

Pain Management Nursing Role/Core Competency A Guide for Nurses



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Pain Management

Nursing Role/Core Competency

A Guide for Nurses

PURPOSE OF THIS EDUCATIONAL GUIDE

The purpose of this document is to assist the licensed nurse in recognizing his/her accountability in effectively managing patients' pain through assessment, intervention and advocacy.

Pain management is only one aspect of the complex process of providing palliative care. It is beyond the scope of this document to address other issues involved in palliative care.

BACKGROUND

Pain management encompasses various types of pain experiences throughout an individual's life cycle from birth to the end of life. Pain experiences may include acute and chronic pain, pain from a chronic deteriorating condition, or pain as one of many symptoms of the patient receiving palliative care. Pain is not exclusively physiological but also includes spiritual, emotional and psychosocial dimensions. The goal of pain management throughout the life cycle is the same - to address the dimensions of pain and to provide maximum pain relief with minimal side effects.

Review of the literature, anecdotal reports and dialogue with colleagues reveals that the majority of patients do not receive adequate pain management. A wide variety of factors including inaccurate information, myths, rumors, fear and cultural issues contribute to inadequate pain management. For example, a prevailing rumor in the nursing profession is that a nurse can lose his/her nursing license for causing a patient's respiratory depression by frequent administration or by giving high doses of opioids, even though there is no documented evidence to substantiate this fear. The literature shows that adequate assessment in conjunction with opioid titration based on patient

response can provide maximum pain relief without adversely affecting respiratory status. Therefore, it is unwarranted to under-utilize or withhold opioids from a patient who is experiencing pain based on fear of causing respiratory depression.

Due to multiple advances in the field of pain management (i.e. pain assessment, pharmacological and non-pharmacological interventions), licensed nurses may have incomplete or inaccurate information about the following variables which contribute to ineffective pain management:

1. What is pain and how do patients demonstrate their pain?
2. How is pain assessed and managed?
3. Is there a difference between psychological dependence, addiction and physical dependence?
4. Does aggressive use of opioids cause addiction?
5. How does the patient's cultural background effect pain expression and management?

Myths and misinformation also contribute to ineffective pain management. Some common myths include:

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1. Too much pain medication too frequently constitutes substance abuse, causes addiction, will result in respiratory depression or will hasten death;
2. Pain should be treated, not prevented;
3. People in pain always report their pain to their health care provider;
4. People in pain demonstrate or show that they have pain - pain can be seen in the patient's behavior;
5. The level of pain is often exaggerated by the patient;
6. Generally a patient cannot be relieved of all pain;
7. Some pain is good so that the patient's symptoms are not masked;
8. Newborn infants do not have pain; and,
9. It is expected that the elderly, especially the frail elderly, always have some pain.

Patient Populations at Risk of Under Management

Because of multiple barriers to adequate pain management, all patients are at risk for under-treatment of pain. Since pain is identified and reported primarily through patient self-reporting, difficulty in communicating increases the patient's risk for under-treatment.

Populations identified by the literature as being at greater risk include: infants and children, women, the elderly, patients with cognitive dysfunction, patients with emotional or mental illness, patients with chronic pain, patients with neuropathic pain, substance abusers, minority populations, the homeless, and patients with terminal illnesses.

In addition, patients who speak a different language or who are from a cultural tradition different from that of the clinician pose a special challenge. In effect, any patient, regardless of age, is at risk of being under-treated for pain. All populations can be placed at greater risk because of the health care provider's own belief system which may include the previously discussed myths and misinformation.

These factors and others have prompted the Board to develop this educational guide for the Maryland licensed nurse. The intent is to provide factual information and assist the licensed nurse in developing core nursing competencies in pain management. The licensed nurse must become familiar with standards, guidelines and definitions regarding pain and its management, including but not limited to those listed in the definition of terms and bibliography and to refer to these documents when advocating for the patient in pain.

Licensed Nurse Role: Knowledge Based Practice

The licensed nurse is responsible and accountable to ensure that a patient receives appropriate evidence-based nursing assessment and intervention which effectively treats the patient's pain and meets the recognized standard of care. In order to advocate for the patient, the licensed nurse must possess the following:

A) Knowledge of Self

The practice of nursing includes the knowledge of one's self through assessment of attitudes, values, beliefs, and cultural background and influences that have formed each of us as individuals. These factors affect the nurse when assessing, evaluating, and interpreting the patient's statements, behavior, physical response, and appearance. The greatest barrier to the patient achieving effective pain management may be the nurse's:

1. Individual experiences with pain;
2. Personal use of medications or non-pharmacological methods to manage pain; and,
3. Family's or significant others' history or experience with substances for pain control or mood altering effect.

When the licensed nurse is influenced or constrained by personal factors, the nurse may not assess, evaluate or communicate the patient's pain level effectively or objectively. This can be further compounded if the nurse does not have adequate knowledge regarding pain management and, as a result, can not recognize the need to seek out additional information to assess and manage the patient's pain appropriately. For instance, a nurse who believes or states, "You can tell by looking at the patient if they are in pain" is demonstrating an inadequate knowledge base.

B) Knowledge of Pain

Pain is subjective. It is whatever the patient says it is. The nurse utilizes the nursing process in the management of pain. Adequate measurement and management of pain includes knowledge in the following areas:

1. Pain assessment:

a) The nurse utilizes a developmentally appropriate, standardized pain assessment tool which includes: a pain measurement tool which has demonstrated reliability and validity and patient participation, which is essential in the assessment process. For those incapable of self-reporting, standardized pain assessment tools should include behavioral observations with or without physiologic measures.

i. Physiologic signs such as tachycardia, hypertension, diaphoresis and pallor are non-specific to pain and may be an indicator of another, unrelated physiologic problem. For patients in pain, these physiologic signs may be present for a short period of time or not at all.

ii. Sole reliance on these physiologic signs to assess pain may be inappropriate.

b) The nurse is knowledgeable regarding the difference in categories of pain (i.e. acute, chronic, breakthrough);

c) The nurse is knowledgeable regarding the most likely potential sources of pain (i.e. neurological, muscular, skeletal, visceral);

d) The nurse assesses the patient's individual pain pattern, including the individual patient's pain experiences, methods of expressing pain, cultural influences, and how the individual manages their pain.

2. Pharmacologic and Non-Pharmacologic Intervention:

a) The nurse is knowledgeable about the pharmacological interventions of opioid, non-opioid, and adjuvant drug therapies

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(including dosages, side effects, drug interactions, etc.) which are most effective for the most likely source of an individual patient's pain.

b) The nurse is knowledgeable that placebos should not be utilized to assess if pain exists or to treat pain.

c) The nurse is knowledgeable regarding non-pharmacologic strategies for pain management (i.e. acupuncture, application of hot and cold, massage, breathing techniques, etc.).

- 3.** Current pain management standards and guidelines.
- 4.** The difference between tolerance, physical and psychological dependence, withdrawal and pseudoaddiction.

C) Knowledge of the Standard of Care

The standard of care is effective ongoing pain assessment and pain management. This includes but is not limited to:

- 1.** Acknowledging and accepting the patient's pain;
- 2.** Identifying the most likely source of the patient's pain;
- 3.** Assessing pain at regular intervals, with each new report of pain or when pain is expected to occur or reoccur.

Assessment includes but is not limited to:

a) The patient's level of pain utilizing a pain assessment tool;

b) Barriers to effective pain management, which may include personal, cultural and Institutional barriers. Sources of these barriers may include but are not limited to patient, family, significant other, physician, nurse and institutional constraints;

- 3.** Reporting the patient's level of pain;
- 5.** Developing the patient's plan of care that includes an interdisciplinary plan for effective pain management involving the patient, family and significant other;
- 6.** Implementing pain management strategies and indicated nursing interventions including:
 - a)** Aggressive treatment of side effects (i.e. nausea, vomiting, constipation, pruritus etc),
 - b.** Educating the patient, family and significant other(s) regarding,
 - (i)** Their role in pain management,
 - (ii)** The detrimental effects of unrelieved pain,
 - (iii)** Overcoming barriers to effective pain management,
 - (iv)** The pain management plan and expected outcome of the plan;
- 7.** Evaluating the effectiveness of the strategies and the nursing interventions;
- 8.** Documenting and reporting the interventions, patient's response, outcomes; and
- 9.** Advocating for the patient and family for effective pain management.

PATIENT ADVOCACY

The nurse's primary commitment is to the health, welfare, comfort and safety of the patient. Self-awareness, knowledge of pain and pain assessment, and knowledge of the standard of care for pain management enhances the nurse's ability to advocate for and assure effective pain management for each patient. When advocating for the patient, it is crucial that the nurse utilize and reference current evidence-based pain management standards and guidelines.

As a patient advocate, the nurse takes all reasonable means to alleviate the patient's pain and suffering. In addition, the nurse consults and collaborates with specially trained experts in pain management, such as registered nurses, licensed physicians, pharmacists, massage therapists, acupuncturists and others to assure an effective interdisciplinary treatment plan to address each patient's pain. When the patient's pain needs are not being adequately addressed, the nurse continues to advocate for the patient through other means, such as referral to the organization's joint practice committee, the ethics committee, and/or the organization's chain of command.

The nurse also has an obligation to advocate for all patients in the aggregate. When an organization's policies, procedures and practices are insufficient to provide consistent effective pain management, the nurse works through appropriate committees and channels to insure that patients' pain management needs are addressed. This advocacy role is particularly critical for populations known to be at risk for under-management of their pain.

SUMMARY

This educational guide is intended to assist the licensed nurse to act in an accountable manner to effectively manage a patient's pain. This document emphasizes that the licensed nurse must continue to develop self-awareness and enhance his/her learning in order to remain current in nursing knowledge and skill relative to attempt to pain management. The licensed nurse is responsible and accountable to work toward effectively managing the patient's pain through assessment, intervention and patient advocacy.

DEFINITION OF TERMS

1. **Pain management:** The use of pharmacological and non-pharmacological interventions to control the patient's identified pain. Pain management extends beyond pain relief, encompassing the patient's quality of life, ability to work productively, to enjoy recreation, to function normally in the family and society, and to die with dignity.
 2. **Pain:** An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. Pain is always subjective and is whatever the person says it is, existing whenever the person says it does. The clinician must accept the patient's report of pain. Categories of pain include but are not limited to:
 - a) **Acute Pain:** A normal, predicated physiologic response to an adverse clinical, thermal or mechanical stimulus. It is generally time-limited and responsive to opioid and non-opioid therapy. Acute pain responses may vary between patients and between pain episodes within an individual patient. Acute pain episodes may be present in patients with chronic pain.
 - b) **Chronic Pain:** Malignant or non-malignant pain that exists beyond its expected time frame for healing or where healing may not have occurred. It is persistent pain that is not amenable to routine pain control methods. Chronic pain is often present with no physiologic signs, which may lull the clinician into falsely believing the patient is not in pain. Chronic pain may result in a look of sadness, depression, or fatigue causing the clinician to misinterpret the picture and not identify that the patient may also be experiencing pain. Patients with chronic pain may have episodes of acute pain related to treatment, procedures, disease progression or re-occurrence.
 - c) **Breakthrough Pain:** An acute exacerbation of pain that breaks through an existing analgesic regime.
 2. **Palliative Care:** The active total care of patients focusing on symptom management, of which pain is only one of many symptoms. The goal of palliative care is achievement of the best quality of life for patients, families and significant others by addressing psychological, social and spiritual problems, in addition to controlling the patient's pain and other symptoms.
 4. **Suffering:** The state of severe distress associated with events that threaten the well being of the person. Suffering often occurs in the presence of pain, shortness of breath, or other bodily symptoms. Suffering extends beyond the physical domain. For example, a woman awaiting breast biopsy may "suffer" because of anticipated loss of her breast, while after the biopsy the woman may have "pain" from the procedure.
 5. **Tolerance:** The process by which the body requires a progressively greater amount of a drug, over time, to achieve the same results. As it relates to pain relief, tolerance is decreasing pain relief over time with the same dosage. Patient can become tolerant to the analgesic effect of opioid therapy, requiring an increase in dose. For many opioids there is no known ceiling to the amount that can be given, meaning that pain relief can increase with an increase in the dose of the opioid. In addition, patients can become tolerant to some adverse effects (respiratory depression, somnolence, and nausea) related to opioid therapy.
 6. **Substance abuse:** The use of any chemical substance for other than its medically intended purpose.
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7. **Pseudoaddiction:** The pattern of drug-seeking behavior among pain patients because of inadequate management of their pain problem which can be mistaken for addiction.
8. **Physical dependence:** A physical response of the body to a substance characterized by signs of withdrawal if the substance is stopped without tapering, markedly reduced after prolonged use, or if an antagonist is administered. Physical dependence is an expected result of opioid use. Physical dependence, by itself, does not equate with addiction.
9. **Abstinence (withdrawal) Syndrome:** Physical symptoms that can occur after abrupt discontinuation or dose reduction of an opioid or administration of an antagonist. The syndrome is characterized by any or all of the following: anxiety, irritability, chills, hot flashes, salivation, lacrimation, rhinorrhea, diaphoresis, piloerection, nausea, vomiting, abdominal cramps, and insomnia. Withdrawal should be avoided by gradual reduction of dose rather than abrupt discontinuation.
10. **Addiction:** A neurobehavioral disorder characterized by compulsive seeking of mood-altering substances and continued use despite harm. Addiction may also be referred to by terms such as “drug dependence” and “psychological dependence.” Addiction is not the same as physical dependence.
11. **Opioid:** Denotes both natural (codeine, morphine) and synthetic (methadone, fentanyl) drugs whose pharmacologic effects are mediated by specific receptors in the nervous system.
12. **Non-Opioid:** A medication that provides pain relief, but that is not an opiate or a nonsteroid anti-inflammatory drugs (NSAIDS), acetaminophen). synthetic analog of an opiate (i.e.
13. **Adjuvant Medications:** Medications that are used to a) enhance the pain relieving effects of opioids and non-opioids, b) treat concurrent symptoms that exacerbate pain such as utilization of anxiolytics, or c) provide independent analgesia for specific sources of pain (i.e. neurologic pain), such as utilization of tricyclic anti-depressants and anti-convulsants.
14. **Opiate:** A drug whose origin is the opium poppy, including codeine and morphine.
15. **Pain Assessment:** The comprehensive evaluation of the patient’s pain including but not limited to: location, intensity, duration of the pain; aggravating and relieving factors; effects on activities of daily living, sleep pattern and psychosocial aspects of the patient’s life, and effectiveness of current management strategies. Pain assessment includes the use of a standardized pain measurement tool.
16. **Pain Measurement Tool:** The quantitative examination of the intensity of the pain as reported by the patient utilizing a standardized instrument which has demonstrated reliability and validity.
17. **Titration:** Adjustment of medication levels within the dosage and frequency ranges stipulated by the authorized prescriber in accordance with an agency’s established protocols, guidelines or policies.
18. **Evidence-Based Practice:** The conscientious and judicious use of current best evidence for making clinical decisions about the care of patients. Evidence may include but is not limited to: research findings, literature, bench-marking data, clinical experts, quality improvement, risk management data, and standards and guidelines.

REFERENCES

Written Resources

1. Kaiser, Karen, RN, MS. "Personal Strategies to Overcome Barriers to Inadequate Pain Management." Presented to Nursing Practice Issues Committee, Maryland Board of Nursing, September 1999.
2. Kaiser, Karen, RN, MS, Clyde, Chris, RN, MS, Perrone, Margaret RN, BS, and Tarzian, Anita RN, Ph.D. "Overcoming Barriers to Adequate Pain Management." Presented to the Nursing Practice Issues Committee, Maryland Board of Nursing, September, 1999.
3. English, Nancy RN, Ph.D., Yocum, Cindy RN, CRNH. "Guidelines for Curriculum Development on End-of-Life and Palliative Care In Nursing." Presented to National Council of Hospice Professionals, National Hospice Organizations, April 1997.
4. Singer, Peter A., MD, MPH, FRCPC, Martin, Douglas K., and Merrijoy, Kelner, Ph.D. "Quality End-of-Life Care: Patients' Perspective." *JAMA*. Vol. 281 No. 2. Jan. 13, 1999. pp. 162-168.
5. Conant, Loring and Lowney, Arlene. "The Role of Hospice Philosophy of Care in Non Hospice Settings." *Journal of Law, Medicine and Ethics*. Vol 24, #4. Winter 1996. pp 365-368.
6. Key, Timothy, MD, M.A.-TH and Schonwetter, Ronald, MD. "Hospice Care in the Nursing Home." *American Family Physician*. Vol. 57, No. 3. February 1, 1998. pp. 491-494.
7. Cameron, Miriam E. "Completing Life and Dying Triumphantly." *Journal of Nursing Law*. Vol. 6, Issue 1. 1999. pp. 27-32.
8. Arnstein, Paul, P.D., ARNP "Policy Statement: The Ordering and Administration of Placebos." Distributed by the Mayday Pain Resource Center. 1998.
9. McCaffery, Margo, Ferrell, Betty R., and Turner, Martha. "Ethical Issues in the Use of Placebos in Cancer Pain Management." *ONF (Ethical Issues)*. Vol. 23, No. 10. 1996. pp. 1587-1593.
10. Fohr, Susan Anderson J.D., MA. "The Double Effect of Pain Medication: Separating Myth from Reality." *Journal of Palliative Medicine*. Vol. 1, No. 4. 1998. pp. 315-328.
11. Promotion of Comfort and Relief of Pain in Dying. Position Statement - American Nurses Association. Sept. 5, 1991.
12. Forgoing Nutrition and Hydration. Position Statement-American Nurses Association. April 2, 1992.
13. Active Euthanasia. Position Statement-American Nurses Association. December 8, 1994.
14. Assisted Suicide. Position Statement-American Nurses Association. December 8, 1994.
15. Portnoy, Russell. "Morphine Infusions at the End of Life: The Pitfalls in Reasoning from Anecdote." *Journal of Palliative Care*. Vol. 12, No. 4. 1996. pp. 44-46.
16. Mount Balfour. "Morphine Drips, Terminal Sedation, and Slow Euthanasia: Definitions and Facts, Not Anecdotes." *Journal of Palliative Care*. Vol. 112, No. 4 1996. pp. 31-37.
17. "Peaceful Death: Recommended Competencies and Curricular Guidelines for End-of-Life Nursing Care." *American Association of Colleges of Nursing*, Robert Wood Johnson Foundation, End-of-Life-Care Roundtable. Nov. 11-12, 1997.
18. Joranson, David E. and Gilson, Aaron M. "Regulatory Barriers to Pain Management." *Seminars in Oncology Nursing*. Vol. 14, No 2. May 1998.

Pain Management Nursing Role/Core Competency

19. "Controlled Substances and Pain Management: A New Focus for State Medical Boards." *Federation of State Medical Board Bulletin*. Vol. 85, No. 2. 1998. pp. 78-83.
 20. Pain Management Policy - California Board of Registered Nursing, Approved 4/94, Revised 3/99.
 21. Pain Management Content Curriculum Guidelines. California Board of Registered Nursing. Approved 6/99.
 22. Standards of Competent Performance. California Board of Registered Nursing, Approved 4/97.
 23. _____. "Strengthening Nursing Education in Pain Management and End-of-Life Care." Supported by a grant from the Robert Wood Johnson Foundation. Completed December 3, 1998, updated edition February 10, 1999.
 24. Model Guidelines for The Use of Controlled Substances For the Treatment of Pain. Federation of State Medical Boards of the United States, Inc. May, 1998.
 25. Byock, Ira M.D. Ethics of End of Life Care: Keynote Address. Care at the End of Life. Baltimore, MD., March 22, 1999.
 26. Portenoy, Russell. "Contemporary Diagnosis and Management of Pain in Oncologic and AIDS Patients." Handbooks in Health Care. Newton, PA. 1998.
 27. _____. "State in End of Life Care." *Focus: Pain Management*. Issue 4. April 1999, pp. 1-8.
 28. Annotated Code of Maryland, Health Occupations Article, Title 8, §§ 8:101(e) and (f).
 29. Maryland Board of Nursing DR 97-6 Re: The Role of the Registered Nurse (RN) in The Management of Analgesia by Catheter Techniques (Epidural, Intrathecal, Intrapleural, or Peripheral Nerve Catheters), issued by the Board June 24, 1997.
 30. Resource Guide: Information about Regulatory Issues in Pain Management. Pain & Policy Studies Group, WHO Collaborating Center for Policy and Communications in Cancer Pain. University of Wisconsin Comprehensive Cancer Center, Madison, Wisconsin. July 1998.
 31. Spross, J., McGuire, D., and Schmitt, R. (1990). ONS position paper on cancer pain. Part I. *ONF*, 17(4):585-614.
 32. Spross, J., MCGuire, D., and Schmitt, R. (1990). ONS position paper on cancer pain. Part II. *ONF*, 17(5):751-760.
 33. Spross, J., McGuire, D., and Schmitt, R. (1990). ONS position paper on cancer pain. Part III. *ONF*, 17(6):943-955.
 34. Bieri, D., Reeve, R.A., Champion, G.D., Addicoat, L. and Ziegler, J.B. "The Facies Pain Scale for the Self-Assessment of the Severity of Pain Experienced by Children: Development, Initial Validation, and Preliminary Investigations for Ratio Properties." *Pain*. 1990. 41:139-50.
 35. Cassel, Eric J., MD. "The Nature of Suffering and The Goals of Medicine." The New England Journal of Medicine. Vol. 306, No. 11. March 18, 1982. pp.639-645.
 36. Joranson DE, Gilson Am, Ryan MA, Nelson, JM. Achieving Balance in State Pain Policy: A Guide to Evaluation Part I. The Pain and Policy Studies Group, University of Wisconsin Comprehensive Cancer Center. Madison, Wisconsin 1999.
 37. North Carolina Joint Statement on Pain Management in End of Life Care, Adopted by the North Carolina Medical, Nursing and Pharmacy Board, October 21, 1999.
 38. California Board of Registered Nursing: A. Pain Management Policy, 4/94. B. Curriculum Guidelines for Pain Management Content, 6/94. C. Testimony before the California Senate Subcommittee on Prescription Drugs, 7/18/95.
 39. State of Washington, Medical Quality Assurance Commission, Guidelines for Management of Pain. 4/18/96.
 40. Gebbie, Kristine M., Wakefield, Mary, and Kerfoot, Karlene. "Nursing and Health Policy." *Journal of Nursing Scholarship*. Third Quarter, 2000. pp 307-314.
-

Pain Management Nursing Role/Core Competency

41. McPheeters, M., MPH and Lohr, K.N., PhD., "Evidenced-Based Practice and Nursing: Commentary." *Outcomes Management for Nursing Practice*. Vol. 13, No 2. July-September, 1999. p. 99.
42. Goode, Colleen J. "What Constitutes the "Evidence in Evidence-Based Practice?". *Applied Nursing Research*. Vol. 13, No. 4. November 2000, p. 222-225.
43. "Why Should Perioperative RNs Care About Evidence-Based Practice?" (Research Corner). *AORN Journal*. Vol. 72, No 1. July 2000 pp. 109-111.
44. Stetler, Cheryl B. Ph.D, RN, FAAN, et al "Evidence-Based Practice and the Role of Nursing Leadership." *JONA*. Vol 28, No. 7/8. July/August, 1998. pp. 45-53.
45. Web site addresses:
 - a) National Guidelines Clearing House - www.mzch.gov
 - b) Americans for Better Care of the Dying - www.abcd-caring.com
 - c) American Pain Society- www.ampainsoc.org
 - d) American Society for Bioethics and Humanities -www.asbh.org
 - e) Center for Ethics in Health Care - www.ohsu.edu.ethics
 - f) Oncology Nursing Society - www.ons.org
 - g) Pain Link Home, A Pain Management Resource - www.edc.org/painlink
 - h) The American Alliance of Cancer Pain Initiative - www.wisc.edu/trc/steony/steint/html
 - i) Hospice Association of America- www.hospice.america.org
 - j) Memorial Sloan - Kiltering Cancer Center-www.mskcc.org
 - k) May Day Pain Link-City of Hope- www.cityofhope.org/medinfo/medresin.htm
 - l) Growth House News--www.growthhouse.org or www.pallcare.org/growth.htm
 - m) Wisconsin Educational Consortium on PainPolicy--www.medsch.wisc.edu/painpolicy/ncjoint.htm.
46. Standards and guidelines for pain management:
 - a) ____, Management of Cancer Pain: Adults. Clinical Practice Guidelines #9. Quick Reference Guide for Clinicians. U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research. March, 1994.
 - b) ____, Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain. 3rd Ed. American Pain Society. Skokie, Ill.
 - c) ____, The Use of Opioids for the Treatment of Chronic Pain. © 1997 AmericanAcademy of Pain Medicine and American Pain Society. Glenview, Ill.
 - d) Ferrell, Betty Rolling P.d., FAAN and McCaffery, Margo, RN, MS, FAAN. "Current Placebo Practice and Policy." American Society of Pain Management Nurses Pathways, Winter 1996. pp. 12-14.
 - e) New JCAHO Standards: Intent, Examples, and Scoring Questions for Pain Assessment and Management in Hospitals. May 1999.
 - f) ____, Acute Pain Management in Adults: Operative Procedures. A Quick Reference Guide for Clinicians. U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research.
 - g) ____, "The Management of Chronic Pain in Older Adults." American Geriatric Society's Panel on Chronic Pain in Older Adults. *Journal of The American Geriatric Society*. Vol.46. 1998. pp. 635-651.

Resources

Personal

1. Karen Kaiser, RN, MS, Clinical Practice Coordinator, University of Maryland Medical System, Baltimore, MD.
2. Margaret Perrone, RN, CRNH, Program Coordinator, Palliative Care Program, University of Maryland Medical System, Baltimore, MD.
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