness Want?

- Pain and symptom control
- Avoid inappropriate prolongation of the dying process
- Achieve a sense of control
- Relieve burdens on their family
- Strengthen relationships with loved ones

(Singer et al, JAMA 1999)

Palliative Care Consults at MUSC

- Available in Adult and Children's Hospitals
 - Formal Consult- provider to provider communication
 - Informal Consult- staff may call consult for support or issues surrounding EOL care or symptom management
 - Contact: Paging operator for Palliative Care provider on-call
 - Call appropriate team case manager to assist with hospice referrals

MUSC Policy C-50: Care at the End of Life

- Palliative care interdisciplinary team:
 - Physicians, nurses, nurse practitioner, care manager, chaplain, hospice liaison, all specializing in palliative care
- Provides practitioners with basic guidelines for the unique needs of dying patients
 - Establishing goals of care
 - Pain and symptom management

End of Life Care Related Policies

- C-1 Patient rights and Responsibilities
- C-12 Advance Directives
- C-13 Resuscitation Orders
- C-23 Withholding / Withdrawing Life-sustaining Treatment

Conclusion

- Quality end of life care focuses on a comprehensive interdisciplinary approach
- Palliative care is an ongoing process not limited to the final days of life
- Patient and family centered care is essential for good outcomes

Question 9

Patients and their surrogates never have the right to refuse care.

True

False

Question 10

Palliative care is offered simultaneously with all other appropriate medical treatment.

True

False

Question 11

Palliative care defines the patient/family as the center unit of care.

True

False

Congratulations!

- You have completed the lesson on Pain and End of Life Care.

Thank you!