PAIN MANAGEMENT

The hospital respects the patient's right to effective pain management. It is a multidisciplinary process working toward the improvement of patient outcomes, increased comfort and mobility, reduced side effects, and enhanced patient satisfaction.

- Collaboration between providers in the inpatient and outpatient setting is crucial in maintaining consistency of pain control and achieving the individualized pain goals
- For patients on chronic pain medication therapy who experience acute pain episodes, equianalgesic dosing is essential. Continue home medications if appropriate based on patient presentation when possible and combine medications with different mechanisms of action, such as NSAIDS with opioids, and non-pharmacologic therapies
- Consider scheduling non-opioid medications for acute pain
- The clinical pharmacists for medication management as well as the anesthesiologists for interventional measures are available on consultation
- Drug and alcohol educators are available to evaluate patients and discuss substance abuse programs
- The nurses must medicate with prn pain medication exactly how the order is written. If not, the nurse is acting out of his/her scope of practice per the Joint Commission. Please have qualifier attached to all prn pain medication orders to avoid duplication of indications. New comment section attached to moderate and severe pain orders (12/2024) that the nurse may medicate with a lesser pain medication if requested by the patient and ordered
- CDC Clinical Practice Guideline for Prescribing Opioids for Pain -United States, 2022
    - Opioids are not first-line routine therapy for chronic pain
    - Establish and measure goals for pain and function
    - Maximize non-opioid therapies
    - Use immediate-release opioids when starting. Start low and go slow
    - Only prescribe opioids needed for the expected duration of pain
    - Follow-up and re-evaluate risk of harm and improvement of function; reduce dose or taper and discontinue if needed
    - Check PDMP for high dosages and prescriptions from other providers
    - Use urine drug testing to identify prescribe substances and undisclosed use
    - Avoid concurrent benzodiazepine and opioid prescribing
    - Arrange treatment for opioid use disorder if needed

Considerations in Elderly Patients

- Non-steroidal anti-inflammatory drugs (NSAIDS)
    - Monitor for increased risk of GI bleeding, especially in combination with corticosteroids, anticoagulants, or antiplatelet agents
- Muscle relaxants
    - Increased side effects due to anticholinergic effects
    - Consider tizanidine or baclofen, but monitor for sedation
- Opioids
    - Lower initial doses suggested, titrate to relief

Drug Interactions to Consider

Interactions	Risks
Opioids + benzodiazepines	Overdose, Respiratory depression, Death
Opioids + gabapentin/pregabalin	Severe sedation, Respiratory depression, Death
Any combination (3+) of: Antiepileptics, Antidepressants, Antipsychotics, Benzodiazepines, Non-benzodiazepine hypnotics, Opioids, Skeletal muscle relaxants	Falls Fractures Severe sedation
Methadone + other QTc prolonging drugs	Arrythmia
Tramadol/Tapentadol + Serotonerigic Agents	Serotonin Syndrome

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Agents for Opioid Use Disorder

- Buprenorphine available in different formulations
  - For pain (dosed in mcg)
  - For substance abuse (dosed in mg)
- Methadone
  - For pain: Found in PDMP
  - For substance abuse: Not found in PDMP, confirm dose with facility
- Naltrexone: Full blockage of opioid receptors
  - Length of time receptors are blocked depends on last dose and route of administration

For all agents:

- Confirm outpatient dosage
- Confirm last dose before ordering