Long-Term Care Survey Alert

Pain Management: Rein In Pain Before Surveyors Pull You Up Short

Follow these 5 expert pain med management strategies.

What your attending physicians don't know about adequate pharmacological pain management can hurt your residents -- and your facility's survey record.

Residents with poorly managed pain can land your facility with F309 tags, which will be even more likely to happen once the revised F309 survey guidance for pain management goes into effect.

These five best-practice steps will take your pain management program in the right direction to ensure a high quality of care and pain-free survey.

1. Consider using the World Health Organization (WHO) ladder as a guide for selecting medications to manage pain. The ladder allows the physician to step in at any point and ascend or descend based on the patient's needs, according to **Jeffrey Behrens, MD, FACP, CMD, CHCQM,** in a presentation, "The ABC's of Pain Management," at the March 2006 **American Medical Directors Association** meeting in Dallas.

For example, starting at the first rung of the ladder, level 1 or mild pain (1-3 on a Likert pain scale) includes non-opioids and adjuvants, such as acetaminophen, NSAIDs, tramadol (Ultram) and dexamethasone. The latter is useful for bone pain or blastic disease, bowel obstructions and increased intracranial pressure -- and it's a mood and appetite stimulant, according to Behrens.

For level 2 pain (4-6 on a Likert scale), you move up the ladder to the milder opioids and can add one of those drugs to the level 1 drugs. Level 3 (severe pain or 7-10 on a Likert scale) requires the strong opioids, with morphine being the "gold standard," said Behrens. You can combine a strong opioid with non-opioids and adjuvants.

2. Go with the oral route, which is effective 95 percent of the time, emphasized Behrens. "You can get adequate drug levels [administered orally], especially with sustained release opioid products," he said. For ongoing pain, use an around-the-clock medication and then additional medication for break-through pain.

Don't treat ongoing pain with PRN medication alone. PRN is a "Latin phase for making them get on their knees and beg," Behrens said.

3. If the resident develops tolerance to an opioid, consider rotating various opioid medications. But keep in mind if a pain medication stops working effectively, that usually means the disease is getting worse -- or there's some new reason the person is having pain, Behrens told AMDA conferees.

4. Avoid polypharmacy, which equates to poor pain control, advised Behrens. The goal is to find one drug that provides optimal pain relief with minimal side effects, he said. What you don't want to do is end up with a scenario where a patient is receiving several opioid medications. "If you're doing this, convert it to one drug or at the most two," he said.

Real-world clinical practice: To manage a patient's serious, ongoing pain, **Karl Steinberg, MD, CMD**, tries to order the same drug in long- and short-acting formulations. For example, he might use a routine long-acting morphine and then PRN Roxanol for breakthrough pain, he tells **Eli.** Steinberg doesn't like to prescribe more than two opioid medications for a patient but may add "adjuvant drugs like an antidepressant or Neurontin for neuropathic pain or an anti-inflammatory."

5. Know the limits and dangers of certain opioids. For example, the Fentanyl patch is used a lot and frequently inappropriately, warned Behrens. Use it for steady state pain as it has a slow onset and isn't "good for acute pain," he advised.

Body fat, temperature and hydration affects how long it takes to take effect, which is why you won't want to use it on frail elderly women in nursing homes who lack body fat, said Behrens.

Sidestep this med: Demerol or "Demonol," as Behrens calls it. He notes that orthopedists and surgeons tend to put patients on Demerol and then the geriatricians get called in when the resident develops "acute onset of dementia" which is really delirium. "No one should use Demerol," he emphasized. It's less effective than morphine or oxycodone and produces toxic metabolites that build up in the central nervous system, causing myoclonus and seizures and potentially death, Behrens said.

An alternative: Methadone can be a very cost-effective pain medication if you know the in's and out's of prescribing and monitoring it correctly. For example, a low dose of morphine LA every 12 hours costs over 9 times more than a comparable dose of methadone, according to Behrens' presentation.

Methadone "can be tricky to titrate" and you have to be aware of some drug interactions, adds Steinberg, associate medical director for skilled nursing care at **SHARP Mission Park Medical Group** in Oceanside, CA. "But a lot of elderly patients can take [methadone] doses as low as 5 mg BID and get good pain relief," Steinberg says.

For a closer look at how to use methadone safely to control resident's pain, see the November 2006 Long-Term Care Survey Alert.