By Genevieve M. Clavreul, RN, Ph.D.

Chronic Pain

What nurses don't know about pain management

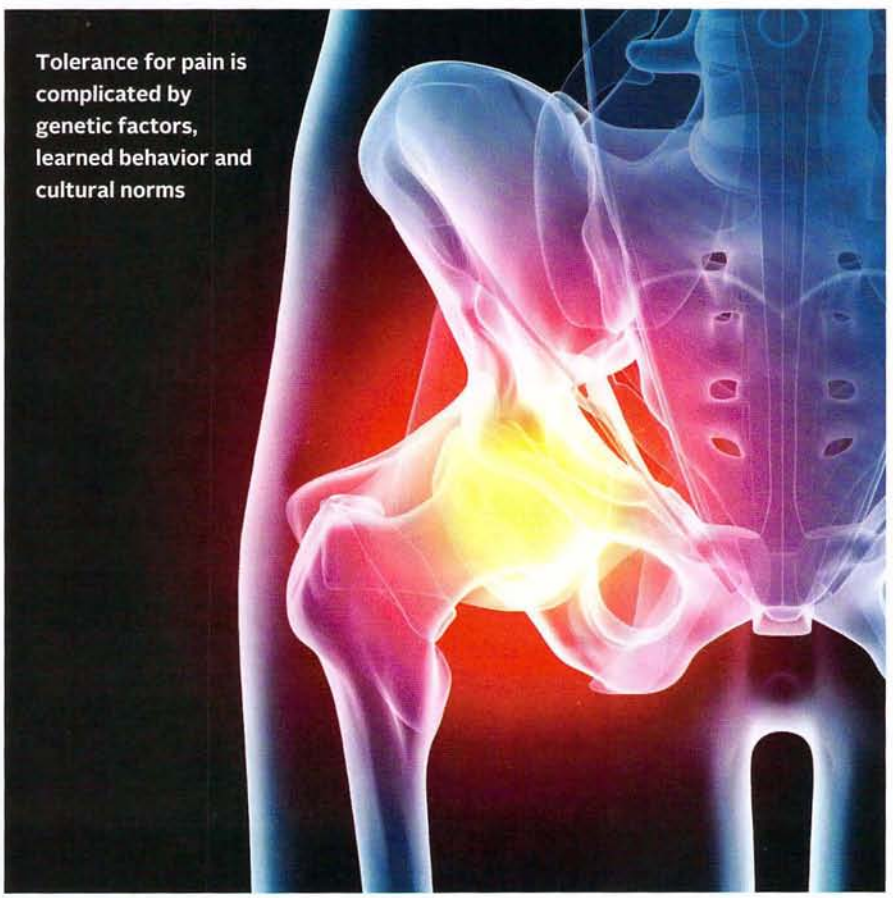
What is pain? There are many definitions. The most widely accepted is the one used by The International Association for the Study of Pain, which defines pain as "an unpleasant sensory and emotional experience arising from actual or potential tissue damage or described in terms of such damage."

The American Academy of Pain defines it as "an unpleasant sensation and emotional response to that sensation."

Margo McCaffrey, MS, RN-BC, FAAN, a specialist in the nursing care of patients with pain, is credited with providing the definition most appropriate for use in clinical practice. She says pain is "whatever the experiencing person says it is, existing whenever and wherever the person says it does."

Isn't Pain Subjective?

Most nurses feel that they have a good understanding of pain. We have, after all, nifty charts, diagrams and whatnots that we use to help our patients describe just how much discomfort they're experiencing. On a scale from one to 10, with one being no pain, and so on; or my favorite, the happy/sad face pictorial chart where we ask the patient to choose the appropriate smiley/frownie face.



Tolerance for pain is complicated by genetic factors, learned behavior and cultural norms

Being able to accurately gauge the intensity and source of pain is a critical component to the nursing team's ability to provide optimal patient care. However, there is a difference between treating the patient in pain and treating a patient living with chronic pain.

My personal experience has lead me to question how well nurses are educated and trained to address the needs of patients living with chronic pain, and the regime of medication that is used to treat them. Many a competent and compassionate nurse has been thwarted and confounded when confronted by such a case. Regrettably, inappropriate care can set back a patient's recovery, cause additional negative *sequelae*, and in some cases, threaten a patient's well-being.

Patricia's Withdrawal

Recently, my daughter Patricia underwent a long-awaited knee replacement surgery (for the record, she gave me permission to out her, so no HIPPA violation here). Patricia suffers from chronic pain and is on a long-term regimen of Kadian, a time-released morphine, and Narco for breakthrough pain.

As the date for her surgery approached, she received the reminder call from the surgical nurse not to eat or drink after midnight. She took this to mean not taking her medication since it

fell within that "no eat or drink" time. Which is why my daughter went into surgery that morning at 0700 without any pain meds on board.

As my other daughter Chris and I waited patiently during the surgery and post-op recovery, I wondered how Patricia would react to being without her meds for so long. Chris and I entered her room later that morning just as a nurse was bringing in additional blankets to address Patricia's uncontrollable shaking. My fears about withdrawal were realized. The nurse assured us that Patricia was simply suffering from a post-anesthesia "cold" and that he'd bring some more blankets in shortly and have her feeling all toasty and warm "real soon."

The Consult

I took the opportunity to assess her myself — because as you know, you never stop being a nurse. Her color was extraordinarily pasty and pale, her lips appeared gray, you could see her muscles twitch with the naked eye and her extremities shook as if she had palsy. I shared my observations with the nurse and he assured me, once again, that it was simply a normal response to the anesthesia.

At this time I reminded him that she was accustomed to taking both Kadian and Narco and had been doing so for many years, and because of the impending surgery had not taken her usual dose. To which he responded that she was ordered a PCA pump, but I could see that it was set to an amount that was nowhere near the level of her pre-surgical dose.

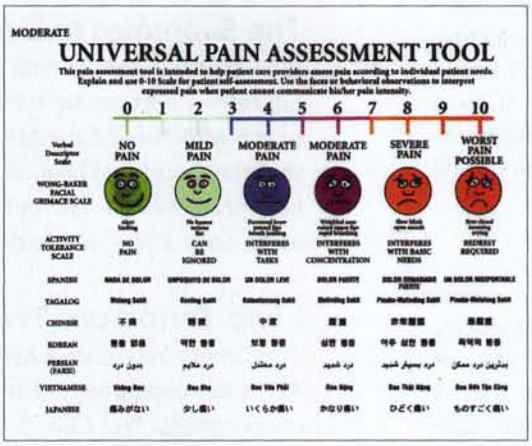
Keep in mind that I had also talked at length on this very issue with the surgeon, the anesthesiologist, and every nurse (and there were many) I came in contact with prior to the surgery. So, I had to wonder, did the various physicians, nurses, technicians and others who are part of the pre-op and post–op process really read and integrate all the information that they demand from their patients? If they had, they would have taken steps to avoid putting my daughter into opioid withdrawal syndrome.

Finally, the nurse informed me that he would ask for a pain consult and he stepped away to the nurses station to place the call. A short time later, a physician whose specialty was pain management arrived. After a brief series of questions, he ordered that Patricia return to her former pain management regime and the PCA dosage be increased as well. As he left, he commented to me that he found it frustrating that so many patients were placed in similar opioid withdrawal "crisis" after following the surgical nurse's instructions to "take nothing by mouth" after midnight. What they should do, he said, was take their scheduled pain medication, but do so with the most minimal amount of water needed to swallow.

Needless to say, once Patricia was back on her pain treatment regime and the PCA dosage increased, the color returned to her cheeks, her lips lost their grey pallor and all signs of shivering ceased.

Educating Ourselves

Understanding chronic pain is an area where more education and instruction is needed. This is not to say that most nurses don't do their utmost to alleviate their patient's suffering, because they do. But treating chronic pain is not as simple as writing out a prescription and reminding the patient to take the medication as prescribed. Addiction is a very real possibility and the need to monitor for that outcome is critical.



The smiley/frownie face charts help with assessment, but there is a big difference between treating the patient *in* pain and treating the patient who is *living with* chronic pain.

Nurses who want to learn more can contact a group such as the American Society for Pain Management Nursing (*www.aspmn.org*). They have chapters in many states, including one in Southern California. Their mission is to advance and promote optimal care for people affected by pain by promoting best nursing practices.

Like many organizations, their meetings have a topic, a speaker and a Q&A. In addition to the meetings, the members themselves are an excellent resource to answer questions related to pain management, and I've found that many have extensive networks that include other experts.

Action Plan

There are many things that nurses can do to better understand this issue. We can ask that our hospital's nursing education department provide continuing education in pain management, as well as provide opportunities for the nursing team to have "personal" time with physicians and nurses who specialize in pain management.

Nurses can lead the charge in advocating for other interventions that may help reduce the need for opioids. Recently there has been a push to encourage the use of long-term physical therapy, aqua therapy, exercise, acupuncture and even yoga to address chronic pain. The results from these therapeutic interventions have been positive and can help reduce the patient's dependence on medication.

There's a lot about pain management that even the experts don't know, so the next time you have such a patient, don't be shy about asking questions. Consult the experts on staff regarding care protocol.

Booked Solid, Forever

In closing, let me share with you a little story about unintended consequences. Not that long ago, the State of Washington legislature decided that it was in the best interest of their constituents who were being treated with opioids for chronic pain that they be required to see a physician specializing in pain management for assessment and to receive their prescriptions.

On the surface, the legislation helped to ally the fears of the medical/nursing community that people living with chronic pain would have their needs met, and hopefully reduce illicit opioid distribution and minimize addiction, misuse and so forth. Unfortunately, what everyone failed to take note of was the shear paucity of pain management experts licensed in Washington — at that time there were *two* in the whole state.

Needless to say, this placed an extraordinary burden on not only the patients, but the two sole practitioners as well. As they say, the road to you-know-where is paved with good intentions. WN

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Healthcare Reform November Update

by Genevieve M. Clavreul, RN, Ph.D.

The Back Story

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA), a sweeping package of provisions we know as "healthcare reform." The new law goes into effect during the next four years, with most changes taking place in 2014. Stay tuned as we guide working nurses through the twists and turns, and provide an answer to the question: "What is going on with healthcare reform?"

The Supremes to Decide Before Election

In September, the Obama Administration filed a petition with the Supreme Court asking for a speedy ruling on the constitutionality of the Affordable Care Act (ACA). This request almost guarantees that the Court will hear at least one of the cases challenging the healthcare reform law before next year's election. Which should make 2012 a very interesting year indeed.

Long-Term Care Too Costly

The Community Living Assistance Services and Support (CLASS) Act, a key component of the ACA, has fallen apart due to actuarial unsoundness. The CLASS Act would be funded by premiums and would pay enrollees $50 or more per day if they became too disabled to perform normal daily activities like eating and bathing.

Employers who chose to participate would sign up their employees, who would then have the ability to opt out. The cash benefits could be applied to nursing-home care, but in an effort to encourage enrollees to stay in their own homes, payouts could cover such things as wheelchair ramps and wages for home healthcare aides.

The CLASS Act was required by law to remain financially self-sustaining. However, the Health and Human Services Department was unable to devise a means of implementation that could both attract healthy participants and pay the minimum level of benefits.

Final Rules for ACOs Released

The Obama Administration released the final rules for Accountable Care Organizations (ACO). ACOs are partnerships of healthcare providers formed to reduce the cost of caring for Americans on Medicare while also boosting quality. ACOs that achieve these goals could share in any savings with the Medicare program. The model outlined by the Obama Administration would require participating groups of doctors, clinics and hospitals to take responsibility for managing the care of at least 5,000 Medicare patients. WN