Care of the Patient with Chronic/Persistent Pain in the Emergency Care Setting

Position Statement

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Description

Chronic pain is pain that persists beyond normal expected healing. It is pervasive and costly worldwide (British Pain Society, 2018; Friedman, 2020; Galinski et al., 2022; National Health Service [NHS], n.d.). The pathophysiology associated with chronic/persistent pain makes it difficult to treat and compels patients to seek medical intervention (Sucu Çakmak et al., 2023). Patients with chronic/persistent pain often turn to the emergency department (ED) for treatment of acute exacerbations. While it is difficult to discern the actual number of patients who seek treatment for chronic/persistent pain in EDs using national databases, researchers estimate that 78% of all ED visits are pain related (Felix et al., 2023) and 10–16% of ED visits are due to chronic/persistent pain (Brady et al., 2021; Galinski et al., 2022). These statistics provide some idea of the effect that chronic/persistent pain has on the ED, not including patients with chronic pain exacerbated by trauma or injury. The ED, which was designed for episodic treatment of acute conditions, is not the ideal setting for managing chronic healthcare problems because of limited ability to follow-up after discharge and fragmented care transitions (Langabeer et al., 2021; Slater et al., 2022). Additionally, ED providers, unlike providers who see patients on a regular basis, have limited information available to them when patients present for treatment, and this can lead to treatment plans that may be counterproductive (Langabeer et al., 2021; Slater et al., 2022).

Over the course of the 1990s, opioids began to be prescribed with increasing frequency in an effort to manage chronic/persistent pain. Prior to 1990, opioids were primarily used for acute and cancer pain (Ali et al., 2019). During this time regulatory agencies developed an expectation that providers would address and manage pain, and pain became known as the fifth vital sign (Sullivan & Ballantyne, 2022). The focus on pain and change in opioid prescribing for chronic/persistent pain had several unintended consequences. Opioids became the first and, in some cases, the only treatment for chronic/persistent pain. This led to increased opioid prescribing, with more prescriptions written (Ali et al., 2019; Davis & Lieberman, 2020;) for a longer duration and at higher dosages (Centers for Disease Control and Prevention [CDC], n.d.-a; Dowell et al., 2022). The higher opioid prescribing led to an increased number of opioid overdoses (Daoust et al., 2022; Hedeggard et al., 2021; Stein et al., 2022; Vivolo-Kantor et al., 2018). There has been a decline in the number of ED visits with opioid prescriptions at discharge, from 12.2% in 2017–2018 to 8.1% in 2019–2020 (Santo & Schappert, 2023). Numerous pharmacological and non-pharmacological treatment modalities are available for a patient presenting to the emergency department with chronic pain. In order to assess and treat chronic pain effectively, emergency nurses should be informed on the current evidence-base and about accessible treatment options.

ENA Position

It is the position of the Emergency Nurses Association (ENA) that:

1. Pain is what the patient says it is and occurs when the patient says it is occurring.

2. Education regarding the care of patients with chronic/persistent pain is essential for emergency nurses to be able to provide safe and quality care.

3. Emergency nurses support the use of evidence-based assessment tools appropriate for selected patient populations with chronic/persistent pain.

4. In order to promote behavior change in patients, motivational interviewing (MI) has emerged as an important evidence-based approach.

5. Patients with chronic/persistent pain require a comprehensive pain assessment that includes an assessment of how physical or social function is affected in addition to a numerical rating score.

6. Emergency nurses collaborate with other healthcare professionals, which may include, but are not limited to physicians; risk management, case management, and pain management specialists; and alternative care providers in the development of treatment guidelines for the management of the chronic/persistent pain patient in the emergency setting.

7. Thorough documentation is an essential form of effective communication and one of the building blocks for safe and therapeutic care of patients with chronic/persistent pain.

8. Emergency nurses should have knowledge related to substance use disorder (SUD) screening tools and evidence-based management strategies and educate the patient and other providers about appropriate options and management.

9. Emergency nurses advocate and care for chronic/persistent pain patients in a manner consistent with the emergency nursing code of ethics, which emphasizes human dignity and respect.

10. Development of a frequently updated interstate prescription drug monitoring program is needed to promote emergency department safe prescribing practices for opioids in the treatment of chronic pain.

Background

Chronic pain is pain that persists after healing is expected to have occurred, usually longer than three months, and it often occurs without any identifiable cause (American College of Emergency Physicians, 2017; British Pain Society, 2018; Murray et al., 2022; Pester et al., 2022; NHS, n.d.). Over time, chronic/persistent pain is associated with changes in the way the brain processes pain signals, and these changes may have a role in the maintenance of pain (Ahmadpour et al., 2019). Chronic pain can be difficult to treat, necessitating multiple visits for care from multiple providers. Chronic/persistent pain that is not well controlled can affect physical and psychological functioning (Ahmadpour et al., 2019; Sihvonen et al., 2022; Yong et al., 2022). *This is why it is essential to clarify the evidence-based indications for opioid therapy* (Montgomery, 2022).

Opioids have become one of the most prescribed medication classes; the number of prescriptions for opioids increased fourfold from 1999 to 2010 (Alam & Juurlink, 2016; Guy et al., 2017). However, a recent statistic shows that the dispensing rate has fallen to the lowest in 15 years, with a total of over 142 million opioid prescriptions in 2020 (CDC, n.d.-c). The amount of opioids in morphine milligram equivalents (MME) prescribed per person has gone down more recently, but it is still around three times higher than it was in 1999 (CDC, n.d.-c; Dowell et al., 2022). The upsurge in opioid prescribing started in the 1990s when opioids, which were previously reserved for acute and cancer pain, began to be prescribed for chronic/persistent noncancer pain (Ali et al., 2019, Manchikanti et al., 2017). Opioids were advertised as a safe, effective method for chronic/persistent pain management (Manchikanti et al., 2017). Their availability and affordability (in terms of direct consumer cost) compared with other options such as massage therapy, acupuncture, and cognitive behavioral therapy made them the go-to choice for chronic/persistent pain management (CDC, n.d.-c; Cohen et al., 2021; Kroenke & Cheville, 2017). The liberal prescribing practices for opioids have been associated with an increase in opioid overdoses (CDC, n.d.-c; Daoust et al., 2022; Dowdell et al., 2022; Dowell et al., 2022). In the United States, 75.4 % of all drug overdose deaths involved opioids (CDC, n.d.-c), with overdose deaths involving

prescription opioids increasing by nearly five times between 1999 and 2020 (National Center for Health Statistics, 2021). The high mortality associated with opioid use has created a national awareness of the dangers associated with long-term opioid use and national efforts to curb opioid use (Alam & Juurlink, 2016; CDC, n.d.-c; Dowell et al., 2022; Slater et al., 2022; World Health Organization [WHO], 2021).

The increased awareness of opioid misuse, addiction, and overdose has made some providers reluctant to prescribe opioids. While some patients who are discharged from EDs with opioid prescriptions are at increased risk for opioid misuse (defined as taking more opioids than the prescribed number or amount, obtaining additional opioids without a prescription, or using the opioids to treat conditions other than pain [Stein et al., 2022]), this does not apply to all patients. Each patient is unique in their response to pain and the treatment of pain (Raja et al., 2020; Stokes, 2018). Emergency room nurses having knowledge of SUD screening tools can help provide the best care for their patients (NIH, 2018). Opioids, while they should not be the first option or used in the long-term management of chronic pain, should not be completely excluded either. Blanket policies prohibiting the prescription of opioids for chronic pain may lead some patients to search for alternative options for pain control. Dart et al. (2015), in a secondary analysis of data obtained from the Researched Abuse, Diversion, and Addiction-Related Surveillance (RADARS) System, found that heroin use increased when prescriptions for opioids decreased, suggesting drug substitution. This is supported by Barocas et al. (2022), who noted that heroin-related deaths have quadrupled over the last decade. There are no easy answers when deciding to prescribe or not prescribe opioids for chronic pain. In each instance the benefits and risks of opioids should be considered individually for each patient prior to writing a prescription. Misconceptions about the risk opioids pose still exist (Heimer et al., 2019), and it is the responsibility of healthcare providers to discuss these risks and alternative treatment options with patients prior to prescribing opioids for chronic pain. Risk mitigation involving state prescription drug monitoring programs, where available, may be of assistance in determining patients who could be at increased risk for opioid misuse (Schuler et al., 2020; Slater et al., 2022; Stein et al., 2022) and should be used. In addition, providers should be aware that the combination of some medications, such as opioids and benzodiazepines, may increase the risk of diversion for patients (Slater et al., 2022).

Non-pharmacological strategies to manage chronic pain include both physical and psychological modalities. These can be used alone or in conjunction with pharmacological interventions. Examples of physical interventions include massage, positioning and physical therapy, acupuncture, thermal therapy, and the use of transcutaneous electrical nerve stimulation (TENS) machines. Examples of psychological interventions include relaxation and breathing techniques, the use of imagery, distraction therapy, music therapy and the use of emotional support animals (Bukola & Paula, 2017). Further evidence is required to fully understand the impact of non-pharmacological interventions on chronic pain. The literature acknowledges some of the challenges of implementing these non-pharmacological interventions within an emergency care setting. Some recognized challenges include accessibility, lack of awareness, affordability and resourcing, scope of practitioners' practice, and personal beliefs and support system (Finnerup, 2019).

Self-reported pain is subjective, and vital signs may not be a reliable measure for quantifying the amount of pain someone is experiencing (Block et al., 2017; Yong et al., 2022;). Self-reported pain occurs however the patient expresses it (Block et al., 2017; Yong et al., 2022). As professionals, it is important that emergency nurses continue to be educated and use evidence-based methods such as motivational interviewing, for assessing and documenting pain (Kahsay et al., 2019; Substance Abuse and Mental Health Services Administration, 2023; Bischof et al., 2021). All patients have the right to be treated in a professional manner and to be educated on their condition and available treatments, even if opioids are not indicated. Dépelteau et al. (2020) found that individuals with chronic pain frequently visit the ED and desire information on pain management and specialty referral. Providing this education and referral to patients conveys that emergency nurses care and believe patients have pain.

Resources

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