ACUTE ON CHRONIC PAIN PILOT PROGRAM. THE LEARNING STARTED WITH THE NURSES

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INTRODUCTION / AIM

There is a gap between the Acute Pain Service, the Palliative Care service and the Chronic pain Service that needed to be filled.
The acute on chronic pain program was developed to provide assistance in a non urgent bases to in- ward patients, to propose a plan of treatment, to expedite their discharge by collaborating with the treating service, an providing a smooth transition to a Chronic pain clinic if needed. To aid other Hospitals within the same health system where this service was not available. There was a resistance from the ward personnel to acknowledge the existence of a lack of experience in the evaluation and treatment of chronic pain patients and the implications in hospital stay. We focus our attention on promoting teaching resources and tools to improve confidence in the evaluation of pain patients by the nurses, to create a learning experience where the nurses were taught how to evaluate a pain patient properly, how to report the pain to a pain specialist or an anesthesiologist and how to spot the mistakes in prescription of pain medications that could have been done by the residents and most important, who to address the referral when they encounter a patient that due to the complexity of their case or the difficult of the post op will become a patient that will be difficult to handle for the treating Physician.

METHODS

1. Teaching sessions were organized for the nursing staff, a RNAO fellowship, the Kouses & Posner Transformational Change Model was used to facilitate engagement of surgical nurses to create practice changes in the assessment and management of chronic and acute-on-chronic pain. (1)

2. The nurses were evaluated before and after in topics of pain and pain evaluation.

3. Knowledge translation was promoted from nurses to residents by word of mouth.

4. Teaching was then organized for the residents as per service request.

5. Residents informed the MRP about the service.

6. The service was presented on Hospital rounds one year after it started and specific referral requirements were proposed.

7. Statistics were taken to identify services that requested de service as per time basis.

SPECIFIC REFERRAL CONDITIONS:

This is reference material for delegates of the Canadian Pain Society Annual Scientific Meeting 2016 and is not intended for any other use or distribution.
1. ADMITTED PATIENTS AND EMERGENCY DEPARTMENT PATIENTS THAT REQUIERE URGENT INTERVENTION WHERE PAIN CONTROL IS OR WILL BECOME A PROBLEM.

2. ESTABLISH DIAGNOSIS OF CHRONIC PAIN AND MANTAIN ON OPIOIDS.

3. CURRENT ANALGESIA REQUIREMENTS > 25% OF ADMISSION MEDICATION, OR CONTINUOUS INTRAVENOUS, EPIDURAL OR INTRATHECAL INFUSIONS.

4. METHADONE USE ALONE IS NOT A REASON FOR REFERRAL, ONLY ASSOCIATED WITH UNMANAGED PAIN OR SURGICAL REASON TO STOP OR RESTART A PREVIOUS METHADONE REGIME.

5. THE SERVICE WILL NOT ACCEPT PATIENTS FOR MANAGEMENT OF METHADONE FOR ADDICTION.

6. PATIENTS WITH PREVIOUS ADDICTION TO OPIOIDS WITH NEW PAIN PROBLEM OF CONSIDERABLE CAUSE (BURNS, AMPUTATIONS, NECROTIZING FASCIATIS, MULTIPLE FRACTURES, EPIDURAL ABSCESS) AS PER CASE BASES.

7. PATIENT THAT REQUIRE INTERVENTIONAL PAIN PROCEDURES TO OPTIMIZE THEIR CONDITION FOR DISCHARGE.

8. PALLIATIVE CARE PATIENTS THAT REQUIERE INTERVENTIONAL PAIN CONTROL PROCEDURES.

RESULTS

The program ran for 5 years in which time statistics were taken for 2 years; 70 difficult pain patients were seen by one pain physician aided with the support system created for the nurses. Multiple services took advantage of this new initiative, being surgery (N=22) and medicine (N=21) the ones that referred the most, followed by acute pain service (N=13), support was also provided to the ER (N=4), ICU (N=3), Pediatric ICU (N=1), Oncology and others (N=6). From the total of 70 patients seen in two years 45 made the transition to the Chronic Pain Clinic, without interruption of their pain care as it was provided by the same physician. Bypassing the waiting time and promoting continuity.

Improved pain management has a potential to improve patient satisfaction and confidence on discharge, increase their postoperative mobility and shorten length of stay. (1) The nurses were instructed and evaluated in two different hospitals (Hamilton General Hospital neurosurgery and Spine Ward and Juravinsky Hospital) before and after using the City of Hope, Pain knowledge and attitude survey, before the course the media was 70% for both hospitals after the training the scores improve to the low 90%.

The feedback from the pilot unit involved statements like:
"Empowerment is starting to be evident, a spark; more autonomy; less hesitant to approach residents; residents more receptive; getting orders sooner; pursuing better pain management more frequently; a small culture shift noticed"
"Pain issues are definitely being addressed in a positive manner."
"The nurses are feeling more confident about pain management."(1)

DISCUSSION / CONCLUSIONS

The teaching of the nurses in order to promote the service was cardinal, as we only had one pain physician available to see all the consults of this service, the nurses function very effectively into coordinating with the residents and reporting back to the pain physician, so it made possible to overcome the lack of resources. Once the nurses were given the tools to correctly evaluate a pain patient, their confidence improved and they gathered experience and felt comfortable with the opioid treatment, use of methadone and interventions performed.

The nurses where not trained to decide how much medication the patient required, they were taught about how to evaluate the treatment effectiveness and report to the pain physician and follow the changes in plan. Unexpectedly but very important as well the fact that the nurses where able aid the residents into correct the doses that may have not been useful to improve other patients therapy (by teaching opioid equivalence and proper calculation of rescue doses)(2)(3) . To suggest the use of co adjugants for neuropathic pain and detect patients that may benefit for Methadone as chronic pain treatment was also part of their training.

During the 5 years that the program ran, not a single opioid or methadone dosing mishap occurred, even though the patients that were treated were complex chronic pain conditions and use moderate to high dose of opioids and combinations with methadone was frequent.

The strength of our program was to promote knowledge with the collaboration of an experience Pain physician, having teaching resources in place and the collaboration of the ward staff promote a growing interest of other services to seek the aid of the ACC program. Our weakness, were the limited resources and personnel, limited interaction with the pharmacy department, lack of infrastructure to treat addiction, reduce operating room time for interventional Pain procedures which limited the number of patients that we were able to accommodate.

We were able to determine that an ACC- Program was useful to promote better pain control on in- ward patients and it translated into adequate discharge of patients with a smooth transition into the chronic pain programs if needed.

Pain management was no longer identified as a barrier to discharge 2-3 months after the initiative started.

References

1. Laura Pokoradi RN, BScN, Leslie Gauthier, RN, BScN, Msc, Transformational Leadership to Improve Chronic Pain Management in Acute Care, Pain Res Manage Vol 17 No 3 May/June 2012, 219 -220

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