Alaska Board of Nursing
Advisory Opinion
Adopted January 20, 2009

This Advisory Opinion supplants the previous Advisory Opinion issued by the Alaska Board of Nursing on June 2006.

Regulatory Implications: the Advanced Practice Registered Nurse in a Pain Management Primary Care Role

(Adopted from the ***Regulatory Implications of Pain Management Resource Pack*****,**

National Council of State Boards of Nursing, 2008)

An advisory opinion adopted by the Alaska Board of Nursing is an interpretation of what the law requires. While an advisory opinion is not law, it is more than a recommendation. In other words, an advisory opinion is an official opinion the Alaska Board of Nursing regarding the practice of nursing as it relates to the health and safety of the Alaska healthcare consumer. Facility policies may restrict practice further in their setting and/or require additional expectations related to competency, validation, training and supervision to assure safety of their patient population and/or decrease risk.

The Alaska Board of Nursing publishes Advisory Opinions regarding safe nursing practice, in accordance with AS 08.68.100(a)(9).

The scope of practice of the APRN is unique in the nursing profession. The APRN practices as an independent primary care provider in a majority of states, with nearly all states conferring controlled substances prescribing authority upon APRNs, in conjunction with the DEA. In the role of primary care provider or licensed independent provider (LIP), the APRN is held to a high standard of education and practice in patient care.

In providing treatment for pain, the APRN is charged with the responsibility to diagnose the causes of pain, intervene with a variety of therapies, and evaluate the effectiveness of pain treatment being prescribed. The APRN is responsible for appropriate, accurate and complete documentation of assessment, treatment plan, informed consent and ongoing review of efficacy.

Introduction to Specific Regulatory Aspects

The Federation of State Medical Boards stated in *Model Policy for the Use of Controlled Substances for the Treatment of Pain,* that the following circumstances contribute to the prevalence of under-treated pain:

Lack of knowledge of medical standards, current research, and clinical guidelines for appropriate pain treatment;

The perception that prescribing [or administering] adequate amounts of controlled substances will result in unnecessary scrutiny by regulatory authorities;

Misunderstanding of addiction and dependence; and

Lack of understanding of regulatory policies and processes. (FSMB, 2004)

Several boards of nursing have addressed expectations regarding pain management. The Arizona and Alaska Boards of Nursing have published Advisory Opinions regarding the use of controlled substances for the treatment of chronic pain by APRNs, providing guidance regarding assessing and treating pain with controlled substances, including clear expectations regarding how the APRN is expected to comply with laws and regulations. (AZ BON, 2004; AK BON, 2006). The California Board of Registered Nursing adopted a standard of care for California RNs of assessing pain and evaluating response to pain interventions using a standard pain management scale, using patient self-report and documentation of pain assessment each time that vital signs are recorded for each patient. (CA BORN, 1999) The Oregon Board of Nursing developed a pain management position statement in 2004, addressing the distinct roles of both the RN and APRN in assessment of pain and administration of relief measures, as well as the APRN role in prescribing opioid analgesics and other interventions (see Appendices).

APRNs need to be knowledgeable about the regulation of advanced practice nursing and the significant variations in APRN scope of practice from state to state.

Professional Standards and Practice Expectations

Promoting pain relief, while at the same time preventing abuse of pain medications, becomes a balancing act. Preventing drug abuse is an important societal goal, but there is consensus by law enforcement agencies, health care practitioners, and patient advocates alike, that it should not hinder patients' ability to receive the care they need and deserve. (Joint Statement of the DEA et al., 2001)

The APRN, like all primary care providers, must work collaboratively with the patient for the best outcome. It is important for the patient to be fully informed concerning side effects as well as realistic expectations for pain relief. There are settings and situations where standards of pain management are unique, i.e. end-of-life care or disaster management.

The APRN treating acute or chronic pain is responsible for understanding the physiology of pain; treatment options, including surgical, physical therapy, pharmacologic and non-pharmacologic interventions; the pharmacokinetics, adverse effects and interactions of the medications selected for treating pain; and the appropriate documentation of treatment choices. While the use of opioid analgesics to treat pain is a legitimate medical use, there is additional responsibility for understanding the complex pharmacokinetics of these medications. Optimal pain management encompasses the correct medication, available in the correct dose, via the correct route of administration, at the correct time, with minimal and manageable side effects.

The field of pain management is rapidly evolving, with improved interventions and greater knowledge of the pharmacokinetics and molecular biology of medications. The APRN must be aware of pain treatment options, which may include aspirin, morphine, antidepressants or anticonvulsants and others, reversible interventions (such as local anesthetics, steroids, nerve blocks, trigger point injections), and irreversible interventions

(such as surgery, nerve destruction). Many alternative interventions may be used in conjunction with other therapies, including acupuncture, nerve stimulation, physical therapy, and psychology. Implantable nerve stimulators and infusion pumps may be used for chronic, intractable pain. New technologies are continually being developed, which requires the APRN to be knowledgeable about the appropriate combinations of pharmacologic and non-pharmacologic treatments.

Acute Pain

Acute pain, resulting from injury or surgical intervention, typically lasts less than three months. The principles of pain relief include the importance of titrating medication to the desired effect of pain relief, taking into account the time needed for the medication to take effect, as well as factors affecting length of effect. Co-morbidities can prolong or shorten pain relief onset and/or duration.

Chronic Pain

Chronic pain is generally defined as lasting longer than three months. Medications, opioid and nonopioid, are frequently used to treat chronic pain. Ineffective pain management may be the outcome when concerns regarding potential addiction impact decisions on the use of opioids.

Opioids are not always the first line of treatment for chronic pain. Some chronic pain syndromes do not respond to opioid medications. APRNs treating chronic pain require knowledge of a variety of categories of medications that can relieve pain. For example, neuropathic pain may respond better to antidepressants, anticonvulsants, or alpha-2 adrenergic agonists. Non-pharmacologic interventions may be helpful. Notwithstanding, the best efforts on the part of clinicians; not all patients will experience optimal relief from chronic pain, despite the appropriate use of analgesic interventions.

Some Guidelines for Documentation of Assessment and Care

There is no objective measurement of pain (MGH Handbook of Pain Management). However, appropriate assessment of history and physical findings, coupled with an understanding of pain pathophysiology guides rational, appropriate treatment. Documentation of assessment, treatment outcomes and ongoing follow-up is important for patient safety and communication with other health care providers.

Consistent with accepted standards (FSMB), accurate, legible and complete records include:

Pain history that includes:

- The onset and character of the pain, such as description, quality, intensity, duration, and impact of the pain on function;
- Treatment history;

Relevant psychological history (including screening for anxiety, depression, somatoform disorder, coping style, and personality traits);

Vocational and medical legal issues;

General medical history;

Patient's perception about the cause of the pain; and

Patient's goals and expectations.

Physical examination that includes an appropriate examination for the symptoms. This may be a more thorough examination in the case of acute pain or initial evaluation for chronic pain. A directed examination in ongoing chronic pain management would include:

Musculoskeletal;

Neurological;

Skin; and

Psychological.

Psychological evaluation should be included in initial evaluation, with regular reassessment, addressing:

Screening for depression, anxiety, substance abuse;

Prior psychological evaluation and treatment review; and

History of alcohol or other drug addiction, including treatment by addiction specialists.

Functional status – self-reported and/or objective evaluation.

Laboratory testing and imaging as appropriate.

Diagnosis, including contributing medical and psychiatric co-morbidities.

Treatment plan, including:

Specific, measurable, realistic goals;

Rationale for interventions;

Documented discussion with the patient of risks, benefits, and alternatives;

Medications selected, with dose and quantity prescribed;

Patient education;

Patient agreements or contracts;

Plan for consultation, when needed; and

Plan for re-evaluation.

Outcomes, including:

Pain reduction;

Physical function changes;

Psychosocial function changes;

Work status;

Medication use; and

Ability to self-manage pain with non-pharmacologic interventions.

In the management of chronic, nonmalignant or malignant pain,[9] a written agreement between the APRN and the patient may be helpful when opioid analgesics are prescribed. Typical elements of a medication management agreement are:

Regular office visits at a prescribed interval;

Informed consent, outlining the potential risks, benefits and alternatives of the medications being prescribed;

Limit prescription to one prescriber only;

Limit refills to only a specified number and frequency, with no early refills;

Use one pharmacy only, giving the name of that pharmacy;

Random drug screens, urine or serum, when requested;

Pill counts, when requested;

Permission to speak with family members about the effects of the medications being prescribed;

Psychological counseling as deemed necessary by the APRN; and

Potential of discontinuation of controlled substance prescriptions.

A written agreement may not be necessary in the management of acute pain, anticipated to last less than three months. This is appropriately determined on a case-by-case basis, taking into account the individual's physical and psychological history.

Periodic review of the effectiveness of the treatment plan is critical. The APRN should reassess the appropriateness of the current plan, altering it as necessary. The treatment of chronic pain is complex and often consultations and referrals are needed for additional evaluation and treatment.

Specialized Knowledge and Skills of the APRN

The treatment of malignant and non-malignant chronic pain, as well as acute pain, is complex, requiring increased awareness and specialized education by the treating APRN. Education must include how to solicit pain level from patient, the phenomena of addiction, pseudo-addiction, tolerance, and dependence, the variety of treatment options, which include non-pharmacologic therapies, and the safe use of controlled substances and other medications.

Specialized education in pain management is the responsibility of the individual practitioner to pursue, appropriate to their practice. Graduate education and

preceptors/mentors can work together to assure that graduate students, novice, and experienced APRNs are exposed to current standards and expectations regarding pain management, the latest research and clinical guidelines, the whole range of therapeutic interventions available to manage pain, and the distinctions between drug dependence and drug addiction.

Education is needed to equip APRNs to understand regulatory policies and processes and their implications for day-to-day practice. In addition to expertise in the pain management modalities, APRNs must develop competence in the expected standards of pain management. The state of Oregon has implemented statute requiring a one-time pain management continuing education course for all healthcare providers in the state.

The Role of the Board of Nursing

Many health care practitioners, including APRNs, fear being investigated for over-administering or over-prescribing controlled substances for pain. This fear can pose a barrier to effective pain management. Regulatory boards must consider the balance of promoting appropriate pain management against deterring inappropriate use of pain medications. Under-treatment of pain decreases patient functional status, safety, and quality of life.

The APRN may feel pulled in different directions by expectations of the employer, licensing board, legal requirements of the Drug Enforcement Agency (DEA), expectations of other health care team members, and the optimal care for the patient. APRNs who effectively manage pain contribute to improved quality of life for individuals, while those who fail to provide adequate pain interventions may be subject to disciplinary action for failing to meet professional standards.

Boards need to be aware that patients, family members, and other members of the lay community may not understand the need for pain management, which adds to the complexity of effective treatment. Patients may fear addiction or being thought of as an addict. They may fear that pain, especially the need for opioid medications, means that their condition is worse. Patients may think that reporting pain will distract from the treatment of the underlying disease, so they may try to be a "good patient" who does not complain. They may be reluctant to take medications, expecting serious side effects. Sometimes those with chronic pain think that using the medication now will limit its effectiveness in the future, "when really needed." As a result, patients may still be in pain. Caregivers are afraid of causing harm and may be conflicted between wanting to ease the patient's pain but also being worried about addiction and side effects.

There have been situations when a prosecutor becomes alarmed because of high and increasing doses of controlled substances for a group of patients, not understanding that this is a pattern that might be expected in a hospice or palliative care setting and in some patients with persistent pain. Boards of nursing can be effective educators related to the implementation of pain management by APRNs, while upholding standards of care and quality.

If a board has identified that an APRN has failed to meet the expectations of pain management standards, the board must determine the appropriate course of action.

Boards of nursing are charged with public protection and recognize that this protection includes access to effective patient care and assurance of the competency and accountability of nurses, including APRNs.

Boards of nursing need to have knowledge about the complexity of pain management, understanding that:

Under-treatment of pain is a critical public health problem;

Standards of practice for pain management have been articulated;

An array of therapies and tools are available for use in pain management;

APRNs and other health care practitioners may fear scrutiny by regulators; and

APRNs and other health care practitioners may fear disciplinary action for administering too much or too little pain medication.

Boards of nursing have an opportunity to collaborate with graduate program educators and preceptors to support pain management practice through education about the:

Standards of pain management; and

APRN authority to prescribe, including:

Prescribing controlled substances.

Guarding against misuse of prescription forms:

Balance between promoting pain relief and preventing drug abuse; and

Regulatory process and disciplinary implications when an APRN fails to meet expectations for managing patients pain effectively.

Boards of nursing expect APRNs to:

Maintain their knowledge of the complexities and challenges of pain management;

Implement pain management treatment standards, including pain assessment, intervention, documentation, and evaluation;

Appropriately consult with specialists;

Comply with state and federal Controlled Substances Law and Regulations;

Advocate for patient needs; and

Collaborate and cooperate with other health team members in addressing patient pain.

Conclusion

As independent primary care providers, APRNs are responsible for providing compassionate, evidence-based healthcare. When statutes and regulations permit, APRNs may accept the additional responsibility for prescribing controlled substances for pain

management. To assure competence, APRNs are accountable for acquiring and maintaining the knowledge and clinical expertise to provide this type of healthcare.

Boards of nursing are charged to protect the public through the regulation of safe nursing practice. It is vital that boards of nursing understand the complexities of pain management and controlled substance prescribing. The ideal result is implementation of nursing regulation that function as a support, not a barrier, to the implementation of pain management by APRNs, while upholding standards of care and quality. When these conditions coexist, the public optimally benefits from the unique skills and knowledge of APRNs.

Works Cited:

Arizona State Board of Nursing. (2004). *The use of controlled substances for the treatment of chronic pain*. Retrieved April 16, 2008, from http://www.azbn.gov/Documents/advisory_opinion/AO%20Controlled%20Substances-Use%20for%20Treatment%20of%20Chronic%20Pain.pdf

Alaska Board of Nursing. (2006). *The use of controlled substances for the treatment of pain by advanced nurse practitioners*. Retrieved April 15, 2008, from http://www.dced.state.ak.us/occ/pub/nur1808.pdf

California Board of Registered Nurses. (2004). *The nurse's role in pain management*. Retrieved April 16, 2008, from http://www.rn.ca.gov/pdfs/regulations/npr-i-32.pdf

Federation of State Medical Boards. (2004). *Model policy for the use of controlled substances for the treatment of pain*. Dallas: Author.

Joint Statement from the DEA and 21 Health Organizations. (2001) *Promoting pain relief and preventing abuse of pain medications: A critical balancing act*. Retrieved April 16, 2008, from http://www.deadiversion.usdoj.gov/pubs/pressrel/consensus.pdf

Oregon State Board of Nursing. (2004). *Position statement for pain management*. Retrieved April 16, 2008, from http://www.oregon.gov/OSBN/pdfs/policies/pain_management.pdf.

Ballantyne, J.C., Fishman, S. and Abdi, S. (Eds.). (2001). *The Massachusetts General Hospital handbook of pain management*. Hagerstown, MD: Lippincott Williams & Wilkins.

Webster, L.R. and Dove B. (2007). *Avoiding Opioid Abuse While Managing Pain*. North Branch, MN: Sunrise River Press.

Additional Appendices related to APRN role in Pain Management

A. Links to Member Board Pain Resources

B. Summary of Literature Review

D. Regulatory Implications of Pain Management: Critical Questions

Appendix A:

Links to State Board of Nursing Pain Management Resources

A number of boards of nursing have developed resources related to the regulatory implications of pain management. This list identifies those Member Boards and provides the link to their resources.

Alaska Board of Nursing Advisory Statement:
The Use of Controlled Substances for the Treatment of Pain by Advanced Nurse Practitioners
http://www.dced.state.ak.us/occ/pub/nur1808.pdf

Arizona State Board of Nursing Advisory Opinion:
The Use of Controlled Substances for the Treatment of Chronic Pain
http://www.azbn.gov/Documents/advisory_opinion/AO%20Controlled%20Substances-Use%20for%20Treatment%20of%20Chronic%20Pain.pdf

California Board of Registered Nurses
The Nurse's Role in Pain Management
http://www.rn.ca.gov/pdfs/regulations/npr-i-32.pdf

Kansas Board of Nursing (with Board of Healing Arts and Board of Pharmacy)
Joint Policy Statement of the Boards of Healing Arts, Nursing and Pharmacy on the Use of Controlled substances for the Treatment of Pain
http://www.ksbn.org/positionstatements/joint_policy_statement.pdf

Maryland Board of Nursing
Pain Management Nursing Role/Core Competency – A Guide for Nurses
www.MBON.org/practice/pain_management.pdf

Michigan Board of Nursing
Guidelines for the Use of Controlled Substances for the Treatment of Pain
http://www.michigan.gov/documents/mdch_nurseguidelinesusecspain_139444_7.pdf

Minnesota Board of Nursing (with Boards of Medical Practice and Pharmacy)
Joint Statement on Pain Management Minnesota Boards of Medical Practice, Nursing and Pharmacy
http://www.state.mn.us/mn/externalDocs/Nursing/Joint_Statement_on_Pain_Management_091704014840_Jointstatement.pdf

New Mexico Board of Nursing
Administrative Rule 16.12.9 *Management of Chronic Pain with Controlled Substances*
http://www.bon.state.nm.us/pdf/nmacpart9.pdf

North Carolina Board of Nursing (with Boards of Medicine and Pharmacy)
Joint Statement on Pain Management in End-of-Life Care
http://www.ncbon.com/content.aspx?id=888&terms=Pain+management

North Dakota Board of Nursing
Role of the Nurse in Pain Management Practice Statement
http://www.ndbon.org/opinions/role%20of%20nurse%20in%20pain%20mgmt.shtml

Oregon State Board of Nursing
Position Statement for Pain Management
http://www.oregon.gov/OSBN/pdfs/policies/pain_management.pdf

Utah Board of Nursing
Rules for all practitioners with prescribing authority: Subsection 58-1-502 (6) it is unprofessional conduct for failing, as a practitioner, to follow the FSMB Model Policy for the Use of Controlled Substances for the Treatment of Pain.

Wisconsin Board of Nursing White Paper
Pain Management
http://drl.wi.gov/boards/nur/pap/pap14.pdf

APPENDIX B

Literature Review

Much has been studied and written about the topic of pain – there are textbooks and many books on the subject. Some of the articles reviewed by the NCSBN Disciplinary Resources Committee were published in academic journals; others were in the popular press and more on the internet. Selected article abstracts, grouped by specific aspect of pain management, are below.

Pain Background

In the early 1990s, the Agency for Health Care Policy and Research, Public Health Service, and the U.S. Department of Health and Human Services conducted expert panels to develop a number of clinical guidelines on a variety of health topics, including pain management. The guidelines describe principles of patient care derived from a systematic analysis of the scientific literature and from opinions of expert panels. In addition to the clinical guidelines, AHCPR developed a quick reference for clinicians and a patient and family practice guideline. Although dated, these references are included because of the process used for development and the historical value of the documents (a snapshot of pain management 20 years ago).

A Robert Wood Johnson Foundation article stated that untreated or inadequately treated pain is one of the worst medical problems in the U.S. and that we face an epidemic of untreated and inadequately treated pain. While the tools are available to treat most pain effectively, many people continue to suffer. The article discusses reasons for this, and discusses the results of a 1999 Gallup survey about Americans and pain.

The Joint Commission (2001) presented an institutional approach to pain assessment and management. It addresses issues of under-treatment; the rights and ethics of pain management; pain assessment, care, and education; and how to improve organizational performance. How pain assessment and management is addressed in Joint Commissions surveys and case studies.

Pain Management Nursing

McCaffery and Pasero's *Pain: a Clinical Manual* is a classic textbook on nursing pain management. Content ranges from reasons for the under-treatment of pain; the anatomy and physiology of pain; types of pain; harmful effects; pain assessment; pharmacological treatment-how different analgesics work;non-pharmacological

approaches to pain; pain in different age groups; selected pain problems; pain and addiction; and how to build institutional commitment to improving pain management.

Compton and Mcaffery (2001) responded to a question about treating acute pain in addicted patients that one should never withhold opioids from someone in acute pain who suffers addictive disease. No scientific evidence exists to show that providing opioid analgesia to these patients worsens the addiction. Acute pain should be treated immediately with opioids and with analgesia around the clock to maintain blood levels. The authors note that a patient tolerant to opioids will likely need more pain control than someone who is not. As acute pain decreases, plan with the patient to taper the analgesic gradually.

Mcaffery, Grimm, Pasero, Ferrell and Uman (2005) investigated the term "drug seeking" and found that nurses believed that term was likely to mean the patient was addicted, was abusing drugs or was manipulative. Their findings indicated there is a high level of confusion and stigma likely to be present in the care of a patient who is labeled "drug seeking." A better description would be "concern-raising behaviors. They recommend a differential diagnosis be done when questionable behaviors occur during the course of pain management.

Wisconsin Cancer Pain Initiative (1995) developed competency guidelines for cancer pain management in nursing education and practice. The following competency areas are identified: knowledge of basic principles, assessment, intervention, and side effects/risk management.

Advanced Practice Registered Nurses and Pain Management

Starck, Sherwood and McNeill (2003) identified factors in the mismanagement of pain, effective tools and best practices for pain management, including guidelines, assessment tools, report cards, and managing interactions with patients and families.

Lazarus and Downing (2003) discuss elements related to pain management and regulatory factors that affect the treatment of pain. They provide an overview of the evolution of advanced practice nursing and research results about nurse practitioners in Alabama, including perceptions about prescriptive practices and pain management. They related experiences of the Alabama Board of Nursing in monitoring and investigating nurse practitioners for compliance with prescriptive authority. The study confirmed the belief that lack of prescriptive authority has delayed pain treatment. However, almost half of the Alabama nurse practitioners did not feel adequately prepared for prescribing controlled substances.

Pain Policy

In 1999, researchers at the University of Wisconsin-Madison Medical School conducted a study of state law and regulatory policies that may promote or impede the use of morphine and other controlled substances for pain relief. Researchers at the Pain and Policy Studies Group at Wisconsin identified law and policies in 16 states and the District of Columbia that could affect pain management. They recommended that "balance" should be the central principle of policies related to pain relief (government policies to prevent abuse of controlled substances should not interfere with the use of controlled substances for the relief of pain).

The Pain and Policy Studies Group of the University of Wisconsin School of Medicine and Public Health, Paul P. Carbone Comprehensive Cancer Center has issued three progress reports (including the 1999 work described above) on Achieving Balance in State Pain Policy, the third edition in 2007. They emphasize the need for balance between practitioners' ability to provide adequate pain management with the need to prevent drug diversion and abuse. States are rated on eight criteria that identify policy language with the potential to enhance pain management and eight criteria that identify policy language with the potential to impede pain management.

Chan and Fishman reviewed the regulatory and legal aspects of the use of opioids in pain relief, concluding that the environment is in a state of flux. The article also looks at future trends concerning the regulation of chronic opioid treatment.

Bolen discussed the role of law in medical decision making in opioid treatment and how to put legal and regulatory materials to work for the practitioner.

Martino argued that a complex "ethic of under-prescribing" underlies the reluctance of many physicians to use opioids to treat chronic pain. She contends that the state medical boards are positioned to promote a new ethic for pain control, and that success hinges on boards being able to change their approach to pain management and persuade a skeptical medical community that under-prescribing not only puts patients at risk, but that physicians can be disciplined for not meeting pain management standards. Effective pain management will better serve patient needs as well as assuring that the physician is meeting expected standards of care.

Gilson and Joranson wrote about likely under-treatment of pain among patients with addiction disease as well as laws and regulations that pose barriers to effective treatment.

Foley discussed how to dismantle the barriers so that practitioners can improve palliative and end-of-life care. These barriers include health care provider's fears and lack of knowledge (major medical and nursing texts devote only a few pages to pain and symptom control) as well as misguided legislation in some jurisdictions.

Gilson, Joranason and Maurer (2003) state that since 1989, 41 states had adopted policies relating to controlled substances, written from multiple perspectives and largely inconsistent. In 1997, the Federation of State Medical Boards (FSMB) recognized the need for more consistency in state pain policies and convened a panel of experts to draft a model policy. The FSMB adopted the guidelines in 1998 and sent it out to state medical boards and asked them to consider adopting As of the writing of this article, 21 states had adopted all or part of the statement. Two additional states endorsed the policy. Many state medical boards have exhibited a willingness to promulgate board policy that encourages treatment of pain and work to remove barriers to pain management. Once a board adopts such a policy, it must be implemented. The authors suggest a three tiered process for implementation: the training of investigators about the current standards of pain management, disseminating the policy to licensees, and using radio and television to reach the general public.

Pain Statements and Positions

American Nurse Association (ANA) and the American Society for Pain Management Nursing (ASPMN)

ANA and ASPMN published *Pain Management Nursing: Scope and Standards of Practice* in 2005. These are discussed in the Standards section of this paper.

American Society for Pain Management Nursing (ASPMN) and the American Pain Society

This consensus statement encourages institutions to develop policies that provide practical information about pain management and promotes education for staff to facilitate competency and safety. Policies should not include explicit dosing recommendations nor should medical orders be open-ended (e.g., titrate to comfort). A pain medication order should specify an appropriate dose range and frequency of administration based on the pharmacokinetics of the opioid, the patient characteristics and the situation.

American Society for Pain Management Nursing (ASPMN)

ASPMN published a 2002 position statement on pain management in patients with addictive disease that emphasized the importance of the nurse advocacy role in pain management. ASPMN adopted a 2003 position statement on pain management at the end-of-life, stating the importance of the nurse to advocate for pain relief and symptom management to alleviate suffering, increase the quality of life and possibly prolong life.

The American Society of PeriAnesthesia Nurses (ASPAN)

ASPAN's position statement on pain management supports a collaborative plan between the anesthesia department and perianesthesia nurses to address pain management in the perianesthesia setting, with goals of relieving pain to allow activity, relaxation, complication prevention, and promotion of healing and optimal health.

The Academy of Medical-Surgical Nurses (AMSN)

AMSN recognizes freedom from pain as a basic human right, thus is committed to the identification of pain management as a patient care priority, and affirms that every patient will have access to the best level of pain relief that may be safely provided.

Oncology Nurses Society

ONS issued a 2006 position on cancer pain management, focusing on the cancer patient's right to optimal pain relief; the need for education of patients, families, and the public about therapies available to treat cancer pain; the need to eliminate regulatory, legislative, economic, and other barriers to effective cancer pain management; and the ethical responsibility of all healthcare providers to use evidence-based pain management guidelines. ONS states the need for a multidisciplinary and collaborative approach for addressing the physical, psychological, spiritual, and socio-cultural effects of unrelieved pain.

Federation of State Medical Boards

Model Policy for the Use of Controlled Substances for the Treatment of Pain provides guidelines for evaluating the patient in pain and developing a treatment plan. It discusses the need for informed consent for treatment, periodic review of the course of pain treatment, consultation, and medical records. The importance of complying with

controlled substance laws and regulations is stressed. Originally adopted in 1998, the policy was revised in 2004 with an added emphasis on the concern that pain is often untreated. A number of medical licensing boards have adopted the model policy.

Pain Management Standards

The American Nurse Association (ANA) and the American Society for Pain Management Nursing (ASPMN) published *Pain Management Nursing: Scope and Standards of Practice* in 2005. Pain is the most common nursing diagnosis, thus is important for the practice of all nurses standards for the RN address assessment, identification of pain problems (nursing diagnosis), outcomes identification, and developing a pain management plan. In addition, there are standards of professional performance, addressing the quality of nursing practice, education, professional practice evaluation, collegiality (interaction with and contribution to professional development of others), collaboration with patient, family and others – to involve them in planning and implementation of pain management and leadership (coordination of care and oversight of licensed and unlicensed staff). The same standards apply to APRN and there are additional measurement criteria for the APRN. In addition, a standard for prescriptive authority and treatment is provided for the APRN.

The Joint Commission on Accreditation of Healthcare Organization's (now the Joint Commission) 2001 pain management standards state that every patient has a right to have his or her pain assessed and treated. These standards were the product of a two-year collaboration between the Joint Commission and the University of Wisconsin – Madison Medical School. PC.2.04.0 states that The [organization] assesses and manages [patient]s for pain.

The Joint Commission published *Pain Assessment and Management: an Organizational Approach* in 2000. This book discusses the Joint Commission's expanded requirements for pain management in hospitals, long term care facilities, behavioral health care facilities, ambulatory care, and health care networks. It provides a step-by-step approach for achieving the organizational commitment needed to improve pain management by identifying and breaking-down organizational barriers to effective pain control.

Chapman (2000) wrote in anticipation of the new standards for pain assessment and management expected to appear in the 2000-2001 Joint Commission standards manual that require healthcare organizations to recognize the right of patients to appropriate pain assessment and management. The author, President of the American Pain Society, observes that healthcare professionals in a wide range of facilities need guidance and instruction about pain and its management. He advocated seizing the moment and stepping forward to help.

Chapman (2000) presented a session at the 19th Annual American Pain Society Annual Meeting, reviewing the requirements for healthcare facilities and how they can be implemented. She described 10 steps to compliance and discussed how to implement the standards in the real world, providing examples from the hospital setting, ambulatory surgery, and a behavioral health setting.

Pain and Addiction

Ziegler wrote about safe treatment of pain in patients with a substance abuse problem and describes the challenge to clinicians as how to help patients manage pain without exacerbating or reactivating the addictive disorder. She says for the acute pain caused by surgery, trauma, or extensive dental work, opioids may be indicated to control severe pain. The treating physician or dentist may reduce the dosage of opioids administered, but this is contrary to the effective approach of giving as large a dose needed to achieve good pain control. She emphasized that untreated pain can be as big a trigger as exposure to an intoxicant. She discusses in depth two case studies.

Scholl and Weaver state that pain is often under-treated and provide tools for addiction screening. They addressed the psychological and behavioral consequences of chronic pain treated with opioids and present guidelines for prescribing opioids.

Grant et al., state that providers tend to under-treat pain in the population with addictive disease due to biases, misconceptions, and systems issues. Inadequate pain relief is more apt to cause relapse than the use of opioids. They discuss a number of complications that can arise when pain is under-treated in the patient with addictive disease, as well as ways to improve pain control for this population.

Markel describes a rigorous substance abuse treatment program for health care providers in Ann Arbor, Michigan. He stated the need for such a program to have a linkage to credible sanctions.

Webster identified risk factors for an increased abuse potential in pain patients.

Leavitt (2004) noted that pain and addiction share some common physiologic pathways in the brain, especially those involving opioids; hence the presence of pain may influence the development and course of opioid addiction and vice versa. The undertreatment of pain is an important concern for addicted persons. Some of the barriers to effective treatment include misguided institutional practices, inadequate physician training, reluctance to provide adequate pain medications to chemically dependent persons, clinician fears of regulatory sanctions, and a reluctance by these patients to seek care because of fear of drug relapse. The author encourages better communication between pain treatment specialists and addiction treatment specialists.

Maher-Brisen (2007) described addiction as an occupational hazard in nursing and noted work-related factors that might be associated with the use and abuse of drugs, including: working nights or rotating shifts; critical care work; excessive overtime; musculoskeletal injuries and pain; and knowledge of medications. The author states that little attention is paid to addiction in schools of nursing, and that stereotypes and stigma persist. She discussed the legal and professional discipline implications of drug diversion.

Cognition and Neuropsychological Evaluation (NPE)

Malik and McDonald describe types of NPE, who and when to refer patients for NPE, test selection, technical issues, and examples of testing.

Ersek et al., (2004) wrote about the cognitive effects of opioids. This article reviews the empiric literature on opioids and cognitive functioning. In general, research reflects

minimal to no significant impairments in cognitive functioning. Despite subjective experiences of mental dullness and sedation, objective tests of cognitive functioning do not always demonstrate marked changes following opioid administration.

Brown et al., conducted a study on a sample of 1,009 patients treated by 235 primary care physicians. Patients on daily opioids experienced more side effects than those taking the medication intermittently. The authors suggest that psychological measures and pain severity are more predictive of decrements in cognitive function and advise physicians to closely monitor patients for adverse effects and adequacy of pain control.

Pain Education

Robert Wood Johnson Foundation (2002) funded an effort led by the City of Hope National Medical Center to improve nursing education in pain and end-of-life issues. Project staff reviewed and critiqued 50 nursing textbooks, surveyed members of key nursing organizations, met with nursing licensure leaders, created and distributed resources, and sponsored a national conference. The textbook analysis revealed that just two percent of textbook content addressed end-of-life issues. A follow-up examination of the 50 textbooks previously reviewed showed that 40 percent of the authors and publishers had made changes or were in the process of doing so.

The American Geriatrics Society Foundation for Health in Aging (2002) has developed an online Patient Education Forum on Persistent Pain. Presented in a question and answer format, it provides basic information about pain, over-the-counter medications, advises how to keep a pain diary, and other suggestions for making the most of time with health care providers.

The American Medical Association (2007) offered online continuing education modules on pain. 12 modules cover topics that include pathophysiology of pain, pain management, and pain in several specific patient populations.

Media Coverage of Pain

Most of the major periodicals in the U.S. have looked at pain at one time or another. Here are some samples:

Schrof, writing for *U.S. News and World Report* (March 17, 1997), told the story of a physician who lost his medical license after he prescribed narcotics for hundreds of patients. His medical board found that the physician' practice was too risky and his monitoring of patients was inadequate. He was treating patients from other states because doctors there would not prescribe narcotics. After the physician stopped practicing, two of his former patients committed suicide. The article suggests that drug regulators don't know about the latest scientific data on treating pain. Some states are beginning to develop policies that support vigorous pain treatment. The physician in this story is still pursuing his case.

Meier, writing for the *New York Times*, looked at the "delicate balance of pain and addiction." He observed that for much of the 1900s, doctors believed that patients could easily become addicted to drugs resulting in many patients in pain were denied relief. Over the past decade, "doctors specializing in pain treatment and drug companies eager to broaden the market for such drugs" championed the view that

drugs posed scant risk to pain patients. This too may have had unfortunate consequences because physicians and patients may have developed a false sense of security about the use of drugs to control pain. Now, the focus is right in the middle of these two extremes. Medical experts agree that most pain patients can use narcotics without consequences. However, the addiction risk for chronic pain patients has not been studied and the long term results are really unknown.

Kalb, writing for *Newsweek* magazine (May 19, 2003) did a cover story on "Taking a New Look at Pain," observed that patients are demanding that pain be seen as a condition in and of itself, not just a byproduct of injury, illness, or surgery. Congress has declared this the Decade of Pain Control and Research. New imaging technology allows researchers to begin to detangle the pain system at its molecular level. Medical scientists are developing new, targeted treatments. The author also addresses the spiritual, cultural, and emotional aspects of pain.

Wallis, writing for *Time* magazine (Feb. 28, 2005), explored the right and wrong ways to treat pain. Presenting actual cases, looking at the cause of the pain, the patient's age, and how they are being treated, the author looked at the causes of chronic pain and the holistic approach being taken at leading pain management centers.

Brody, writing for the *New York Times* (Nov. 6, 13 and 20, 2007), did a series on chronic pain, observing that pain that doesn't quite change a person. Delving into the causes of chronic pain the effects on families, she presents some ideas adapted from the American Chronic Pain Association's Family Manual, about what patients and families can do to cope. In the third article, she outlines medications and other non-drug approaches that can ease chronic pain.

Works Cited

Academy of Medical Surgical Nurses. Pain Management. Retrieved April 22, 2008, from http://www.medsurgnurse.org/cgi-bin/WebObjects/AMSNMain.woa/1/wa/viewSection?wosid=4OMY5Z9MDjcx2D63qm96JI37WtP&ss_id=536873229&s_id=1073744079&tName=positionsPainManagement

Acute Pain Management Guideline Panel. *Acute pain management in adults: Operative procedures. Quick reference guide for clinicians*. AHCPR, Pub. No. 92-0019. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services.

Acute Pain Management Guideline Panel. *Acute pain management in adults: Operative or medical procedures and trauma. Clinical practice guideline*. AHCPR, Pub. No. 92-0032. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services. Washington, DC 1992

American Geriatric Society Foundation for Healthy Aging. (2002). Persistent pain. *Patient Education Forum*. Retrieved April 22, 2008, from http://www.healthinaging.org/public_education/pef/persistent_pain.pdf

American Medical Association. (2007). Pain management modules. Retrieved April 22, 2008, from http://www.ama-cmeonline.com/pain_mgmt/

American Nurses Association and the American Society for Pain Management Nursing, (2005). *Pain management nursing: scope and standards of practice*. Silver Springs, MD: nursebooks.org.

American Society for Pain Management Nursing and American Pain Society. (2004). *The use of as needed range orders for opioid analgesia in the management of acute pain: A consensus statement of the ASPMN and APS*. Retrieved April 23, 2008 from http://www.ampainsoc.org/advocacy/pdf/range.pdf

American Society of PeriAnesthesia Nurses. (1999). *A position statement on pain management*. Retrieved April 23, 2008, from http://www.aspan.org/PosStmts5.htm

Bolen, J. (2005) Taking back your turf: Understanding the role of law in medical decision making in opioid management. *Journal of Opioid Management*, 1(4): 1885-92.

Brody, J. (2007,November 6). Living with pain that just won't go away. *New York Times*. Retrieved April 22, 2008, from http://query.nytimes.com/gst/fullpage.html?res=9A0DE3DE1131F935A35752C1A9619C8B63

Brody, J. (2007, November 13). Chronic pain: A burden often shared. *New York Times*. Retrieved April 22, 2008, from http://www.nytimes.com/2007/11/13/health/13brod.html?_r=1&oref=slogin

Brody, J. (2007, November 20). Many treatments can ease chronic pain. *New York Times*. Retrieved April 22, 2008, from http://www.nytimes.com/2007/11/20/health/20brod.html

Brown, T, Zueisdorff, M., and Fleming, M. (2006, May-June). Adverse effects and cognitive function among primary care patients taking opioids for chronic nonmalignant pain. *Journal of Opioid Management*, 2(3):137-46.

Chan, KT and Fishman, SM. (2006, December 16). Legal aspects of chronic opioid therapy. *Current Pain and Headache Report*, 10(6):426-430.

Chapman, C., (2000). New JCAHO standards for pain management: Carpe diem! *American Pain Society Bulletin*, 10 (4). Retrieved April 21, 2008 from http://www.ampainsoc.org/pub/bulletin/jul00/pres1.htm

Compton, P. and Mcaffery, M. (2001). Treating pain in addicted patients. *Nursing*, 2001, 31(1): 17.

Dahl, J. (2000). *Implementing the JCAHO Pain Management Standards*. Presentation at American Pain Society 19th Annual Meeting, Atlanta, Georgia, Nov. 2-5, 2000

Ersek, M., Cherrier, M., Overman, S., & Irving, G. (2004). The cognitive effects of opioids. *Pain Management Nursing*, 5(2):75-93.

Federation of State Medical Boards. (2004). *Model policy for the use of controlled substances for the treatment of pain*. Dallas: Author.

Foley, K. (2000). Dismantling the barriers: Providing palliative and pain care. *JAMA*, 283(1).

Gilson, A.M. and Joranson, D.E. (2002). Addiction and pain: Assessment and treatment issues. *Clinical Journal of Pain*, 18(4 Suppl): S91-S98.

Gilson, AM, Joranson, D.E., Maurer, M.A., Ryan, K.M. and Garthwaite, J.P. (2005). Progress to achieve balanced state policy relevant to pain management and palliative care: 2000-2003. *Journal of Pain and Palliative Care Pharmacology*, 19(1):13-26.

Gordon, D.B., et. al. (2004). The use of as-needed range orders in the management of acute pain: A consensus statement of the American Society of Pain Management Nursing and the American Pain Society. *Pain Management Nursing*, 5(2)53-58.

Grant, M, Cordts, G., Doberman, D. (2007). Acute pain management in hospitalized patients with current opioid abuse. *Topics in Advanced Practice Nursing*. 7 (1). Retrieved April 23, 2008 from http://www.medscape.com/viewarticle/557043

Joint Statement from the DEA and 21 Health Organizations. (2001). *Promoting pain relief and preventing abuse of pain medications: A critical balancing act*. Retrieved April 16, 2008, from http://www.deadiversion.usdoj.gov/pubs/pressrel/consensus.pdf

Kalb. C. (19 May 2003). Taking a new look at pain. *Newsweek*. 43-62.

Lazarus, J. and Downing, B. (2003). Monitoring and investigating certified registered nurse practitioners in pain management. *Journal of Law, Medicine & Ethics*, 31:101-118.

Leavitt, S. (2004). Pain in opioid-addiction patients entering addiction treatment. *Pain Treatment Topics.* Retrieved April 21, 2008 from http://pain-topics.org/pdf/Pain_Addiction_Addiction_Tx.pdf

Maher-Brison, P. (2007). Addiction: An occupational hazard in nursing. *American Journal of Nursing*, 107(8); 78-79.

Malik, A. and McDonald, D. (2000). Neuropsychological evaluation. *eMedicine Specialties*. Retrieved March 6, 2007, from http://www.emedicine.com/pmr/tiouc149.htm

Markel, H. (2004). When health professionals abuse drugs and alcohol: Personal problems and public health consequences. *Medscape Public Health & Prevention*, 2(1). Retrieved April 21, 2008 from http://www.medscape.com/viewarticle/481520_print

Martino, A.M. (1998). In search of a new ethic for treating patients in chronic pain: What can medical boards do? *Journal of Medicine and Ethics*, 26(4):332-49, 263.

Meier, B. (2003, November 25). The delicate balance of pain and addiction. *New York Times*. Retrieved April 22, 2008, from http://query.nytimes.com/gst/fullpage.html?res=9D04E0D8113BF936A15752C1A9659C8B63

Oncology Nurses Society. (1998; rev. 2006). Oncology nursing society position on cancer pain management. Retrieved April 23, 2008, from http://www.ons.org/publications/positions/CancerPainManagement.shtml

Robert Wood Johnson Foundation. (2002). Grants results report: Patients desperate for pain relief stymied by state drug laws. Retrieved April 22, 2008, from http://www.rwjf.org/reports/grr/035950.htm

Robert Wood Johnson Foundation. (2004). How much does it hurt? Retrieved April 22, 2008, from http://www.rwjf.org/newsroom/feature.jsp?id=21342&parentid=20938

Robert Wood Johnson Foundation. (2002). Strengthening nursing education in pain management and end-of-life care: grant results report. Retrieved April 22, 2008, from http://www.rwjf.org/reports/grr/032829.htm

Scholl, S. and Weaver, M. (2003). Addiction and pain. *American Journal of Addiction*. 12(2 Suppl):S27-35.

Starck, P., Sherwood, G. and Adams-McNeil, J. (2000). Pain management outcomes: Issues for advanced practice nurses. *The Internet Journal of Advanced Nursing Practice*, 4(1).

Wallis, C. (28 February 2005). The right (and wrong) way to treat pain. *Time*. 46-57.

Webster, L.R. (2004). Assessing abuse potential in pain patients. *Medscape Neurology & Neurosurgery*. 6(1). Retrieved April 21, 2008, from http://www.medscape.com/viewarticle/471663_print

Wisconsin Cancer Pain Initiative. (1995). Competency guidelines for cancer pain management in nursing education and practice. Retrieved April 22, 2008, from http://trc.wisc.edu/WCPI_RN.pdf

Ziegler, P.P. (2007). Safe treatment of pain in the patient with a substance use disorder. *Psychiatric Times*, 24 (1). Retrieved April 21, 2008 from http://www.psychiatrictimes.com/display/article/10168/46596

APPENDIX D

Regulatory Implications of Pain Management: Critical Questions

APRN Role in Pain Management

Where does the APRN work and what is his/her practice role?

Does the APRN work with patients in pain?

Does the APRN have prescriptive authority and a DEA number for prescribing controlled substances?

Is the APRN concerned about regulatory scrutiny of his/her practice and the prescription of controlled substances?

Is the APRN familiar with the standards of pain management nursing and the additional standards for APRNs?

Is the APRN familiar with the policies and procedures of the practice, facility or agency relating to pain management?

What professional development activities has the APRN pursued? Are any related to pain management, pharmacology, and other treatment options for pain?

What is the APRN's attitude toward patients in pain?

Does the APRN understand the difference between tolerance, dependence, and addiction?

Is the APRN knowledgeable about the laws and rules that govern the use of controlled substances?

Does the APRN collaborate with other health team members to develop, evaluate, and adjust/change the pain management plan?

How does the APRN advocate for patients in pain?

