

**Managing Individuals With Pain in LTC**

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Effective Care Approaches and the F309 Surveyor Guidance

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**Pain Scenario**

- Patient has Duragesic patch q 72h for pain
- Nursing Assistant tells nurse that resident is "crabby," and would not go for his walk after dinner
- Nurse checked Duragesic patch
- Nurse updated Nurse Practitioner (NP)
- NP ordered patch to be changed q 48 hours instead of previous q 72 h

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## Questions

- What is right or wrong with this scenario?
- What is present and what is missing?

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## Pain Scenario

- Resident requesting PRN analgesic four times in past week between 3:00 PM and 4:00 PM
- Been having more restless nights and using call light quite often between 3:00 AM and 4:00 AM
  - Same complaint: "I just can't get comfortable and I can't relax"
- Receives Oxycontin 20 mg q 12 hours

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## Pain Scenario

- Nurse has tried to schedule the 12 hour doses at different times of the day to see if there is a change in PRN usage or a change in complaints of discomfort but it didn't seem to make a difference.
- Doctor ordered 5 mg oxycodone at 2:00 PM and 2:00 AM.
- Resident allegedly achieved maximum pain control and restful sleep

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## Questions

- What is right or wrong with this scenario?
- What is present and what is missing?

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## Missing Elements

- No evidence of adequate assessment, including physical assessment and symptom details, by nurse or physician
- No apparent attempt to differentiate cause of symptoms
  - No validation that pain was cause of behavior

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## Missing Elements

- Superficial report to nurse
- Lack of any meaningful nurse assessment
  - No important details about the symptom
- Superficial report to practitioner
- Inadequate dialogue between staff and practitioner

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## Missing Elements

- Medication adjustment based on inadequate information and isolated incident
- Missing evidence about rationale and indications for current treatment

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## Missing Elements

- No evidence of nonpharmacological measures tried
- No evidence of alternative medication regimens
- No evidence of effectiveness of current treatment
  - Actually, evidence of ineffectiveness in both cases

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## A Contrasting Perspective

- "Relief for aching backs"
  - Consumer Reports, May, 2009, p. 12-13
- "Be wary of narcotics to treat back pain"
  - Orly Aviztur, Consumer Union Medical Advisor
- CR low-back-pain survey
  - More than 50 percent of those given a prescription drug received an opioid pain reliever
  - Despite little research to support the use of opioids for acute low-back pain

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## A Different Perspective: CR

- Prescriptions of opioids among patients with spinal disorders more than doubled from 1997 to 2004
- Opioids may reduce chronic low-back pain when compared to placebo
  - .But clinical trials have shown about half who take them suffer adverse effects

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## A Different Perspective: CR

- Adverse Effects of Opioids
  - About half of the people who take opiates for pain relief suffer adverse effects
  - Drowsiness, gastrointestinal symptoms such as constipation, reflux, heartburn, cramping, nausea, and vomiting
  - Paradoxical increase in pain sensitivity
  - Reduced testosterone levels

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## A Different Perspective: CR

- Other Issues
  - Substance-use disorders reported to affect about 25 percent of people taking opioids for back pain
    - For example, overuse, getting drugs from more than one doctor, or giving or selling pills to friends
  - Emergency department reports of opioid overdose have risen with the numbers of prescriptions

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## Interpretive Guidelines: F309 Pain

- Care processes for pain management (CMS Training Slide #29)
  - Assessment
  - Address / treat underlying causes
  - Develop and implement approaches
  - Monitor
  - Modify approaches

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## Conditions Associated With Pain

- Degenerative joint disease
- Rheumatoid arthritis
- Crystal-induced arthropathies
- Osteoporosis
  - With or without vertebral body compression fractures
- Neuropathic pain
  - e.g., diabetic neuropathy, postherpetic neuralgia, trigeminal or occipital neuralgia
- Headaches

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## Conditions Associated With Pain

- Oral or dental pathology
- Peripheral vascular disease
- Post-stroke syndromes
- Immobility, contractures
- Pressure ulcers
- Amputations

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## Triggers For Review

- Surveyors to use pain protocol when resident
  - States he/she has pain or discomfort
  - Displays possible indicators of pain, not readily attributed to another cause
  - Has disease or condition for which he/she receives treatments that cause or can reasonably be anticipated to cause pain

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## Triggers For Review

- Surveyors to use pain protocol when resident
  - Has had an assessment that indicates that he/she experiences pain
  - Receives or has orders for treatment for pain
  - Has elected a hospice benefit for pain management

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## Additional Triggers For Review

- If a resident
  - Exhibits signs or symptoms of pain
  - Verbalizes presence of pain
  - Requests interventions for pain
  - Appears to be having pain affect his/her function or ability to participate in routine care or activities

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## Areas For Review

- See if staff have
  - Assessed the situation
  - Identified and implemented interventions to try to prevent or address pain
  - Evaluated status of the resident's pain after interventions

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## Areas For Review

- If care and services are being provided that reasonably could be anticipated to cause pain
  - Have staff identified and addressed these issues, to the extent possible?
- If resident, family, or staff report a resident is experiencing pain
  - How have staff responded?

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## Areas For Review

- Whether staff has implemented any pain management interventions
- Whether pain management interventions have documented rationale
  - Consistent with current standards of practice

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## Areas For Review

- Any deviations from the care plan
  - If so, were they warranted
- Potential adverse consequence(s) associated with treatment for pain (e.g., medications)
- How staff responded, if interventions did not reduce the pain consistent with goals for pain management

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## Areas For Review

- Review documentation and other information regarding pain
  - For example, orders, medication administration records, multidisciplinary progress notes, the RAI/MDS, and elsewhere,

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## Areas For Review

- Does this information, in the aggregate, identify
  - Pain indicators and related characteristics, causes, and contributing factors
  - History of pain and related interventions, including effectiveness and any adverse consequences of such interventions

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## Areas For Review

- Does this information, in the aggregate, identify
  - Impact of pain on a resident's function and quality of life
  - Identify resident's response to interventions
    - Including efficacy and adverse consequences and any modification of interventions as indicated

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## Care Plan Review

- Does care plan, in the aggregate, offer
  - Measurable pain management goals, reflecting resident needs and preferences
  - Pertinent non-pharmacological and/or pharmacological interventions
  - Time frames and approaches for monitoring the status of the resident's pain, including the effectiveness of the interventions

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## Care Plan Review

- Does care plan, in the aggregate, offer
  - Identification of clinically significant medication-related adverse consequences such as falling, constipation, anorexia, or drowsiness, and a plan to try to minimize those adverse consequences

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## Areas For Review

- Interview a nurse who is knowledgeable about a resident's needs and care
- How and when staff try to identify whether a resident is experiencing pain and/or circumstances in which pain can be anticipated
- How the resident is assessed for pain

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## Areas For Review

- How interventions for pain management have been developed and their basis
- How staff monitor for the emergence or presence of adverse consequences of interventions
- If resident receives routine pain medication, how, when, and by whom are results of medications are evaluated

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## Other Review

- What is done if pain persists or recurs despite treatment?
  - What is basis for decisions to maintain or modify approaches?
- How staff communicate with practitioner about a resident's pain status, current measures to manage pain, and possible need to modify current interventions

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## What Is Not Being Reviewed

- Surveyor guidance does not advise surveyors to evaluate whether facility chose the right treatment
- Surveyors are guided to consider whether facility could demonstrate how they did the right thing, based on
  - Resident assessment
  - Clinical standards of practice

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## Case Discussions

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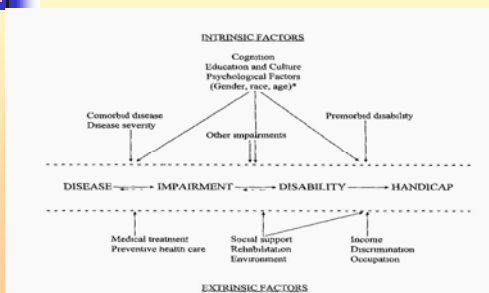
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## Causes and Consequences



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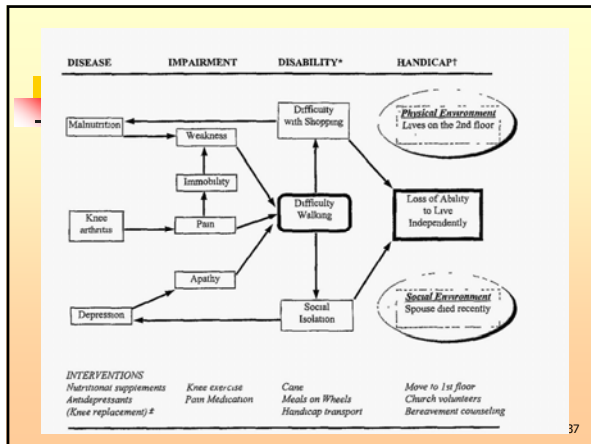
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## Implications

- All organ systems interact
- Disease may or may not → impairment
- Many factors influence whether disease will → impairment; for example
  - Acute and chronic illness
  - Psychosocial factors
  - Pre-existing disability
  - Other impairments

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## Implications

- Impairments often have multiple simultaneous causes
- Impairments often combine to cause disability
- Impairment may be prevented or improved by
  - Treating or preventing underlying disease
- Disability may be prevented or improved by
  - Treating underlying disease
  - Addressing underlying impairments

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## Steps to Impairment Assessment

- Four essential steps
  - 1) Characterize the disabilities
  - 2) Identify causal impairments
  - 3) Determine specific diseases underlying identified causal impairments
  - 4) Discover any contributing factors
    - Hoenig H, Nusbaum N, Brummel-Smith K. Geriatric rehabilitation: State of the Art. J Am Geriatr Soc 45:1371-1381, 1997

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## Implications

- What are the implications of the preceding for assessing and managing the individual with pain?

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## Physiology and Function: Summary

- All parts of the body work together
- All human beings have 3 key domains
  - Physical
  - Functional
  - Psychosocial

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## Physiology and Function: Summary

- Human biology = coordinated function of all organ systems
- Biological activity is essential for personal and psychosocial function

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## Causes and Consequences

Consequences →	One	Multiple
Causes		
One	+ / +	+ / +++++
Multiple	++++ / +	++++ / +++++

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## Causes and Consequences (1:1)

- One cause → One consequence (1:1)
  - No other factors involved
  - Usually occurs in otherwise healthy people or those with minor chronic conditions
- Example: Fall → fracture → impaired mobility until fracture heals
  - When fracture heals, baseline function is restored fully

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## Causes and Consequences (1:Multiple)

- One cause → multiple consequences
  - A single illness or risk factor
  - Multiple consequences (i.e., risks / complications / impairments)
  - May or may not have significant pre-existing impairments
- Treatment of causes often complicated

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## Causes and Consequences (1:Multiple)

- Example
  - Major stroke in previously well individual → impaired mobility, self-care deficit, pain, altered nutritional status, altered mood
  - Myocardial infarction with cardiac arrest → impaired cognition, chronic renal failure, angina, activity intolerance
  - COPD (advanced) → activity intolerance, altered breathing patterns, impaired gas exchange, self-care deficit
- New and old impairments may interact to increase risk for additional impairments

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## Causes and Consequences (1:Multiple)

- Consequences may resolve only partially despite treatment
- Often challenging to identify whether a new symptom or complication is due to the underlying cause, an existing complication, a new cause or complication, or a combination

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## Causes and Consequences (Multiple:1)

- Multiple causes → one impairment
  - A single illness or risk factor
  - Multiple complications
  - Often made worse by pre-existing impairments

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## Causes and Consequences (Multiple:1)

- Example
  - Hydration risk due to
    - CVA and dementia (neurological), chronic renal failure (urinary), colitis r/t antibiotic use (gastrointestinal)
  - Pain due to
    - Parkinson's Disease (neurological), osteoarthritis (musculoskeletal), side effects of medications used to treat hypertension
- Treatment of causes not straightforward
- Impairments may resolve only partially despite treatment

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## Causes and Consequences (Multiple:Multiple)

- Multiple causes → Multiple impairments
  - Several acute and/or chronic conditions + risk factors
  - Multiple complications
  - Often made worse by pre-existing impairments
- Very common in the nursing home population
  - Both short-stay and long-term

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## Causes and Consequences (Multiple:Multiple)

- Example
  - [New stroke + diabetes + ischemic cardiovascular disease + previous neurological disease + chronic renal failure] → [impaired mobility + pain + altered nutritional status + impaired fluid balance + pain + risk of altered skin integrity]

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## Causes and Consequences (Multiple:Multiple)

- Treatment of multiple causes is complex
  - Impairments may come and go despite efforts to treat underlying causes
- Very challenging to diagnose and treat
  - What caused what, and in what order?
  - What is treatable?
  - What will treatment do, given the overall picture?

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## Causes and Consequences

- For any of the 4 key circumstances
  - 1:1
  - 1:Multiple
  - Multiple:1
  - Multiple:Multiple
- Decisions to intervene must be made in the context of the whole situation
  - *Not just in context of a single symptom or risk factor*

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## Causes and Consequences

- For any circumstances, critical to identify
  - Sequence of events
  - Links between causes, and between causes and consequences (i.e., risks / complications / impairments)
  - Whether treating causes will have meaningful impact on consequences
  - Treatment priorities
  - Need to try to balance managing certain consequences without causing or exacerbating others

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## Implications of Biology For Care

- The care must reflect biological reality
  - As must any attempts to assess quality
- Outcomes (impairments, disabilities) are affected by the same reality

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## Sound and Unsound Care

- *Biologically compatible*
  - Care of patient with [Condition A + Condition B + Condition C + Condition D + Condition E]

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- *Biologically incompatible*
  - [Care of Condition A] + [Care of Condition B] + [Care of Condition C] + [Care of Condition D] + [Care of Condition E]

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## Identifying Pain or Pain Risk

- Impairment or disability identified as related to pain
- Patient reports pain
- Someone observes apparent pain
- History of pain
- Predisposing conditions
- Taking analgesics

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## Asking About Pain

- What questions should I ask?
  - Onset, characteristics, location (including radiation), duration, intensity, frequency, relieving and exacerbating factors
- How do I ask the questions?
  - Same as for any other symptom

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## QIS Critical Elements Pathway

- Surveyors instructed to ask
  - Do you have pain?
  - How long have you had pain?
  - How often do you have pain?
  - What factors or situations cause or aggravate pain?
  - Who have you told about having pain?

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## QIS Critical Elements Pathway

- Surveyors instructed to ask
  - What has been tried to relieve pain?
    - Including nonpharmacological approaches
  - What has been effective, and to what degree?
    - How long does the relief last?
  - Have you been involved in planning approaches to managing your pain?

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## Pain Assessment Tools

- What do I need to assess about pain?
- Do I have to use a pain tool?

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## General Assessment of Someone With Pain

- How do I assess someone for pain?
  - Inspection (look)
  - Palpation (touch)
  - Percussion (tap)
  - Auscultation (listen)
- Perform basic neurological evaluation
  - Sensory, motor, pain, position sense, touch

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## General Assessment of Someone With Pain

- Take vital signs
- Note progress of ongoing medical conditions
  - Identify painful conditions
  - Note conditions that can have remote effects

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## Medications Associated With Pain

- Calcium channel blockers
  - Nifedipine, others
- Statins (lipid lowering medications)
- Anti-Parkinson medications
  - Eldepryl, pergolide
- Osteoporosis medications
  - Alendronate, teriparatide

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## Medications Associated With Pain

- Alzheimer's medications
  - Aricept, Exelon, reminyl
- ACE inhibitors / Angiotensin receptor blockers
- Rheumatoid arthritis medications
  - Etanercept, Enbrel, infliximab, leflunomide, remicade
- Seizure medications
  - Keppra

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## Questions

- What good is it to fill out assessment forms but
  - Not get enough symptom detail
  - Not know what to do with the information on it?
- What good is it to keep asking someone about pain repeatedly but not include relevant details?

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## More Case Discussions

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## Specific Situations: Headache

- Symptom details essential
- Tap over the sinuses
- Press over the temples
- Palpate scalp
- Feel the area of the temporal arteries

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## Specific Situations: Neck pain

- Symptom details essential
- History
  - Location, radiation, frequency, intensity, nature, all help distinguish causes

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## Specific Situations: Neck pain

- Causes
  - Neck sprain
  - Muscle strain
  - Infection or inflammation
  - Osteoarthritis
  - Nerve root impingement

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## Specific Situations: Neck pain

- Move shoulders and neck through range of motion
- Palpate neck
- Check hands, fingers for neurological function

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## Specific Situations: Abdominal pain

- Symptom details essential
- Palpation to help specify location
  - Relates to underlying organs
  - Liver, gastritis, peptic ulcer, gallbladder disease, intestinal ischemia, partial intestinal obstruction, inflammatory bowel disease, abdominal malignancy

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## Specific Situations: Abdominal pain

- Listen to bowel sounds: who cares how many quadrants?
- Voluntary vs. involuntary guarding
- Rectal exam

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## Specific Situations: Face and eye pain

- Symptom details essential
- Inspect and palpate face
- Percuss sinuses
- Shine a light in the eye

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## Specific Situations: Face and eye pain

- Palpate globe with eyes closed
- Look at conjunctivae
- Look at pupils
- Palpate orbital area
- Press and tap on sinuses

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## Specific Situations: Mouth, throat pain

- Symptom details essential
- Examine teeth, gums, palate, tongue, oral mucosa
- Look under the tongue
- Look for ulcers, inflammation, candida
- Odor of breath

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## Specific Situations: Painful swallowing

- Symptom details essential
- Reflux
- Throat infection
- Review medications

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## Specific Situations: Arms and shoulders

- Symptom details essential
- Inspect, palpate, move through range of motion
- Bursitis, tendinitis, arthritis
- Edema
- Red, tender, swollen, hot

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## Specific Situations: Hand, Wrist, and Fingers

- Symptom details essential
- Palpate hand and wrist
- Have patient move thumbs while holding rest of fingers still
- Thumb to fingers

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## Specific Situations: Hand, Wrist, and Fingers

- Look at joints and compare on both hands
- Note all swollen or tender joints, and location
- Note redness, warmth, tenderness, swelling, deformity
- Tap over median nerve
- Have patient flex and extend wrist and thumbs

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## Specific Situations: Chest Pain

- Symptom details essential
- Observe patient for splinting, respirations
- Palpate for local pain
- Location very important
  - Differentiate thorax, musculoskeletal

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## Specific Situations: Back Pain

- Symptom details essential
  - For example, costovertebral pain and fever
- Inspect, palpate, percuss
- Move through range of motion
- Tightness, swelling, asymmetry, localized tenderness
- Pelvis
- Radiation: legs, thighs

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## Specific Situations: Pelvic Pain

- Symptom details essential
  - Pain before, after, during urination?
- Inspect external genitalia
- Men: scrotum, penis, testicles

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## Specific Situations: Perineal / Rectal Pain

- Symptom details essential
  - Pain before, after, during bowel movement?
- Inspect
- Look for skin rash or breakdown, swelling, inflammation
- Rectal exam

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## Specific Situations: Leg / Thigh Pain

- Symptom details essential
- Palpate
- Pinpoint location
- Check pulses
- Note relation to activity
- Neurological
- Pattern of radiation
- "Restless legs"?

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## Specific Situations: Foot Pain

- Symptom details essential
- Inspect, palpate, percuss
- Move foot through range of motion
- Check pulses

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## Specific Situations: "Hurting All Over"

- Symptom details essential
- Diffuse musculoskeletal pain, tenderness at pressure points, stiffness
- Often accompanying mood and anxiety disturbances
- Fibromyalgia

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## Review of Steps

- Talk to the patient, to the extent possible
- Supplement information from the patient, with detailed assessment
  - Inspection
  - Palpation
  - Percussion
  - Auscultation
- Validate the information

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## Review of Steps

- Review relevant past and current information
- Define the issue
  - A statement of the pain problem
  - Clarification of likely or known causes

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## Steps

- Select intervention(s)
  - Based on location, nature, severity, likely cause(s), and other related conditions and issues
  - Review past and current interventions, relative to comparable situation
  - Consider whether side effects matter
  - Consider existing regimen
  - Try nonpharmacological measures

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## Avoid diagnostic fallacies

- If you don't know what you're doing, don't do it!
- Limited efficacy of all interventions

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## Treatment Principles

- First of all, don't do harm while trying to do good
- Give treatment in context
  - Tailor to the patient and detailed pain characteristics (location, intensity, etc.)
- Never assume treatment can only do good
  - Elderly more likely to have treatment-related complications

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## Pain Medications: Guiding Principles

- Perform careful assessment and diagnosis
  - So treatment can be targeted
- Analgesic medications: common for pain management
  - They are often helpful, but—in the aggregate—not all that great
- Analgesics may sometimes be more effective when combined with complementary treatments

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## Pain Medications: Guiding Principles

- Analgesic medications: common for pain management
  - They are often helpful, but—in the aggregate—not all that great
- Analgesics may sometimes be more effective when combined with complementary treatments
- Goals of treatment
  - For example, decrease pain and improve functioning, mood, and sleep

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## Pain Medications: Guiding Principles

- Based on assessment and diagnosis
  - Chronic pain: start with low dose and systematically increase until highest tolerable dose reached
  - Acute pain: start with moderate dose and titrate accordingly
- PRN OK under many circumstances
- Use regular *not* PRN (as needed) administration if
  - Frequent patient PRN use for relief
  - Pain persists with PRN approach
  - AND reconsideration of whether on right track
- Reassess and adjust dose frequently
  - Adjust dosage to meet pain goals, limited by side effects or potential toxicity

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## Pain Medications: Baseline

- Acetaminophen: 1<sup>st</sup> choice in those without significant liver disease or ETOH intake
  - Example: 500 or 650 mg. q4h 8AM-8PM and q4h PRN 12MN-8AM
- Topical agents: possible additional relief for those with musculoskeletal, neuropathic pain
- Neuropathic pain: anticonvulsants (neurontin) or tricyclic antidepressant may help
  - Keep in mind risks of tricyclics in many elderly

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## Pain Medications: Alternative

- Alternatively, or if acetaminophen fails to provide relief, consider nonsteroidal anti-inflammatory drugs (NSAIDs)
  - Risk in frail elderly: GI bleeding and renal impairment
  - NSAIDs have "ceiling effect": point after which increasing dose offers no additional pain relief and may produce added side effects
  - Chronic use of indomethacin, piroxicam, tolmetin, and meclofenamate *not recommended*
  - Frequency of more serious side effects

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## Pain Medications: Alternative Continued

- Cyclooxygenase-2 (cox-2) inhibitors may still be useful
  - Current examples: Vioxx, Celebrex
- Tramadol: a centrally acting analgesic
  - May be next agent added to acetaminophen or NSAIDs

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## Pain Medications: Combinations

- Combining smaller doses of drugs from different classes
  - If maximizing acetaminophen dosage fails to achieve pain relief
  - May reduce risk of side effects associated with higher doses of a single medication
- Close monitoring important when multiple medications prescribed

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## Topical Analgesics

- Counterirritants (e.g., menthol, methylsalicylate, trolamine salicylate)
  - Supplied as liniments, creams, ointments, sprays, gels, or lotions
- May be effective for arthritic pain, but effectiveness is limited when pain affects multiple joints
- Can cause skin injury, especially when used with heat or with an occlusive dressing

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## Musculoskeletal or Osteoarthritic Pain

- Appropriate complementary treatment
- Topical analgesics
- Acetaminophen
- NSAIDs (primarily short-term, low-dose use)
- Tramadol (as substitute for opioids)
- Opioids

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## Treatments for Neuropathic Pain

- Confirm that it truly is neuropathic
  - Don't just assume
  - Someone needs to do neurological exam
- If related to diabetes, establish control of blood glucose levels
- Nonpharmacological interventions
- Topical analgesics

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## Treatments for Neuropathic Pain

- Acetaminophen
- NSAIDs
- Tramadol (if patient or advocate wishes to avoid opioids)
- Anticonvulsant or antidepressant
- Opioids

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## Opioid Analgesics

- Before using opioids long-term, address other conditions, diagnoses contributing to patient's pain
- May interact adversely with many other medications
- Reducing or eliminating other medications may minimize these adverse effects

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## Opioid Options

- Codeine, oxycodone, hydrocodone, morphine, and fentanyl, commonly used opioids
- When starting patient on opioids, begin with immediate-release preparation
  - As indicated, after establishing amount needed daily to control pain, convert daily dose to sustained-release preparation given routinely every 12 hours
- May still need doses of immediate-release drug for "breakthrough" pain
  - About 10% of daily dose every 1 to 10 hours PRN for breakthrough pain

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## Opioid Options

- Transdermal patch another option for patients requiring around-the-clock pain control for moderate to severe pain
  - Use with *extreme caution*
  - Dangers of indiscriminate use
  - FDA warnings
- Use bowel regimens to avoid constipation
  - Be aware of many other side effects

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## Propoxyphene

- Propoxyphene not recommended to treat chronic pain
  - Efficacy no better than acetaminophen
  - Undesirable central nervous system side effects
- May be OK to continue patients on propoxyphene if taking the drug for a long time have difficulty obtaining same degree of pain relief with other medications

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## Other Undesirable Options

- Meperidine not appropriate for chronic pain management
- Pentazocine, butorphanol, and other agonist-antagonist combinations also not recommended

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## Science and Politics

- Any medication—whether politically palatable or not—has potential to do harm
  - Do not dismiss this possibility just because the “conventional wisdom” tells you it is OK

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## Other Classes of Drugs Used to Manage Pain

- Several non-opioid drugs not classified as analgesics may be helpful in managing chronic neuropathic pain
  - Anticonvulsants (especially, gabapentin)
  - Tricyclic antidepressants
- Often most effective when used for baseline pain management, supplemented by analgesics for breakthrough pain

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## Complementary Therapies

- Physical and behavioral treatments may improve overall pain management
  - Alone or in combination with appropriate drug regimens
- Few complementary therapies shown more beneficial than placebos
  - May enhance therapeutic effect of medication, allowing smaller doses to be given

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## Complementary Therapies

- Evidence of effectiveness exists for:
  - Patient education programs
  - Cognitive/behavioral therapy
  - Physical exercise
- Few adverse effects but may be costly

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## Factors in Selecting Complementary Therapy

- Patient's underlying diagnosis and co-existing conditions
- Effectiveness of current treatment
- Patient or advocate preferences
- Advance directives

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## Factors in Selecting Complementary Therapy

- Past patient experience with therapy
- Availability of skilled, experienced providers
- Decisions about continuation of a specific treatment should be based on a review of how well it has achieved the stated goals

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## Adjusting Treatment

- How do I know what to do with the treatment?
- Must look at whole picture, not just 1 or 2 pieces, such as severity or prognosis (e.g., terminal condition)
- If a certain amount of analgesic has not somewhat relieved symptoms, then more of it may not be better
  - Twice as much of an unsuccessful intervention will not be twice as effective

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## If Partial Relief

- Like insulin, focus on overall use of PRNs and duration and degree of results
- Adjust standing dose or frequency or dose of PRNs

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## Monitoring

- Essential questions
- How is the pain, compared to xxx?
- Severity, location, radiation, relieving and exacerbating factors, nature

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## Monitoring

- Can we adjust the interventions?
- What is the result of adjustments?
  - Get details of current symptoms
  - Assess progress of managing causes
  - Look at multiple parameters related to pain and its consequences

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## Progress Assessment

- Some basic examples, rarely found in documentation or reporting
  - Less intense
  - Less radiating
  - Does not last as long
  - Longer duration of relief with intervention
  - Lesser dose of medication needed to obtain comparable relief

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## Progress Assessment

- Some basic examples
  - Less frequent use of interim PRN medication
  - Lower standing dose with comparable interval relief
  - Relief obtained with nonpharmacological measures
  - Improved function / improved sleep
  - Able to focus more on things other than pain

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## When to Reconsider

- If patient does not seem to get relief but keeps asking for more medication
- When relief is not roughly proportionate to increased dose or frequency
- When pain has diminished or stopped
- When cause(s) of pain are corrected
- When adverse consequences are identified or suspected

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## What to Reconsider

- Whether the problem is defined properly
- Whether underlying diagnosis(es) is (are) accurate and complete
- Whether the intervention is appropriate
- Whether we need
  - More, less, or same amount of intervention
  - A completely different intervention
  - Additional intervention(s)

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