

The Nurse's Role in Pain Management

Statement of Purpose

To guide the practice of the Licensed Practical Nurse, Registered Nurse and Advanced Practice Registered Nurse in promoting patient access to the appropriate, therapeutic and effective assessment, diagnosis and management of acute and chronic pain. Such pain assessment and management serves to improve the quality of life for those patients who suffer from pain as well as to reduce the morbidity and costs associated with untreated or inappropriately treated pain including non-treatment, under-treatment, over-treatment and the continued use of ineffective treatment.

Background/Significance

Pain is one of the most common reasons clients seek medical attention, and is a symptom that is encountered by every health care provider. Health care professionals must be knowledgeable regarding effective and compassionate pain relief, while clients and their families should be assured such relief will be provided. Communication and collaboration between members of the healthcare team, the client and the family are essential in achieving adequate pain management. Ideally, the client directs the plan of care and the pain level to be achieved.

Board Statement

Pain is a nursing diagnosis and as such, nurses have primary responsibility for its assessment and management. The nurse is often the healthcare professional most involved in on-going pain assessment, implementing the prescribed pain management plan, evaluating the response to such interventions and adjusting medication levels, based on the individual's response.

Pain is multifactorial and therefore the management of pain may include the use of both pharmacologic and non-pharmacologic modalities. An individual's self-report of pain, along with level of functional impairment are the optimal standards upon which pain management interventions are based. In the absence of ability to self-report level of pain, an appropriate non-verbal scale should be used.

The management of pain must be a priority for nurses and all others who provide care to individuals in pain. This interpretative statement is intended to:

1. Provide a balanced approach to pain management. A balanced approach addresses the potential for abuse without keeping individuals from receiving the level of care and pain management that is needed.
2. Promote the optimal level of nursing practice in pain management using pharmacologic, non-pharmacologic multimodal approaches.
3. Establish a framework leading to sound clinical judgment in managing acute, chronic, and end-of-life pain.

Definitions

For the purposes of this statement, the following terms are defined:

1. **Acute Pain** is brief and responds to timely intervention, or subsides as healing takes place.
2. **Addiction** is a combination of cognitive, physiological and behavioral symptoms (such as compulsive craving and compulsive use of a controlled substance) in which the individual continues the use of a substance despite harm or adverse consequences. Neither physical dependence nor tolerance alone, as defined below, constitutes addiction.
3. **Breakthrough Pain** is pain that comes on suddenly for short periods of time and is not alleviated by the individuals' normal pain suppression management.
4. **Chronic Pain** is ongoing or frequently recurring, and may become unresponsive to intervention over time.

Oregon State Board of Nursing: Interpretive Statement

5. **Intractable Pain** means a pain state in which the cause cannot be removed or otherwise treated, and no relief or cure has been found after reasonable efforts.
6. **Medication Range Order** is an order that allows the nurse to titrate medication to the desired effect through changes in dose with fixed time intervals (American Society for Pain Management Nursing & American Pain Society, 2004). Example: "Morphine sulfate 1–2 mg IV q2hours prn pain"
7. **Multimodal** is the use of medication and/or other therapies with different modes of action i.e. application of heat and cold along with acetaminophen.
8. **Neuropathic Pain** is caused by a lesion or a malfunction in the nervous system.
9. **Nociceptive Pain** is caused by active illness, injury or inflammatory process associated with actual or potential tissue damage.
10. **Non-opioid** is pain medication that does not contain opioids i.e. NSAIDs and acetaminophen
11. **Pain** is an unpleasant sensory and emotional experience related to adverse nociceptive or neuropathic stimuli.
12. **Pain assessment scale** is a pain assessment tool that is appropriate to the needs of the individual and the demand of the care situation that takes into account such variables as language, cognitive ability, age, culture, disability and other factors (International Association for the Study of Pain, 2006, Objectives).
13. **Physical Dependence** is the physiologic adaptation to the presence of a controlled substance, characterized by withdrawal when its use is stopped abruptly.
14. **Pseudoaddiction** is an iatrogenic syndrome resulting from poorly treated pain and may be mistaken for addiction.
15. **Substance Abuse** is a pattern of substance use leading to clinically significant impairment or distress as manifested by one or more of the following:
 - a. Recurrent substance use resulting in failure to fulfill obligations at work, school or home;
 - b. Recurrent substance use when such use is physically hazardous;
 - c. Recurrent substance-related legal problems; or,
 - d. Continued substance use despite recurrent consequences socially or interpersonally.
16. **Tolerance** is the physiologic adaptation to a controlled substance over time, resulting in the need to increase the dose to achieve the same effect, or in a reduction of response with repeated administration.

Scope of Practice

Consistent with the licensee's scope of practice, the nurse is accountable for implementing the pain management plan utilizing his/her knowledge base and documenting assessment of the individual's needs. It is the responsibility of the nurse to utilize critical thinking and integrate multimodal approaches for effective pain management.

The nurse has the authority to adjust medication levels within the dosage range stipulated by the prescriber and according to the institutions established procedures. When pain is not controlled under the currently prescribed treatment plan, the nurse is responsible for reporting such findings to the prescriber, advocating for an optimal pain management plan and documenting the continuum of care provided an individual with pain.

Advanced Practice Nurses who are authorized by law to prescribe or dispense drugs, including controlled substances see Division 56 for additional standards of practice.

Nursing Pain Management Knowledge and Skills

Principles of pain management include:

- Assessment - the process of pain management starts with an adequate assessment of the pain which can include but is not limited to:
 - Nature of the pain (including the use of an appropriate, evidence-based pain assessment

Oregon State Board of Nursing: Interpretive Statement

- scales)
 - Cause of the pain
 - Personal context of pain, including how pain impacts daily function and quality of life
- Development and implementation of an individualized pain management plan that is evidence-based and includes comprehensive and on-going pain assessment, including impact on daily functional ability, appropriate pharmacological and non-pharmacological modalities, and substantiation of adequate symptom control;
- Implement measures in the care plan that include non-pharmacological modalities, interventions, and comfort measures for pain management i.e. positioning, pillow placement, music, dimming lights, heat and cold etc.
- Document assessments, interventions, treatment and response;
- Utilization of controlled substances when appropriate including opioid analgesics in the management of all pain types;
- Collaboration and consultation with Interdisciplinary teams;
- Recognition that:
 1. tolerance and physical dependence are normal consequences of sustained use of opioids and are not synonymous with addiction;
 2. pseudoaddiction may develop as a direct consequence of inadequate pain management and that pseudoaddiction can be distinguished from true addiction in that inappropriate drug seeking behaviors resolve when pain effectively treated;
 3. patients with chemical dependency may require special pain management involving controlled substances including opioids;
 4. individuals who suffer from extreme pain or disease progression may require increased doses of pain medication and the appropriate dose is the dose required to effectively manage the patient's pain in that particular circumstance;
- Adherence to system safe-guards that are designed to minimize the potential for abuse and diversion when controlled substances are used;
- Acceptance of an individual's self-determination and autonomy;
- Culturally sensitive patient, family/significant other, and/or caregiver pain management education.

Pain Education and Training

The nurse is responsible and accountable for acquiring and maintaining current knowledge, skills and abilities necessary to practice in accordance with accepted standards of care for pain management. Such competencies may be acquired through basic, graduate or continuing education programs, as appropriate to the nurse's scope of practice. These competencies include, but are not limited to knowledge of the current federal and state laws and regulations for the prescription, dispensing, administration and destruction of controlled substances, current evidence-based guidelines developed by nationally recognized professional organizations in the assessment and management of pain and the use of pharmacological and non-pharmacological modalities (e.g. heat and cold therapies).

Resources/References:

The Joint Statement from 21 Health Organizations and the Drug Enforcement Administration Promoting Pain Relief and Preventing Abuse of Pain Medications: A Critical Balancing Act

http://www.aspmn.org/documents/A_JOINT_STATEMENT_FROM_21_HEALTH_ORGANIZATIONS.pdf

Institute of Medicine report: "Relieving Pain in America" June 2011. Accessed at:

<http://iom.nationalacademies.org/Reports/2011/Relieving-Pain-in-America-A-Blueprint-for-Transforming-Prevention-Care-Education-Research.aspx>

Oregon State Board of Nursing: Interpretive Statement

International Association for the Study of Pain. (2006). Outline Curriculum on Pain for Schools of Nursing (2 nd ed). Retrieved from: http://www.nursingceu.com/courses/412/index_nceu.html

American Nurses Association (2003). Position statement on pain management and control of distressing symptoms in dying patients. Retrieved from <http://www.ana.org/>.

American Pain Society, Advocacy & Policy. (2004) The Use of 'as needed' range orders for opioid analgesics in the management of acute pain. Retrieved from <http://www.ampainsoc.org/>.

California Board of Registered Nursing. (1999). Pain management policy. Retrieved from <http://cbn.org/>.

Federation of State Medical Boards: Model policy for use of controlled substances for the treatment of pain. Retrieved from <http://www.fsmb.org/>.

Standards for Joint Commission Accreditation of Healthcare Organizations.

Kansas Board of Nursing (2001). Guideline for pain Management. Retrieved from <http://www.ksbn.org/>.

Levi, B. (2005). North Dakota Medical Association: Ethics Moment.

Minnesota Board of Medical Practice, Nursing and Pharmacy (2004). Joint statement on pain management. Retrieved from <http://www.mbn.org/>

North Carolina Board of Nursing, Pharmacy and Medicine (1999). Joint statement on pain management in end-of-life care. Retrieved from <http://www.ncsbn.org/>.

Resources/References Specific to APRNs and Prescribers:

OSBN Division 56: http://arcweb.sos.state.or.us/pages/rules/oars_800/oar_851/851_056.html

Oregon Regulatory Statue 689.681 on Naloxone:

https://www.oregonlegislature.gov/bills_laws/lawsstatutes/2013ors689.html

Oregon Prescription Drug Monitoring:

<http://www.orpdmp.com/>

Washington State AMDG 2010 Policy: <http://www.agencymeddirectors.wa.gov/opioiddosing.asp>

NIH National Institute on Drug Abuse: <http://www.drugabuse.gov/related-topics/trends-statistics/infographics/abuse-prescription-pain-medications-risks-heroin-use>

Frequently Asked Questions

Q: Are range orders for pain medications acceptable?

A: Range orders are commonly used to provide flexibility in dosing to meet individual patients' needs because a wide variability exists in patients' responses to medications. Evidence-based clinical practice guidelines support the need for individual titration of the dose of medications such as opioid analgesics. Range orders enable necessary and safe adjustments in doses based on individual responses to treatment. In order to promote

Oregon State Board of Nursing: Interpretive Statement

patient safety and reduce medication errors it is critical that physicians, nurses, and pharmacists share a common understanding of how to properly write, interpret, and carry out PRN range orders.

The nurse is often the health professional most involved in on-going pain assessment and implementing the pain management plan. The LPN may assist in the assessment however the RN has the overall responsibility. In order to achieve adequate pain management, the RN and LPN must base decisions concerning the implementation of range dose orders based on a thorough pain assessment. Both the RN and LPN must be knowledgeable of the:

- medication to be administered,
- anticipated time of onset of the medication,
- time to peak effect, duration of action of the medication,
- and side effects of the medication to be administered.

Consistent with the licensee's scope of practice, both the RN and LPN is accountable for implementing the pain management plan including pharmacologic, non-pharmacologic and complimentary interventions utilizing their knowledge, skills and abilities and organization policy.

More information can be found at

- 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 Manag Nurs.* 2004;5(2):53-58. Accessed here: <http://www.aspmn.org/documents/RangeOrderPublished2014.pdf>
- Range Orders for Pain Medication. *CRITICALCARENURSE* Vol 28, No. 4, AUGUST 2008. Accessed here: <http://ccn.aacnjournals.org/content/28/4/66.full.pdf>

Q: Can an RN re-dose a PRN pain medication if he/she assesses the patient and finds the patient to still have pain?

A: When adequate pain management is not achieved under the currently prescribed treatment plan, the nurse is responsible for reporting such findings to the prescriber and documenting this communication. Only the licensed health care practitioner with prescriptive authority may change the pharmaceutical management plan.

Q: What is the nurse's role in equianalgesic conversions?

A: Equianalgesic dose is defined as the dose of one analgesic drug that is equivalent in pain relieving potential to another analgesic drug. To ensure effective pain management, it is essential for nurses to be skilled in interpreting an equianalgesic table, calculating equianalgesic dosing, and advocating for safe doses of analgesics. While nurses are not independently responsible for choosing the medication, they are responsible for recognizing and giving the proper dose.

Q: Is it within the scope of practice for a Registered Nurse or Licensed Practical Nurse to administer a placebo medication for pain management (except in clinical trials for which the patient has provided consent)?

A: Placebos should only be given when ordered by a health care provider as part of an approved research study where patients are aware and have given written consent that they may be receiving a placebo. If a health care provider orders a placebo for management of pain for a patient not in a research study, the nurse should advocate on behalf of their patient and consider a consultation with others within the agency if the health care provider is unwilling to change the order.

Oregon State Board of Nursing: Interpretive Statement

Frequently Asked Questions for APRNs

Q: Does the OSBN have guidelines for APRN prescribers for chronic opioid therapies in non-cancer pain?

A: The Oregon Nurse Practice Act (NPA) has specific rules around prescribing for controlled substances and pain management in Division 56 under section **851-056-0026**. These rules are in congruence with many of the The American Pain Society (APS) and the American Academy of Pain Medicine (AAPM) guidelines. Recommendations from these expert panels stress that **therapy should be discontinued if patients are, “known to divert opioids or those engaging in serious aberrant behaviors.”** Further, they **recommend the use of PDMP** to help identify patients who obtain drugs from multiple providers and locations.

Q: Is participation in the Oregon Prescription Drug Monitoring Program (PDMP) mandatory for APRNs who prescribe?

A: In 2011, the Oregon Prescription Drug Monitoring Program (PDMP) was established to provide clinicians the ability to review a patient’s controlled substance prescription history to avoid over prescribing and diversion. Currently it is not a regulatory requirement for prescribers to utilize the PDMP, however, its use is strongly encouraged.

Q: Is there a specific requirement for referral to a Pain Management Specialist?

A: No, currently in Oregon referral would be indicated if the patient was demonstrating a limited response or no improvement, if abuse or misuse was suspected or if requested by either the patient or the provider.

Oregon Providers should be aware of neighboring state requirements, especially if dually licensed and treating WA patients. Washington State’s Agency Medical Director’s Group (AMDG) in 2010 developed an opioid dosing guideline to address the crisis in drug abuse, misuse, and diversion in their state. Differences between the Oregon NPA and the Washington NPA include the requirement for Washington prescribers to complete:

1. Four hours of continuing education on pain management with every two yr. licensing cycle.
2. Mandatory consultation with pain management specialists, when patients reach a specific morphine equivalent dose (MED) higher than 120 mg. The commission developed a calculator that helps providers convert opioid medications to the morphine equivalent (Available at the AMDG website <http://www.agencymeddirectors.wa.gov/guidelines.asp>).

References: Oregon Nurse Practice Act, Divisions 45, 50, 52, 54 and 56

Authority for Approval: ORS 678.010(7), OAR 851-045-0030 through 0060; ORS 678.150

History of Document: Adopted June 17, 2004; Reviewed/Revised February, 2012

Revised: Adapted to Interpretative Statement 01/01/2016

The Oregon State Board of Nursing (OSBN) is authorized by Oregon Revised Statutes Chapter 678 to exercise general supervision over the practice of nursing in Oregon to include regulation of nursing licensure, education, and practice in order to assure that the citizens of Oregon receive safe and effective care. The OSBN further interprets statute and rule and issues opinions in the form of Policy and Interpretive Statements. These policies and interpretive statements are advisory in nature and issued as guidelines for safe nursing practice.