the Remedi Pulse

PAIN MANAGEMENT

Remedi SeniorCare EDUCATION Rx

A CLINICAL AND REGULATORY UPDATE FROM REMEDI SENIORCARE

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Survey Solutions

with William Vaughan, BSN, RN
VP of Education & Clinical Affairs

Taking the Regulatory "Pain" out of Pain Management

Decubitus ulcers, drugs, care plans, and even call bells have one they can call their own … but when the OBRA '87 regulations were enacted, pain didn't make the cut. I'm of course referring to F tags, the numerical reference assigned to various federal regulations governing nursing homes. To be fair, the standard of assessing pain as the fifth vital sign and the realization that pain was generally under-treated in the elderly did not fully come of age until after OBRA '87 was implemented. In today's regulatory environment, surveyors use a variety of regulations when evaluating a facility's pain management program (F157 - physician notification, F281 - professional standards of quality, F329 – unnecessary drugs, etc.), but deficiencies typically end up being cited under F309, quality of care. To clarify regulatory expectations, in 2009, CMS published guidance to surveyors related to pain management and incorporated it into the state operations manual under F309 (I was honored to be a member of the expert panel that developed this guidance).

The concepts listed below provide a framework for compliance and ultimately quality care for nursing home residents in the area of pain management:

RECOGNITION: Pain is not a natural or inevitable aspect of aging, but nursing home residents do frequently suffer with co-morbidities that involve pain. Medical directors, administrators, directors of nurses, and others that hold leadership positions in nursing homes should develop a culture that prioritizes the assessment and treatment of pain. While a pain free existence for every resident cannot be guaranteed, caregivers should partner with each resident and provide a robust and individualized pain management program.

Surveyors use a variety of regulations when evaluating a facility's pain management program.

ASSESSMENT: When it comes to assessment, the question, "*Are you in pain?*" is just the starting point in a complex process.

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Pain Management in End-of-Life

Prepared by Jim Salmons, Pharm.D., Clinical Consultant Pharmacist

Many of us, as health-care professionals, are involved at some level with the care of those entering the last phases of life. Indeed, this can be one of the most challenging and rewarding elements of our careers, as we attempt to balance our emotions with the so-called "science" of providing care. The many associated symptoms that may arise in the terminally-ill patient (including anxiety, depression, chronic nausea, etc.) require us to move away from the traditional approach of a long-term or curative plan of treatment and instead focus on the concept of "palliative" or "comfort" care. The primary goal in end-of-life therapies, then, is not to provide cures, but instead assist in providing as dignified and peaceful a passing as can be expected.

While many symptoms may require medication therapy for adequate control or treatment, one that is among the most prevalent is pain. Patients may have multiple sources and types of pain; a single patient may have pain in bone, soft tissue and organs, such as the liver or lungs at one time. Also, as body systems, such as the kidneys and heart begin to fail, swallowing becomes diminished and altered consciousness occurs, we must think outside of traditional routes of medication administration (e.g., oral) to provide adequate symptom control. Some of these options include:

- Crushed tablets
- Rectal (suppositories or tablets)
- Subcutaneous (SQ)/ pumps
- Sublingual
- Topical

CRUSHED TABLETS

Many "simple" tablets, such as lorazepam or APAP, may be crushed and even mixed with a small amount of fluid or applesauce and may be used, when appropriate, until a liquid form of the drug is delivered from the pharmacy (if the liquid medication is covered by the payor). Tablets should not be coated in lubricants that may alter absorption. Note that some tablets, such as MS Contin, OxyContin and other sustained-release drugs should NOT be crushed, as this releases all of the drug at once and may actually be dangerous to the patient. Check with your pharmacist if you are not sure!

RECTAL

Suppositories containing morphine and other narcotics are commercially available or can be made in the pharmacy. However, many of the narcotic pain tablets (e.g., morphine, hydromorphone, methadone, oxycodone, and tramadol), may be administered via the rectal route. Also, such meds as APAP, ibuprofen, and aspirin are suitable for rectal administration. The rectum should be empty, insertion of the tablet should be about 1 finger's length into the rectum and placed against the rectal wall, and a small (10mL) amount of water may be added via syringe to help the tablet dissolve.

SUBCUTANEOUS (SQ)

When oral access is no longer an option, and rectal administration is undesired or not feasible, another option is the SQ route. Morphine and hydromorphone are the most common narcotic pain medications used. Patient-controlled analgesia (PCA) pumps provide another way to provide larger doses of medication. SQ sites may be placed in the patient's skin and changed weekly or as needed. Other non-narcotic or adjuvant meds for pain, such as ketorolac for pain or metoclopramide or ondansetron for nausea, may be considered as well.

SUBLINGUAL (SL)

Sublingual preparations of morphine and oxycodone are readily available. Tablets, unless specifically designed to dissolve under the tongue, etc., are usually not used in this manner. Swabbing the oral cavity with a wet toothette, etc., to moisten the surfaces and to clear oral buildup may be helpful for some patients. A note of caution: most sublingual narcotics are CONCENTRATED, meaning they contain more drug per milliliter than traditional formulations. Without extreme caution, it is not difficult to overdose a patient with these SL preparations and potentially cause serious harm.

TOPICAL

The most common form of topical narcotic pain medication is the fentanyl patch. However, using pain patches in the dying patient can be tricky, as the patient may be febrile or may not have adequate stores of fat or muscle to support proper absorption of the drug into the body. This can result in "dose-dumping," or delivery of drug too quickly into the bloodstream and side effects or inadequate pain control over the entire dosing period. Other topicals include specially-prepared gels that may contain such drugs as mirtazapine for appetite and depression and lorazepam-haloperidol for nausea and anxiety/agitation (often associated with pain).

Ultimately, the choice of alternative routes of administration of pain medications in the terminally-ill patient will be driven by the many factors associated with each patient (e.g., patient preference, degree of consciousness, etc.). Sometimes the patient will require multiple routes of drug administration. By being observant and interactive partners in the care process, we can share information and utilize the best alternatives for drug delivery for each of our patients nearing the end of life.

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Buprenorphine for Opioid Addiction-Access and Requirements

Prepared by Jennifer Hardesty, Pharm.D., FASCP, Chief Clinical Officer

Buprenorphine is a semisynthetic mixed opiate agonist-antagonist indicated for moderate to severe pain, and is also used for the treatment of opioid dependence. Available products include Subutex, Suboxone, Zubsolv, Butrans, Bunavail, and generic formulations. As a Schedule III (C-III) controlled substance, buprenorphine can be prescribed for pain without any limitations other than the standard DEA C-III prescription requirements. However, when prescribed for substance abuse treatment, there are additional federal obligations that must be met.

For the purpose of improving access to opioid addiction treatment, *The Drug Addiction Treatment Act* (DATA2000) now permits prescribers to obtain a waiver from the original separate registration requirements of the Narcotic Addict Treatment Act to treat opioid addiction (e.g., traditional methadone clinics). Prescribers may take an 8-hour CE course, or alternatively have prior certification/sub-specialty in **addiction medicine** to meet the waiver requirements. Once the waiver is obtained, prescribers may treat up to 30 patients per year, and will be supplied with a unique DEA number that should be used whenever prescribing buprenorphine for opioid addiction. Pharmacy will verify the unique DEA number before dispensing any buprenorphine for addiction treatment.

To avoid delay in receiving buprenorphine orders, please be sure to address the following:

- Include indication for all buprenorphine-containing orders
- Ensure prescriber is aware of waiver requirement, if prescribing for opioid addiction treatment
- Prescriber must include unique DEA waiver number on any order for opioid addiction treatment
- Educate admissions coordinators to be vigilant for these medications and alert the administration/prescriber well in advance to avoid delays or misunderstandings of the federal requirements

Additional information can be obtained by visiting: http://buprenorphine.samhsa.gov/data.html or calling 1-866-287-2728.

Nurse of the Month

MARLAYNE OLENICK, RN, DON
Heather Hill Care Communities, Chardon, OH

CONGRATULATIONS to Marlayna Olenick, RN, DON, Heather Hill Care Communities, Chardon, Ohio for being chosen as the Remedi "Nurse of the Month." Marlayna was nominated by her administrator, Lisa Deering, RN, MSN, CRRN, BC, LNHA, Director of Hospital and Long-Term Care Services. Marlayna has been the DON at Heather Hill for four years and has been a nurse for nine years. Per Lisa, "Marlayna is one of the most organized DONs I have ever worked with throughout my 24 years in healthcare. She leads by example each and every day. Her organizational skills and ability to multitask multiple projects at once is outstanding. Our medical campus is extremely complex with some of the highest skilled nursing acuity in the state. She leads her team through these complex cases, and the outcomes achieved are remarkable. Marlayna most recently led the facility through an eMAR conversion that was completely seamless. Her positive nature helps create a culture of caring and commitment to our residents. She is often consulted at the corporate level on transitioning new buildings or training new staff. Marlayna is the ultimate professional nurse and deserving of this recognition!"

The Remedi "Nurse of the Month" exemplifies excellence in nursing practice. Email your Nurse of the Month nomination(s) to Rebecca.Ogden@RemediRx.com. Nurses Rock!!

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Noting the location, duration, nature and intensity of a resident's pain, determining what makes the pain better or worse, and exploring treatments that have been effective in the past are all important considerations when developing a resident centered pain management program. Remember, too, that pain is a symptom of an underlying condition (e.g., fractures, cancer, osteoporosis) and its diagnostic value should not be overlooked.

INFORMED CONSENT: The federal regulation at F154 acknowledges that a resident has a right to be fully informed of his/her total health status, including medical condition. The management of pain carries with it mutual risks and benefits, both of which should be clearly communicated to a resident or surrogate decision maker. Staff should then work with residents to establish goals of care, which will help frame various approaches to treatment. For example, some residents may accept a certain level of pain to avoid the potential adverse effects of powerful narcotics, while others will want pain relief at all cost.

TREATMENT: While culturally outside of a long-term care facility we approach pain management by reaching for a pill, the regulatory expectation in a nursing home is that non-pharmacological interventions are incorporated into all pain management programs. How this plays out at the bedside varies by each resident's needs, but ultimately, facilities must be able to demonstrate that their pain management arsenal includes non-drug therapies and that those therapies are routinely used.

Note: Bill was a surveyor with the Maryland State Survey Agency from 1988 until 2001. He became Chief Nurse of the agency in 2001 and remained in that position until joining Remedi SeniorCare in 2013.

Coming next month, a deeper dive into what prompts deficiencies involving pain management.