The Hardware of a Functional Acute Pain Service

In the workshop I will highlight a number of important factors that I have learned in establishing or directing several successful pain programs; one at the University of California at Los Angeles and the other at Seattle Children’s Hospital. Although, both programs were physician directed, many of the factors impacting the successes and failures of each can be generalized to other models of practice such as a nurse run pain service.

Problems Facing Pain Services

Despite the advancements made in the last decade in the understanding of the psychological and physiological problems associated with acute and chronic pediatric pain and in the technological and clinical arenas, significant challenges in pediatric pain management still remain. Pain services face issues of poor staffing with the dearth of well-trained pain specialists, inadequately trained nursing staff, and a shortage of psychologists trained in pain. Compound this with the problem of declining reimbursement and worries about safety and patient satisfaction in an atmosphere of increasing regulatory scrutiny, one can see why pain services are under even more pressure than ever. Lack of efficiency and standardization often stems from breakdowns in workflow and leads to poor customer satisfaction.

Solving the Problems

Develop a Plan

Running a pain service is very similar to operating a business, a compassionate, people oriented business, but nonetheless a business. Assuming a champion or leader has been identified to lead the pain team (this can be a physician, nurse or other healthcare professional) one of the first steps is to develop a business plan. Your goals (immediate and future), available resources and challenges should guide the development of the plan. A needs assessment will determine what goals are to be targeted. Making pain a quality assurance or quality improvement goal, will add credibility to your efforts. Enlisting the help of a business consultant will make this task less painful. Next, determine the order in which the goals are to be accomplished. Set a timetable for their completion. Again, what resources are available to achieve the goals will play a major role in how this is achieved. Include time, space, money, education and personnel. Ultimately this will have a great impact on your success. Optimize early successes by capturing the “low hanging fruit”. An example of this would be if there are a great
number of patients in your hospital population that needed sedation for procedures, and this was not being provided for by another service, then incorporating sedations into your pain service could be financially rewarding for the department. Performing sedations under the auspices of the anesthesiology department has a good reimbursement rate for the time being.

**Organization and Staffing**

There are a number of models in the literature depicting how a pain service could be organized. Several of the models have a physician as the lead, whereas other schemes have a nurse as a point person. Your choice of structures will be determined by availability, commitment and the experience of your staff. Whichever model one chooses, a multidisciplinary team should be identified from available personnel within the institution. Minimally the team should include an anesthesiologist, a nurse advocate, child life personnel, a pediatric psychologist and a physical therapist. These people will act as resources in more difficult cases and as sources of new ideas. Pastoral care, occupational therapy and palliative care can be added as the team grows. At least three faculty members should be available to share call, unless the hospital is very small and you are very energetic. Four faculty members are ideal so that each could cover a week of call per month. If you utilizing epidurals, 24 hour, in-house coverage of the patients is highly suggested. This provides a responsive, very visible, component to your service. Major and minor problems can be addressed immediately. New collaborators and advocates can be gained with the visibility of such a supportive service. The in-house call person can be a resident, fellow, or nurse, depending on the availability of personnel and their level of training. A nurse with the proper credentials can handle many problems with telephone backup. In addition, most institutions have an anesthesiologist available at all times who could serve as an immediate resource.

A specific pager or phone for the pediatric pain service should be made available. A monthly call schedule listing the daily call team and home numbers should be sent to the page operator and to all of the pediatric unit secretaries. Online availability of this information can decrease confusion and promote fast service.

**Administrative Work**

Once a need has been identified and a special interest group for pain i.e., the pain team, has been formed, policies for procedures, credentialing, monitoring, and documentation should be established. This is an area where nursing, psychology and pharmacy must be consulted. All too often the nursing staff is overburdened with busy work dictated by state and national requirements for documentation. These valuable people are taken away from their most important function, patient care. Remember one gains political capital and minimizes the risk of offending the nursing staff by involving them in policy development from the beginning. All procedures, such as setting up a PCA pump, should have a detailed protocol readily available for review. Competence in these procedures needs to be demonstrated and documented regularly.

**Education**

The importance of good pain control may not be obvious to many of your coworkers. An intensive educational program focusing on pain assessment, non-invasive,
and invasive pain management strategies will help to solidify the need for a pediatric pain
service. Lectures to the house staff, potentially high end users from other departments,
and to the nurses will be of great benefit. A variety of pediatric pain experts are available
to speak at your institution. They can also act as consultants. The pediatric pain
community is small and very friendly so take advantage of the resource. Good, reliable
easy to use pain assessment scales should accompany each child’s vital sign sheet. The
pain score is an important vital sign that should be taken with the other vital signs.

Customer Satisfaction

The customers you service include the patients and your physician referral base. Partner
with a surgeon or pediatrician who can provide an opportunity to demonstrate how much more
effective and efficiently pain management can be delivered by a committed pain team. A surgeon champion that can be convinced of the great benefits good pain control can bestow will be an excellent partner. Minimizing evening calls from patients and nursing staff is an important means of achieving this goal. One of the best ways to do this is to take care of the patient’s pain early, provide reliable avenues of communication for the patient and nurses and to have a well delineated set of options in case of problems.

Services

Choose early what services need to be provided at your institution. Start with the least invasive things like PCAs and behavioral therapy. As the service becomes more established, epidural infusions and peripheral nerve blocks can be added to the offerings. Performing single shot caudal anesthesia on a regular basis can prepare the nurses and house staff for continuous epidurals.

Billing

The patients should be billed for services provided. The billing codes can be found in the CPT code book. Initial consults, follow-up visits, all procedures and telephone consultations can be billed. One needs to establish a reasonable rate of reimbursement for each code. Establish a good rapport with your departmental biller, the departmental representative to the hospital reimbursement committee, and the medical directors of the top three insurance agencies used by your patients. National and regional pain coding courses are available regularly.

Alliances

The hospital administration will need to be more than just involved; the administration must be committed to good pain control. Approaching the administration with a solid plan will improve the chances of your success. This will also be useful in finding funding and for marketing the pain service. The hospital wins because it can show how it takes better care of its most vulnerable patients.

Maintenance of a Pain Service

A periodic review of policies and procedures is necessary. Eliminate useless guidelines and things you do not do. In addition, regular quality assurance meetings to
review any cases where untoward events have occurred need to be undertaken. This will help in the establishment of, “best practice”, therapies at your institution.

A good relational pain database can help to track events and improve patient care. Patient surveys and periodic in-services will minimized misconceptions and reaffirm the commitment of the pain team. Listen carefully to patients, parents, nurses and the primary consulting service since they are all your customers. Communication and managing expectations are the key to success.

Please contact me if you would like any of our protocols or policies
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Resources:

Child Health Corporation of America
6803 West 64th St.
Shawnee Mission, KS 66202
(913) 262-1436
(913) 262-1575 Fax
info@chca.com

American Academy of Pediatrics
http://www.aap.org/

Joint Commission on Accreditation of Healthcare Organizations

World Health Organization

Agency for Health Care Policy and Research

Federal Drug Administration

American Pain Society

American Academy of Pain Medicine

American Society of Addiction Medicine
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Goals and Objectives (at least 3)

Upon completion of this lecture, the attendee will be able to be familiar with the steps needed to institute and maintain a pediatric acute pain service. Major components to consider when starting a pediatric acute pain service include:

1. Identifying if there is a need for a pediatric acute pain service.
2. Ensuring appropriate hospital and departmental financial support and backing for the proposed medical consult service.
3. Ensuring appropriate manpower/scheduling to cover the pain service.
   a. Anesthesiologists
   b. Nurse practitioners
   c. 24/7 coverage
   d. Educational program for trainees
4. Ensuring that the program is a collaborative effort by multiple services.
   a. Anesthesiologist
   b. Nursing leadership
   c. Surgeons
   d. Critical care physicians
   e. Psychologists
   f. Pharmacists
   g. Physical therapists
5. Ensuring that all pain medicine order sets have conservative safety measures built into them.
   a. Monitoring orders
   b. Management of analgesic side effects
   c. Trouble shooting orders
   d. Level of nursing care by ward taken into account
   e. Identifying patients at risk (neonates, premature)
6. Academic vs. private practice group models.
   a. NP driven vs. MD driven
   b. Teaching of trainees
   c. Billing issues
7. Which patients to initially focus on.
   a. Post operative
   b. Critical care- difficult to sedate, opioid tapering
   c. Heme One- sickle cell disease
   d. Bone marrow transplant- mucositis
   e. GI- abdominal pain, pancreatitis
   f. Neurology- headache
   g. Chronic pain- CRPS
   h. Out of the OR sedation
8. Common post op pain issues
   a. PCA management, trouble shooting
   b. Epidural management, optimization, trouble shooting
   c. Peripheral nerve block catheters
   d. Transitioning to PO pain medications
   e. Safety management and monitoring
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Disclosures
Renee Manworren has no financial interests in products to be discussed directly or indirectly during the presentation. She has not been an employee of a company with such financial interests. She has not had industry research support in the past year to study any products to be discussed during this presentation.
Renee Manworren is on the board of directors for the American Pain Society and Master Faculty for the American Society for Pain Management Nursing

Session Objectives:

1. Identify if there is a need for a pediatric acute pain service at the institution

2. Ensure the appropriate hospital and departmental support for the proposed medical consult service

3. Ensure the appropriate pain nurse practitioners are able to provide the daily evaluation and treatment of patients and provide nursing education to the floor/PACU nurses.

4. Ensure that all pain medicine order sets have built in/idiot proof safety mechanisms that are individualized to each institution.

5. Ensure that the pain staff MDs have appropriate pediatric pain/regional anesthesia experience.
3. Ensure the appropriate pain nurse practitioners are able to provide the daily evaluation and treatment of patients and provide nursing education to the floor/PACU nurses.

Responsibility of registered nurses to assess, plan, intervene, evaluate.

This includes contacting prescribers to make recommendations.

- Registered Nurses can perform complete histories and physicals
- Registered Nurses make nursing diagnosis:
  - Pain: Acute,
  - Pain: Chronic,
  - Pain: Procedural
- Pain Management Board Certification: ANCC
- Registered Nurses cannot bill for services

**Advanced Practice Nurses:**

- Registered Nurses
- Advanced degrees
  - Post-diploma certification
  - Master’s degree
  - Doctorate of Nursing Practice
- Board Certification
- Titles
  - Clinical Nurse Specialists
  - Nurse Practitioners
    - Pediatric Nurse Practitioners: Primary Care
    - Pediatric Nurse Practitioners: Acute Care
    - Family Nurse Practitioners
    - ???
  - Nurse Anesthetists
  - Nurse Midwives
- Responsibility of Registered Nurses to assess, plan, intervene, evaluate.
- Perform complete histories and physicals
  - Advanced skills
  - Order diagnostic tests
- Medical and Nursing diagnosis
Advanced Practice Nurses (cont.)

• Bill for services, but reimbursement typically 85% of physician fee
• Prescriptive Authority – defined by State
  – Physician collaborative agreement
    • Number
    • Proximity
    • Defined roles
  – Controlled substances
• Institutional Policies??

1. Identify if there is a need for a pediatric acute pain service at the institution

DRAFT RECOMMENDATIONS:

“The panel recommends facilities in which surgery is performed...

• have an organizational structure in place to develop and refine policies and processes for safe and effective delivery of postoperative pain control.”

• provide clinicians with access to consultation with a pain specialist for patients with inadequately controlled postoperative pain or at high risk of inadequately controlled postoperative pain (e.g., opioid tolerant, history of substance abuse).

• “The panel recommends that facilities in which neuraxial analgesia and continuous peripheral blocks are performed have policies and procedures to support their safe delivery and trained individuals to manage these procedures.”

3. Ensure the appropriate pain nurse …elements of JOB Description

• Provide education to physicians, nurses, pharmacists and other clinicians
• Collaborate with members of the health care team and participate in the discussion of pain management issues
• Monitor all patients utilizing pain management technologies
• Monitor clinical practices and clinical outcomes related to pain management
• Discuss pain assessment strategies, analgesics, and the use of pharmacologic and non-pharmacologic adjuvants
• Evaluate the effectiveness of the pain relief plan of care and facilitate revision of the plan as necessary
• Facilitate the continuity of pain management services across the continuum of care
• Monitor the use of analgesia technologies in collaboration with the primary service and anesthesiologists
• Recommend that appropriate referrals are made to the inpatient psychiatry service and massage therapists
• Facilitate continuity of pain management services with the inpatient psychiatry service
• Serve as a clinical resource to all departments
• Develop, present and evaluate educational programs and information to meet identified educational needs of patients, families and staff
• Monitor the use of analgesia technologies in collaboration with the primary service and anesthesiologists
• Recommend that appropriate referrals are made to the inpatient psychiatry service and massage therapists
• Facilitate continuity of pain management services with the inpatient psychiatry service
• Serve as a clinical resource to all departments
• Develop, present and evaluate educational programs and information to meet identified educational needs of patients, families and staff
• Update policies, procedures, and protocols
  ✓ Pain control Policy
  ✓ Atraumatic Care Policy
  ✓ Preprinted Epidural Orders
  ✓ Preprinted PCA Orders
• Monitor clinical practices and clinical outcomes as part of the hospital's quality program
• Recognize the need for additional research and initiate scientific inquiries related to pediatric pain assessment and management

2. Ensure the appropriate hospital and departmental support for the proposed medical consult service  
   or

Identify opportunities for pain service expansion and describe successful methods of infiltrating the organization
• Positive introduction
• Be available for rounds (ride the elevator)
• Introduce new effective interventions
• Present data
• Fill an educational gap
• Develop guidelines
• Propose research
• Be ready to change your mind.
References:
ANCC Pain Management Certification Eligibility Criteria
http://www.nursecredentialing.org/PainMgmt-Eligibility.aspx

AMERICAN ACADEMY OF NURSE PRACTITIONERS
Discussion Paper: Doctor of Nursing Practice

Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education
http://www.nacns.org/docs/APRN-RegulatoryModel.pdf

NATIONAL ASSOCIATION OF CLINICAL NURSE SPECIALISTS
http://www.nacns.org/
• APRN Fact Sheet (PDF)
• CNS Core Competencies (PDF)
• Current List of CNS Core Competencies’ Endorsers (PDF)
• Core Practice Doctorate CNS Competencies (PDF)


Grant, Marcia; Ferrell, Betty; Hanson, Jo; Sun, Virginia; Uman, Gwen; (2011). The Enduring Need for the Pain Resource Nurse (PRN) Training Program. Journal of Cancer Education, Dec; 26 (4): 598-603
