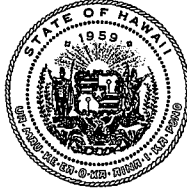


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REPORT TO THE LEGISLATURE REGULAR SESSION 2012, PURSUANT TO HOUSE CONCURRENT RESOLUTION NO. 55, SLH 2011

This report is filed pursuant to House Concurrent Resolution No. 55 (HCR 55), SLH 2011, which was adopted by both the Senate and House of Representatives and which requires the Hawaii State Board of Nursing (Board) to develop and implement a pain and palliative care policy.

According to HCR 55, the inadequate treatment of severe acute pain and severe chronic pain originating from cancer or noncancerous conditions is a significant health problem. For some patients, pain management is the single most important treatment a physician can provide due to the complexity of its problems. Many patients who suffer from severe acute pain or severe chronic pain may require referral to a physician with expertise in the treatment of severe acute pain and severe chronic pain. In some cases, severe acute pain and severe chronic pain is best treated by a team of clinicians to address the associated physical, psychological, social, and vocational issues. In the hands of knowledgeable, ethical, and experienced pain management practitioners, opiates administered for severe acute or severe chronic pain can be safe and may be part of an overall treatment plan for a patient in severe acute pain or severe chronic pain who has not obtained relief from any other means of pain management.

Act 57, SLH 2010, amended Hawaii Revised Statutes Chapter 457, Nurses, by allowing the Board to adopt provisions of the National Council of State Boards of Nursing NCSBN Model Nursing Practice Act and Model Nursing Administrative Rules relating to the scope and standards of nursing practice for registered nurses, licensed practical nurses, and advanced practice registered nurses. The Board recognizes the NCSBN Model Nursing Practice Act and Model Nursing Administrative Rules as the standards of nursing practice generally accepted throughout the United States.

In 2007 the NCSBN adopted the "*Statement on the Regulatory Implications of Pain Management*". This statement identifies the regulatory issues to be addressed by

boards of nursing as well as articulating the role of the board of nursing in pain management. Not only does the statement address chemically dependent nurses, it also provides standards of pain management nursing by registered nurses as well as advanced practice registered nurses in pain management in a primary care role. This statement provides an invaluable resource tool for Boards of Nursing developing pain management and palliative care policies. The NCSBN fully supports the nursing role in the thorough assessment and effective management of pain. The Boards' of Nursing mandate of public protection includes a responsibility to protect the public from the mismanagement of pain.

Consequently, at its November 3, 2011 meeting, pursuant to HCR 55, SLH 2011, the Hawaii State Board of Nursing adopted the NCSBN's "*Regulatory Implications of Pain Management Resource Pack*" as its model for the development and implementation of a pain management and palliative care policy. (See attachment).

Attachment

Attachment A

Regulatory Implications of Pain Management Resource Pack

SECTION ONE: Executive Summary

Pain management raises important regulatory issues to be addressed by boards of nursing. The treatment of pain is a complex issue, requiring increased awareness and specialized education by nurses.

In recent years there have been pharmacological and technical advances that provide new approaches to pain management. Nurses may be concerned about possible side effects of analgesics or fear patients becoming tolerant, physically dependent, or addicted to analgesics. Nurses may fear the scrutiny of regulation, especially related to controlled substances. When a nurse experiences pain, that nurse's ability to practice safely may be questioned due to the nurse's condition and/or pain treatment. For these reasons, the National Council of State Boards of Nursing (NCSBN) developed a national statement identifying the regulatory implications for nursing that was adopted by the 2007 NCSBN Delegate Assembly, which is included in this resource pack.

Based on the 2007 statement, the NCSBN Disciplinary Resources Committee developed additional resources to support boards of nursing dealing with the regulatory implications of pain management. These materials provide information, model policies, and strategies for making licensure decisions when pain management becomes a board of nursing regulatory issue.

The pain resources provide background information about the phenomenon of pain. Each of the four regulatory issues identified in the statement is addressed in a section of the resource pack: the nurse in pain, the chemically dependent nurse in pain, the role of the registered nurse (RN), and licensed practical/vocational nurses (LPN/VN) in pain management as well as the advanced practice registered nurse (APRN) prescribing for patients in pain.

When nurses experience pain, most are able to recognize when the effects of pain and/or pain treatment are having a negative impact on his/her ability to practice safely and take appropriate action. But when a nurse does not have insight into the situation or feels compelled to continue working, the board of nursing may need to intervene. Nurses sometimes present to the board with dual diagnoses of chemical dependency and pain. In addition, nurses being monitored for chemical dependency and recovery compliance may have health issues that require the medically directed use of analgesics. Professional evaluations are an important tool for boards addressing situations where the nurse is unable to practice safely as the result of pain or the treatment for pain. These resources include recommendations of what to look for in an evaluator and how to use evaluations effectively.

Other regulatory issues relate to the nurse's ability to meet the needs of patients experiencing pain. Standards of pain management nursing are included. There is a discussion of the regulatory implications of the RN and LPN/VN role in pain management. One section is devoted to the unique role of the APRN in pain management. Although many health professionals fear the scrutiny of regulatory boards, nurses who meet the nursing standards for pain management and practice within the appropriate nursing role are likely to avoid violations of nursing practice acts. The appendices provide additional resources and tools.

NCSBN fully supports the role of the nurse in the thorough assessment and effective management of pain. Boards of nursing mandates of public protection include a responsibility to protect the public from the mismanagement of pain. Boards also must address the impact

that being in pain and receiving pain treatment have on the ability of nurses to practice safely. *Pain Management Resources for boards of nursing* will support boards of nursing in meeting the regulatory challenges presented by pain management.

SECTION TWO:

Introduction and Purpose

The following materials were developed as a resource for boards of nursing to provide information, model policies, guidelines, and strategies for making licensure decisions and taking disciplinary actions when pain management becomes a board of nursing regulatory issue. This work will support boards of nursing in meeting the regulatory challenges presented by pain management. Nurses, nursing students, and other healthcare professionals, as well as policymakers and other public entities, may also find these resources useful.

The Statement on the Regulatory Implications of Pain Management was adopted by the NCSBN Delegate Assembly at its annual meeting in August 2007. The statement identifies the regulatory issues to be addressed by boards of nursing as well as articulating the role of the board of nursing in pain management. It provided the framework for the development of additional board resources on pain management.

SECTION THREE:

National Council of State Boards of Nursing Statement on the Regulatory Implications of Pain Management

Pain management raises important regulatory issues to be addressed by boards of nursing. The treatment of pain is a complex issue, requiring increased awareness and specialized education by nurses. In recent years there have been pharmacological and technical advances that provide new approaches to pain management. Nurses may be concerned about possible side effects of analgesics or fear patients becoming tolerant to analgesics or addicted to the medications. Nurses may fear the scrutiny of regulation, especially related to controlled substances. In addition, when a nurse experiences pain, that nurse's ability to practice safely may be questioned due to the nurse's condition and/or pain treatment. For these reasons there is a need for a national statement identifying the regulatory implications for nursing.

Role of the Board of Nursing

Boards of nursing deal with four unique pain management situations:

1. A nurse fails to meet the expected standards of nursing pain management, resulting in the risk of harm and suffering for patients.
2. An APRN fails to appropriately prescribe medications for pain management.
3. A nurse's personal pain or treatment for pain affects his/her ability to practice safely.
4. A chemically dependent nurse requires pharmacologic pain management.

Boards of nursing can be proactive in their charge to protect the public by:

- Acknowledging the unique regulatory challenges presented by pain management.
- Holding a nurse accountable for:
 - Acquiring the education necessary to effectively manage patients experiencing pain.
 - Adhering to accepted nursing pain management standards.

- Practicing within the appropriate role for the level of licensure.
- Evaluating one's own ability to safely and competently practice.
- Imposing appropriate action when a nurse fails to comply with the statutory and regulatory requirements and places patients at risk.
- Collaborating with stakeholders (e.g., regulatory entities, educators, professional organizations, employers, and consumers) in implementing regulatory processes that support effective pain management.

NCSBN fully supports the nursing role in the thorough assessment and effective management of pain. Boards' of nursing mandate of public protection includes a responsibility to protect the public from the mismanagement of pain. Boards also must address the impact that being in pain and receiving pain treatment have on the ability of nurses to practice safely.

Future Steps

Additional resources are planned to provide model policies and guidelines for each of the regulatory issues addressed above. This work will support boards of nursing in meeting the regulatory challenges presented by pain management.

Adopted August 2007

SECTION FOUR:

Background – a Discussion of Pain

Pain ...holds sway over individual lives much as a sovereign power governs a state... not only when it appears in full regalia, displaying its power like a king at a banquet, but also when it remains behind the scenes, more or less invisible, its presence diffused through a thousand daily acts...

Jeremy Bentham, 1789¹ (Morris, 1998)

Pain is an alarm system for the body, warning that something is wrong or injured. Pain triggers thoughts, emotions, memories, and an array of biochemical events to protect the body from further harm. Pain is a protective response and is communicated through both language and nonverbal behavior. (American Pain Foundation, 2007)

The Joint Commission considers pain to be the fifth vital sign.² (JACHO, 2000) In 1979, the International Association for the Study of Pain introduced a commonly used definition of pain: "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage or both." (Usunoof, 2006) While the capacity to discern noxious stimuli is largely consistent among people, the meaning of pain and the subjective sense of suffering that accompanies the perception of pain is private and unique, set within one's larger life context. (Malik, 2000) Unrelieved pain is a serious public health problem in the U.S. (Pain and Policy, 2007)

Pain can be acute or chronic. Acute pain begins suddenly, is time limited, and can be mild or severe. Acute pain usually disappears when the underlying cause has been effectively treated or healed. It is typically responsive to analgesics and non-pharmacologic interventions. Unrelieved acute pain may lead to chronic pain problems.

Chronic pain is a persistent state that lasts longer than the expected healing time. It results from injury or disease or can occur for no apparent reason, last for weeks, months or years,

¹ Jeremy Bentham was a nineteenth century English philosopher, economist, and theoretical jurist. He was the earliest and chief expounder of Utilitarianism.

² The suggestion to associate pain assessment with vital signs and documentation originated with the American Pain Society and has been implemented by many hospitals where pain assessment is included on the vital sign record. (McAfferly, 1999, p 3)

and can be mild to severe. Some chronic pain is organic, the result of an ongoing disease state or physical condition. But with some chronic pain, the pain signal continues, even when the cause and physical danger have passed. Dr. Sean Markey, chief, Pain Management Division, Stanford University, says “Pain causes a fundamental rewiring of the nervous system. Each time we feel pain there are changes that occur that tend to amplify our experience of pain.” (Wallis, 2005, p.51-52) He describes pain as a “symphony” – a complex dynamic involving not only pain sensors but emotions, memory, and hormones. (Kalb, 2003) Chronic pain can be disabling and is often associated with long-term, incurable medical conditions.

The experience of pain is subjective, “that which cannot be denied, and that which cannot be confirmed.” (Scarry, 1985, p.4) The same person experiencing pain may achieve a high level of functioning at one time and be dysfunctional at another.

Pain can adversely affect quality of life – physically, emotionally, socially, spiritually, and economically. Inadequately managed pain can produce anxiety, fear, depression, or cognitive dysfunction. Pain can affect one’s ability to concentrate and think; physical mobility; and ability to perform daily tasks and sleep as well as overall mood.

Clinical experience has demonstrated that adequate pain management leads to enhanced functioning and quality of life, while uncontrolled chronic pain contributes to “disability and despair.” (Pain, 2007) There are many effective drug and non-drug approaches to pain management that vary according to the patient’s needs and situation. There have been medical advances in pain treatment, but there remains a gap between what is known and what is done in many settings. Another complicating factor in the treatment of pain is the potential for abuse, particularly of opioid medications where the interface among policy, practice, and patient care is complex. However, if the goal is to enhance healthcare with effective pain treatment, policies that encourage pain management and recognize the use of controlled substances are an expected part of healthcare practice and are preferable to policies that provide no positive guidance. (Pain, 2007)

Patients have the right to appropriate assessment and treatment of pain. (JCAHO, 2000, p. 7) The goal of pain management is to reduce the patient’s pain to the lowest level possible while supporting the patient’s level of functioning to the greatest extent possible. Since pain is individualized, pain treatment and management also must be individualized. An array of tools are available for use in pain management, including comfort measures, pharmacotherapy, psychosocial support, psychotherapy, surgery, technology and complementary therapies. (Loitman, 2000) Effective pain management is a high priority in the care of all patients, including nurses who are patients.

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SECTION FIVE:

Professional Evaluations

Boards of nursing often seek professional assistance to guide them with complex decisions. A professional evaluation may be one of the first necessary steps in determining a nurse's ability to practice safely. When weighing the nurse's desire to practice nursing, the public's need for access to care and the board's responsibility to protect the public, the evaluation's findings may be crucial to the board's determination.

Some boards are authorized by law, upon demonstration of probable cause, to require physical or mental health evaluations as part of the investigatory process. (NCSBN, 2004) If a board is not authorized to require such an evaluation, the board may request that the nurse comply with a recommendation for an evaluation. Another approach is for the board to make tentative findings conditioned upon the nurse having a thorough evaluation by a board-approved evaluator.

Professional evaluation includes both physical and psychological examination results. Board staff and attorneys may be involved in the selection of professionals who meet identified selection criteria and can provide assessments for use by the board. An assessment can provide valuable information to assist the board in determining an appropriate course of action. A qualified healthcare professional, with experience in the evaluation of pain and pain management, should be selected to assess the nurse's cognitive and physical abilities. A professional evaluation regarding the impact of pain on a nurse's ability to practice is complex. Ideally, a collaborative approach provides input from different professional perspectives. It is important to select qualified, expert evaluators, experienced in the evaluation of subjects whose medical knowledge may influence the evaluation findings (i.e., subjects who can use their knowledge and experience to skew the evaluation). Any board decision should be based on reliable evidence pertaining to the nurse's ability to practice and the risk of harm to the patient.

This paper offers one approach to selecting qualified expert evaluators. Every state has unique laws and regulations regarding what information can be shared and with whom. As with other sections of this paper, the recommendations must be evaluated to determine what is congruent with a jurisdiction's laws and rules. The following criteria are general recommendations, some of which may not be appropriate for every state.

Evaluator Selection:

Suggested characteristics for evaluator selection include:

- A practitioner, i.e., a physician, psychiatrist, psychologist, APRN, or other health professional, licensed in good standing who has experience evaluating professionals with pain issues.
- A practitioner who is not involved with the ongoing treatment of the subject nurse.
- A practitioner who is able to interpret psychological and neuropsychological test results.

- A practitioner who has an understanding of cognitive and psychomotor abilities and their relationship to nursing practice.
- A practitioner who can make recommendations regarding nursing practice, considering the risk factors in a particular nursing role and setting (e.g., someone is safe performing repetitive functions with predictable outcomes but not complex functions with variable outcomes). (NCSBN, 2001)

Neuropsychological Testing

Neuropsychological tests can provide quantifiable data about the following aspects of cognition:

- Reasoning and problem solving ability;
- Ability to understand and express language;
- Working memory and attention;
- Short- and long-term memory;
- Processing speed;
- Visual-spatial orientation;
- Visual-motor coordination; and
- Planning, synthesizing and organizing abilities. (Malik, 2006)

Guidelines for Evaluators

Health professionals who conduct third party evaluations must be aware of the limits of privacy and confidentiality. The evaluator should make sure that the nurse is informed as to the purpose of the evaluation and who will be receiving the report. Before the evaluation begins, the evaluator must articulate the goals of the assessment in a way to make clear to the nurse the reality of the situation. It is possible that the nurse's situation may be further complicated by the findings of the evaluation.

A third-party evaluator needs to review allegations, access expanded sources of information, and consider interviews with family members and employers. The evaluator may find it helpful to consult with nurses regarding specifics of the practice setting and nursing care.

Evaluation Reports

States may vary as to who controls the report. In some states it is the nurse's decision who receives the report; in others, the report belongs to the board directing the evaluation. The nurse needs to understand that refusal to provide the report to the board may have adverse licensure consequences. Failure to complete an evaluation would also be considered in determining the case resolution. Information may surface after the referral that could affect the evaluation. The evaluator can be apprised so that he/she can determine if this information would impact the evaluation.

Board Use of Professional Evaluations

Addictionologist Stephen Merlin, MD, Substance Abuse Consultants, Columbia, South Carolina, advises that assessments be conducted at the time of day that most closely mirrors the nurse's work situation. The nurse must be on his/her normal medication regimen to accurately evaluate functionality in their clinical practice. Dr. Merlin advises that it is not the type of medication, or the amount of medication that should be of concern to boards; rather, the concern is whether the nurse is able to think clearly and function safely.

Another key consideration is whether or not there have been any reported practice issues during the time the nurse has been taking the medication. Any incident of concern certainly increases the possibility that the nurse is having difficulty with competent practice as a result of the pain itself or the medication/treatment for pain.

Conclusion

Professional evaluations include both physical and psychological examination results. An evaluation regarding the impact of pain on a nurse's ability to practice is complex. Ideally, a collaborative approach provides input from different professional perspectives. An evaluation conducted by an expert provider provides additional information and analysis to inform board of nursing decisions regarding nurses dealing with pain.

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S. Merlin, (personal communication, March 10, 2004)

SECTION SIX:

The Ability to Practice Nursing Safely

Regulating the practice of nurses involves only one issue: can the nurse practice safely? Coping with personal pain and/or the treatment for pain can affect a nurse's performance. Boards of nursing often deal with nurses who are unable to practice safely because of the nurse's pain and/or the treatments they are receiving for pain. Other nurses are unable to practice safely because of the dual challenges of chemical dependency combined with the need for pain management.

Whether a nurse should continue active nursing practice when that practice becomes compromised depends upon the nurse's ability to function safely and effectively. The assessment of functional ability is an individualized process that does not lend itself to application of a set format based on select elements. On the contrary, assessment of functional ability requires active consideration of all relevant factors such as diagnosis, prescribed treatment and situational events, as well as an evaluation of the impact of those factors on the individual being assessed. (Idaho BON, 2005)

A nurse may need a professional evaluation to determine whether he/she should continue nursing practice safely at times when that practice may be compromised. If the nurse lacks the insight to realize when there are serious safety issues, the board of nursing is the ultimate decision maker.

In addressing situations where the nurse demonstrates the inability to practice safely as a result of pain or the treatment for pain, boards should consider action that is fair and appropriate to protection of the public. Punitive action may not be the best course of action in many of these situations. If allowed by law, boards may consider alternatives to discipline, including monitoring or specific practice restrictions, among other options.

Works Cited:

Idaho Board of Nursing. (2005). *Idaho Position on Safety to Practice*. Boise, ID: Author.

SECTION SEVEN:

Regulatory Implications: The Nurse in Pain

Not all nurses who experience pain or are taking medications for the treatment of pain have a compromised ability to practice safely. In most situations, nurses are able to self-limit by recognizing when the effects of pain and/or pain treatment negatively impact their ability to practice nursing safely and competently. It is the professional responsibility of all nurses to recognize and limit one's practice when one's competence is or may be affected by pain or pain treatment.

However, sometimes recognition and self-limitation does not take place. There may be many reasons why the nurse does not self-limit. A nurse may have a lack of insight into his/her situation or feel compelled to continue working because of familial responsibilities, financial need, or employer demands. These are situations when the board of nursing may become involved. If the nurse is either unable or unwilling to self-limit and thus creates a risk of harm to patients, to self or both, the board may be compelled to intervene.

The board of nursing must evaluate the impact a nurse's pain has on his/her behavior and ability to practice safely. The board must balance its responsibility to protect the public while recognizing the privilege of the nurse to practice a chosen profession. Board actions may include:

- Educating the nurse;
- Admonishing the nurse;
- Requiring evaluation and/or treatment;³
- Monitoring the nurse's practice;
- Limiting or restricting the nurse's practice; and
- Separating the nurse from practice (e.g., suspension or revocation).

What Boards Need to Know

Boards need to recognize when the experience of pain affects a nurse's ability to practice safely. At what point does a nurse's pain⁴ impair his or her ability to practice safely? In addition to feedback from the nurse's employer, primary care provider and/or pain management specialist or treatment program, some boards use independent evaluators to assess the nurse's functional ability.

Although constant evaluation of one's ability to safely and competently practice is the responsibility of each individual nurse, the board of nursing becomes the ultimate decision-maker. In some instances, it may be necessary for the Board to require objective physical and/or functional assessment, using reliable psychometric instruments and methods administered by qualified licensed professionals...
(Idaho BON, 2005)

The board staff coordinates the collection of the evaluation report and other evidence regarding the nurse's ability to practice (see Section Five for specific information regarding professional evaluations).

The Role of the Board of Nursing

The professional evaluation is a tool that the board may use to make informed decisions. Boards may:

³ When an evaluation is mandated, states vary as to who pays for the evaluation. In some states, usually those with the authority to mandate evaluations, the board pays for a mandated evaluation. In other states, the subject nurse is expected to pay for the evaluation.

⁴ Throughout this discussion of impact of pain on a nurse's ability to practice, the term pain refers to both the effects of pain and the effects of pain treatment.

- Use the evaluator's recommendations to support board decisions regarding a nurse's ability to practice safely.
- Use the evaluator's recommendations to develop requirements for monitoring compliance with the board's order.
- Identify and resolve discrepancies between the Board's findings and the outcomes of the evaluation
- Provide additional information to the evaluator if needed.
- Base disciplinary actions on the behavior and the resulting harm or risk of harm.

Conclusion

Complaints involving pain management are complex and challenging cases for boards of nursing. The opinion of a qualified professional evaluator is assistive in identifying any safety to practice implications for the nurse in pain. The nurse must have insight into how pain and pain treatment is affecting his/her ability to practice safely. When this insight is lacking, final authority rests with the board.

Board actions may range from revocation or suspension of the nurse's license, to restrictions or conditions on practice, to reprimanding or warning the nurse of the potential risk to patients and/or herself/himself. The nurse is accountable for her/his conduct and practice but must understand that the board is the final decision-maker. The board's decisions will affect the nurse's license to practice and the nurse's employment options.

Work Cited:

Idaho Board of Nursing, (2005). *Idaho Position on Safety to Practice*. Boise, ID: Author.

SECTION EIGHT:

Regulatory Implications: The Chemically Dependent⁵ Nurse in Pain

Regulating the practice of a chemically dependent nurse who is in pain, on one hand, involves only one issue: can the nurse practice safely? Typically, a chemically dependent nurse is already in a board directed alternative program or under a disciplinary probation contract. If the terms and conditions of alternative program or disciplinary action provide for a monitoring process, thereby insuring safe practice, then a chemically dependent nurse can practice while in pain.

On the other hand, a chemically dependent nurse who is in pain presents a not-so-unique circumstance for a board of nursing (can a board intrude in a relationship between a nurse in

⁵ The phrase chemical dependency is used in this paper because it is commonly used and understood by the public. The literature usually refers to addiction rather than chemical dependency. The terminology used by DSM-IV is substance abuse and substance dependency. Substance abuse is a maladaptive pattern of substance use leading to clinically significant impairment or distress, manifested by (one or more) of the following:

- Recurrent use resulting in failure to fulfill major obligations.
- Recurrent use in situations where it is physically hazardous.
- Recurrent substance-related legal problems.
- Continued use despite problems caused by effects of substance.

Substance dependency is maladaptive pattern of substance use leading to significant impairment or distress as manifested by (three or more) of the following:

- Tolerance, shown by a need for markedly increased amounts of the substance to achieve desired effect or a markedly diminished effect with continued use of the same amount of the substance.
- Withdrawal, where the same substance is taken to relieve or avoid withdrawal, or when symptoms characteristic for the substance occur when the substance is not available.
- Substance taken in larger amounts or over longer period than intended.
- Persistent desire or unsuccessful efforts to cut down.
- Time spent in activities to obtain, use, recover from substance.
- Important activities given up.
- Continued use despite knowledge of having problems likely caused by substance. (DSM-IV, 2000).

pain and her treatment provider?) and the treatment provider (can pain medication safely be prescribed to a person dependent on that medication?).

McCaffery and Pasero state that “pain and addiction are not unrelated phenomena. Multiple sources of potential overlap between these conditions exist in both psychological and physiological domains. Evidence exists that the presence of pain and addiction affect the expression of each other.” (1999) Nurses being monitored for chemical dependency and recovery compliance may have health issues that require medically directed use of analgesics. Nurses may present to the board with dual diagnoses of chemical dependency and pain. Pain relief is a primary goal for any person in pain, regardless of whether that individual has a history of addiction. A patient’s history of addiction should be openly discussed as part of pain assessment and developing a plan for pain management. (ASPMN, 2002)

What the Board Needs to Know

Promoting pain relief while, at the same time, guarding against abuse of pain medications becomes a critical balancing act.

Preventing drug abuse is an important societal goal, but there is consensus by law enforcement agencies, health care practitioners, and patient advocates alike, that it should not hinder patients’ ability to receive the care they need and deserve.⁶ (Joint Statement of the DEA et al., 2001)

Chemically dependent nurses in pain who are prescribed drugs with addictive potential are at substantial risk of relapse and compromise of their recovery. Nurses often identify pain issues as the start of a cascading problem. Boards hear from many addicted nurses that pain issues led to the overuse of medication. Prescription misuse evolved into drug seeking behaviors that ultimately resulted in using multiple providers, fraudulent prescriptions and/or drug diversion. Poorly managed pain conditions can lead to self-medication, drug seeking behavior, and pseudo-addiction.⁷

Guidelines for the Treatment Provider

1. The plan for management and eventual discontinuance of the prescribed medications is ideally developed by the nurse’s pain management provider in consultation with the nurse’s chemical dependency treatment provider. Providers without experience treating chemically dependent nurses who in are pain can consult with a healthcare practitioner knowledgeable about addiction (e.g., an addictionologist) to develop a pain management plan for a chemically dependent nurse. (Ziegler, 2007)
2. The use of opioids, even in controlled settings and under carefully supervised conditions, does make the nurse more vulnerable to relapse. However, so does unrelieved pain. (ASPMN, 2002) Appropriate use of analgesia during and immediately after any procedure requiring pain treatment should be used to assure adequate pain relief. (McCaffery, 1999)
3. The plan should include a return to abstinence when the other medical issues are resolved.

⁶ This Joint Statement was signed by: American Academy of Family Physicians, American Academy of Hospice and Palliative Medicine, American Academy of Pain Medicine, American Alliance of Cancer Pain Initiatives, American Cancer Society, American Medical Association, American Pain Foundation, American Pain Society, American Pharmaceutical Association, American Society of Anesthesiologists, American Society of Law, Medicine and Ethics, American Society of Pain Management Nurses, American Society of Regional Anesthesia and Pain Medicine, Community-State Partnerships to Improve End-of-Life Care, Drug Enforcement Administration, Last Acts, Midwest Bioethics Center, National Academy of Elder Law Attorneys, National Hospice and Palliative Care Organization, Oncology Nursing Society, Partnership for Caring, Inc., and University of Wisconsin Pain and Policy Studies Group. However, not all law enforcement agencies act in accordance with this statement.

⁷ Pseudo-addiction refers to behaviors indicative of uncontrolled pain or fear of uncontrolled pain. These behaviors include demanding behavior, “clock-watching,” and hoarding of opioid analgesics. The behaviors resolve when the pain is effectively treated. (McCaffery, p. 173)

Guidelines for the Chemically Dependent Nurse in Pain

The nurse should be aware that detoxification treatment may be necessary to support a return to sobriety. (Mcaffery, 1999) New medications, unexpected activity and/or a change in diet often requires a diabetic to take steps to reduce serum glucose back to normal levels; similarly, a chemically dependent person administered analgesics to support recovery from surgery must take steps to regain abstinence. This is not intended as a penalty but part of the treatment necessary to manage a serious illness. The nurse is ultimately accountable for his/her conduct and practice.

1. The nurse should continue to meet all terms and conditions of a board disciplinary order or the alternative program monitoring contract including meeting attendance, identification of prescribed medication, and submission to random drug screens performance evaluations and monitoring reports.
2. The nurse should provide documentation from the treating health care provider indicating the reason for the prescribed controlled substance, the name and dosage of the controlled substance being prescribed, and the anticipated duration of use. (Ziegler, 2007)
3. The nurse may be required to submit a negative drug screen before the nurse can return to work. (Brown, 2007)
4. Participating in nurse support groups and seeking support from one's sponsor have been shown to be effective strategies. An increase in attendance at support meetings should be promoted as soon as medically possible.
5. The nurse should not be in possession of the controlled substance. Any medication for a controlled substance should be "held" by a trusted family member, friend, or sponsor who understands the need for caution with the medication and is readily accessible.
6. The nurse may be expected to discontinue active nursing practice until evidence is provided that controlled substance use has been discontinued.

If a nurse is unable to discontinue use of controlled substances, the situation must be evaluated on a case-by-case basis. The needs of a diagnosed chemically dependent nurse who has had a relapse are very different from the same chemically dependent nurse whose medical condition requires ongoing pain control. (Weissman, 2005) These situations need customized evaluation and interventions.

The Role of the Board of Nursing

The board's role in the management of nurses with dual diagnoses of chemical dependence and pain must address both issues.

When a board uses a non-disciplinary alternative program to manage the nurse with both chemical dependency and pain, appropriate program oversight is essential and includes:

- To have in place policies that articulate board expectations when recovering nurses are dealing with pain issues.
- To periodically review program policies and procedures.
- To deal with cases referred for board discipline.
- When a board uses the disciplinary process to address cases involving chemical dependency and pain, evaluations support informed decisions.
- To use evaluator's recommendations to support board decisions regarding a nurse's ability to practice safely, including whether the nurse should be separated from practice or can continue to practice or re-enter nursing practice.

- To use the evaluator's recommendations to develop requirements for monitoring compliance with the board's order.
- To identify any discrepancies between the board's findings and the outcomes of the evaluation, and to provide additional information to the evaluator if needed.
- To protect the public by basing disciplinary actions on the behavior and the resulting harm or risk of harm.
- To be responsible for determining the outcome of a case.

An evaluation report addressing the nurse's chemical dependency and pain management can be used to assist board members in making an informed decision. As with the nurse in pain, disciplinary action should be based on the behavior and the resulting harm or risk of harm. The evaluator's recommendations can be incorporated into the final order in relation to the requirements for continued recovery, pain management, monitoring, and staying in or re-entering nursing practice. If there is discrepancy between the board's findings and the outcomes of the evaluation, the board may need to provide additional information and request re-consideration by the evaluator.

Conclusion

As noted in the previous section, situations involving pain management are challenging cases for boards of nursing. Adding an overlay of chemical dependency increases the complexity of the situation. It is imperative that a chemically dependent nurse inform all health care providers that he/she is in recovery, as well as advising to other unique health needs. The nurse should consult a health care provider who understands chemical dependency, prescribes appropriately and will support the nurse's recovery. If a nurse is unable to discontinue use of controlled substances, the situation must be evaluated on a case-by-case basis. These situations need customized evaluation and interventions, and may ultimately impact safety to practice.

The opinion of a professional evaluator, addressing both pain and chemical dependency issues may be assistive in identifying any safety to practice implications for the chemically dependent nurse in pain. The nurse must have insight into how the combination of chemical dependency, pain, and pain treatment is affecting his/her ability to practice safely. When this insight is lacking, final authority rests with the board. The licensee must understand that while the board is the final decision maker, ultimately, the nurse is accountable for his/her practice and professional behavior.

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SECTION NINE:

Standards of Pain Management Nursing

Many nursing organizations develop professional standards to guide specific areas of nursing practice. The American Nurses Association (ANA) and American Society for Pain Management Nursing (ASPMN) have developed Standards of Practice for Pain Management Nursing. (ANA and ASPMN, 2005) These standards provide guidance in the areas of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation (see appendix for more information about these standards, as well as other pain resources). These standards provide guidance for the nurse who tailors nursing care to each unique patient situation. Boards of nursing often refer to professional standards of practice to support decisions.

Standards of Pain Management Nursing

Documentation of assessment, treatment outcomes, and ongoing follow-up is important for patient safety and communication with other health team members. The ASPMN and ANA standards of pain management nursing practice include:

- Assessment – the collection of comprehensive data pertinent to the pain problem.
- Analysis – of the assessment data to determine pain diagnoses or problems.
- Outcome identification – for an individualized care plan for the patient in pain.
- Planning – developing a plan that prescribes strategies and alternatives to attain expected outcomes.
- Implementation – of the pain management plan, including documentation of implementation and modifications, including changes or omissions.
- Coordination of care – including the pain management plan, health teaching/promotions and consultation.
- Evaluation – of progress toward attainment of acceptable outcomes. (ASPMN/ANA, 2005, 11-21)

In addition, the ASPMN/ANA include standards of professional performance, addressing the:

- Quality of nursing practice – including documentation, evaluation, creativity and innovation in nursing practice to improve pain management.
- Education (ongoing competency) – attaining knowledge and competency reflecting current pain management practice.
- Professional practice evaluation in relation to standards, guidelines, relevant statutes, rules, and regulations – self-evaluation of one’s own nursing practice compared to expected standards.
- Collegiality (interaction with and contribution to professional development of others) – including sharing knowledge with others, maintaining caring relationships and contributing to a supportive and health workplace.
- Collaboration with patient, family and others – to involve them in planning and implementation of pain management.
- Integration of ethical standards – to protect patient autonomy, dignity and rights, maintain confidentiality, develop effective therapeutic relationships, deal with ethical issues and report illegal, incompetent, and/or unsafe pain management practices.

- Use of research findings – integrating pain research findings into clinical practice.
- Resource utilization – by considering factors related to safety, effectiveness, cost and impact on practice.
- Leadership – including direct coordination of care (including oversight of licensed and unlicensed staff in assigned or delegated tasks) and promotion of health work environments to better meet desired patient outcomes. (ASPMN/ANA, 2005, 23-33)

Standards of Pain Management Nursing for the APRN

The ASPMN/ANA Standards also address practice of the APRN. They include:

- Assessment – initiation and interpretation of diagnostic tests and procedures.
- Diagnosis – uses data and information from patient interview, physical examination, and diagnostic procedures; and compares and contrasts complex clinical findings with normal and abnormal variation along with developmental events to formulate an individual diagnosis.
- Outcome identification – that incorporates scientific evidence, support the use of clinical guidelines, and are achievable through evidence-based practices; and considers cost and clinical effectiveness, patient satisfaction; and promotes continuity and consistency of care.
- Planning – assessment, diagnostic testing, and therapeutic interventions in the pain management plan that reflect current evidence and clinical guidelines.
- Implementation – collaborates with nurses and other disciplines to use systems and community resources to implement the pain management plan, including documentation of implementation and modifications, including changes or omissions.
- Coordination of care – provides leadership in the coordination of interdisciplinary health care team for integrated delivery of the pain management plan and coordinates resources to enhance delivery of pain care across systems.
- Consultation – influences the management of pain, enhances the ability of others, involves patients and families in decision-making, and communicates recommendations to facilitate understanding, enhance work of others, and effect change.
- Prescriptive authority and treatment – uses authority in accordance with state and federal laws and regulations to prescribe evidence-based treatments and therapies based on the clinical pain indicators, the patient status and needs, and the results of diagnostic and laboratory tests.
- Evaluation – the accuracy of diagnosis and effectiveness of interventions as well as the impact on the patient, family, and community; and recommend/make process or structural changes, including policy, procedure, or protocol documentation as needed. (ASPMN/ANA, 2005, 11-21)

In addition, the following APRN professional performance standards are identified:

- Quality of practice – obtains/maintains professional certification in pain management and evaluates self, environment, and the quality of pain nursing care in relation to existing evidence.
- Education – continues to expand clinical skills, enhance role performance, and increase knowledge of pain management.
- Professional practice evaluation – uses a formal process to seek feedback regarding one's practice from patients, peers, professional colleagues, and others.

- Collegiality – models expert pain management practice, mentors other nurses, and participates with interdisciplinary teams who contribute to APRN role development and healthcare.
- Collaboration – facilitates an interdisciplinary process to enhance patient care through education, consultation, management, technological development, and research; documents changes and rationale in plan of care; and pursues collaborative discussions to improve pain management.
- Ethics – informs patients of risk, benefits, and outcomes of pain management plan and participates in interdisciplinary teams that address ethical risks, benefits and outcomes of pain management plan.
- Research – contributes to pain management nursing knowledge by conducting or synthesizing research and disseminates research findings.
- Resource utilization – uses organizational and community resources, and develops innovative solutions that use resources effectively while maintaining quality.
- Leadership – provides direction, initiates, and revises pain management protocols or guidelines to reflect evidence-based practice, accepted changes, and addresses emerging pain management problems; promotes communication of information and advances profession through writing, publishing, and presentation to lay or professional audiences; and works to influence decision-making bodies to improve pain management. (ASPMN/ANA, 2005, 23-33)

These professional standards provide guidance for the nurse and advanced practice nurse addressing pain management issues. Their application in patient situations should be customized to the individual patient needs and situation. All nurses need to understand state and federal laws related to their practice; keep current in knowledge and skills; establish and maintain appropriate therapeutic boundaries; and adhere to professional, behavioral and ethical standards. Nurses who do these things, with caring and common sense, can enhance a patient's quality of life by meeting their needs for safe and effective pain management.

Conclusion:

Boards of nursing often refer to established professional standards when making licensure decisions. Boards expect nurses to be knowledgeable, skillful and follow professional, behavioral and ethical standards of nursing practice. Nurses who adhere to nursing standards for pain management and practice within the appropriate nursing role are likely to avoid violations of Nurse Practice Acts.

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SECTION TEN:

Regulatory Implications: the Role of the Nurse in Pain Management

The under-treatment of pain is a serious public health issue in the U.S. (Pain and Policy Studies Group, 2007) An estimated 50 million Americans suffer from persistent pain each year according to the American Pain Foundation. Many of them do not receive effective pain relief. Pain can hinder patient recovery from injury and disease and affect the patient physically, psychologically, socially, spiritually, and economically.

Boards of nursing fully support the nursing role in the thorough assessment, interventions, and effective management of pain. A board's mandate of public protection includes a

responsibility to protect the public from either over- or under-treatment of pain. If pain is managed appropriately, the patient can recover more quickly. In meeting the needs of patients in pain, nurses fulfill the classic nursing role as a patient advocate by promoting and implementing collaboration with health care professionals to provide pain management for patients in pain.

The role of the RN is to first have an understanding of pain. The RN identifies pain and assesses the patient's condition. The RN implements the pain management regimen by safely and accurately administering pain medications and treatment as ordered and on time. The RN is a patient advocate and provides a patient safety net by seeking clarification of unclear orders and questioning risky treatment. The role of the LPN/VN is to contribute to the planning of care, monitoring of patient conditions, and implementing ordered pain treatment. The LPN/VN assists in providing a patient safety net by recognizing condition changes and reporting observations to the RN or physician. The LPN/VN also can advocate for the patient and assist in educating patients. (NCSBN, 2004) The role of the APRN is discussed under a separate heading in this document.

What the Board Needs to Know

Effective treatment of pain requires nurses to be aware of patient needs and to become skillful at the assessment of pain. The nurse needs to be knowledgeable about available treatment options and ordered protocols. Expanding knowledge and emerging new technologies require the nurse to maintain current information about pain management standards and topics relevant to the nurse's practice role.

In all types of facilities and homecare, the nurse typically has the most direct contact and spends the most time with patients. The nurse has the opportunity to assess the various physical, psychological and social elements that can complicate effective pain management. *As the patient advocate who recognizes the importance of the patient's values, goals and preferences, the pain management nurse uses effective communication skills and coordinates the pain plan of care with the patient/family, physician and other healthcare providers.* (ANA, ASPMN, 2005, p.5)

Boards also need to be aware that patients, family members, and other members of the lay community may not understand the need for pain management. Patients may also fear addiction or being thought of as addicts. Other fears may include:

- Pain means the patient's condition is worse.
- Reporting pain will distract from the treatment of the underlying disease (this often results in patients behaving stoically, trying to be a "good patient" who does not complain).
- Serious side effects may result from the use of pain medications, especially opioids.
- Using the medication now will limit its effectiveness in the future, "when really needed." (Mcaffery, p. 10)

Several state boards of nursing have addressed expectations regarding pain management. The California Board of Registered Nursing adopted a standard of care for California RNs assessing pain and evaluating response to pain interventions using a standard pain management scale. Patient self-reports and pain assessment are to be recorded with each set of vital signs for each patient. (CA BORN, 1999) The Oregon Board of Nursing developed a pain management position statement in 2004 that addresses the role of the RN and APRN in assessment of pain and administration of relief measures. The Minnesota and Kansas Boards of Nursing have developed joint statements with their respective state boards of medicine and pharmacy regarding the importance of adequate pain control (see Appendices for links to these and other board of nursing statements).

North Carolina also collaborated with medical and pharmacy boards to develop a statement that addresses how pain management is essential at the end-of-life. Scott Fishman, MD, Chief of the Division of Pain Medicine and Associate Professor of Anesthesiology at the University of California, Davis, observes:

When someone is dying, time is a luxury and wait-and-see is not an option. What matters most in the final days is that patients are free of crippling pain and unbearable suffering so that they can finish their lives in ways that bring comfort, peace, and completion. Concerns about lasting side effects or diminished physical capacity from months of using a drug become secondary to making a patient comfortable. No one has to die in pain.” (Discovery Health, 2008)

Resources such as the *American Pain Society Statement on Treatment at the End-of-Life* are available to educate board members and staff regarding the role of pain management in palliative and end-of-life care.

The Federation of State Medical Boards (FSMB) indicated in *Model Policy for the Use of Controlled Substances for the Treatment of Pain* that the following circumstances contribute to the prevalence of under-treated pain:

- Lack of knowledge of medical [and nursing] standards, current research, and clinical guidelines for appropriate pain treatment;
- The perception that prescribing [or administering] adequate amounts of controlled substances will result in unnecessary scrutiny by regulatory authorities;
- Misunderstanding of addiction and dependence;⁸ and
- Lack of understanding of regulatory policies and processes. (FSMB, 2004)

These circumstances relate to nursing as well as medicine. Employers, boards of nursing, the Drug Enforcement Agency (DEA), and others, including patients and their families, may communicate differing, or even conflicting, expectations. Nurses may feel unsure about pain management because these differing expectations seem to pull in different directions. In addition, nurses may be concerned about possible side effects or fear patients will become tolerant or addicted to controlled drugs.

Other groups that may not be adequately informed about pain management are law enforcement and prosecutors. There have been situations when a prosecutor became alarmed because of high and increasing doses of controlled substances for a group of patients, not understanding that this is a pattern that is expected in a hospice or palliative care setting. Bringing actions against medical personnel for over-treatment of pain contributes to the fear of being investigated for over-administering or over-prescribing controlled substances for pain. This fear can pose a barrier to effective pain management. Nursing boards can be effective educators for law enforcement and prosecutors as well as consumer groups.

The Role of the Board of Nursing: Framework for Proactive Board of Nursing Functions

Boards of nursing are charged with regulating the practice of nursing by assuring the competency, safety, and accountability of nurses. Traditionally, this work has been accomplished through the licensure process (requiring individuals to meet requirements before being authorized to practice nursing) and the disciplinary process (responding to problems brought to the attention of the board through board action). Boards are beginning to develop other proactive strategies to address the regulatory aspects of pain management. The elements that provide the foundation for proactive board functions include:

⁸ Addiction is a primary, chronic disease while physical dependence is a state of adaptation that is manifested by signs and symptoms produced by abrupt session or rapid dose reduction. Physical dependence does not equate with addiction. (FSMB, 2004)

- State Statutes and Administrative Rules provide the board's authority to regulate nursing. Specific areas that can support pain management:
 - Nursing education approval – most boards of nursing approve nursing education programs in their jurisdiction. Rules should provide flexibility and support the inclusion of the following elements in nursing education:
 - Theory and clinical experience in pain management (usually presented as part of an integrated nursing curriculum).
 - Balance between promoting pain relief and protecting against drug abuse.
 - Continued competence – pain management is an important topic to be addressed in ongoing professional development activities. (e.g., one state legislature has mandated pain management continuing education for all licensed health care providers, including nurses. A mandatory online program introduces the pain management domain in Oregon. Nurses are then required to acquire at least seven additional hours of continuing education within their license renewal period.) (OR BON)
 - Disciplinary process – holding nurses accountable for practice:
 - Authority to require physical, mental and/or chemical dependency evaluations upon the demonstration of cause;
 - Investigations of alleged violations of the Nurse Practice Act;
 - Actions required when nurse's pain or treatment for pain impairs the ability to practice safely;
 - Actions required when a chemically dependent nurse in pain impairs the ability to practice safely; and
 - Actions required when a nurse fails to meet expectations for managing patients' pain effectively.
- The Board's Mission Statement and Strategic Goals articulate the goals of the board and how they are to be achieved, including the expectations that:
 - Public protection includes access to effective patient care and assurance of the competency and accountability of nurses.
 - Boards of nursing need to have knowledge about the complexity of pain management, understanding that:
 - Under-treatment of pain is a critical public health problem;
 - Standards of practice for pain management have been articulated;
 - An array of therapies and tools are available for use in pain management;
 - Nurses may fear scrutiny by regulators, fearing disciplinary action for administering too much pain medication; and
 - Under-treatment of pain decreases patient functional status and quality of life, just as over-treatment can result in serious patient harm. The balance of promoting appropriate pain management with inappropriate use of pain medications and patient safety, while those who fail to provide adequate pain interventions may be subject to disciplinary action for failing to meet professional standards.
- Identification of who is involved/affected – stakeholders affected by or involved in the regulatory issues of pain management could include board members, board staff,

nursing educators, nursing employers, professional evaluators, nurses, students, policy makers, the public and others depending on the type of regulatory issue involved.

- Expectations – examples of desired outcomes include demonstrated nurse competence, patient advocacy/safety, and adherence to laws and rules. Specifically, boards may articulate expectations regarding pain management and provide support for practicing nurses through board statements, guidelines, and other resources.
- Collaboration with others with an interest in public protection, best health care practices, patient advocates:
 - Promoting and implementing collaboration with other healthcare team members to provide effective pain management, so continuing education in communication, teamwork and advocacy are also desirable.
 - Boards, educators and nursing service can work together to assure that students, novice and experienced nurses are exposed to current standards and practice expectations, the latest research and clinical guidelines, the whole range of tools to manage pain (not only medications), and provide the opportunity to learn about the difference between drug dependence, drug addiction, and other concepts of pain management.
- Assurance of appropriate intervention, decision-making when problems are reported – once a board has identified that a nurse has failed to meet the expectations of nursing standards, the board must determine the appropriate course of action.
 - To provide remedies that may include education, monitoring and other requirements customized for the nurse’s situation.
 - To base disciplinary actions on the behavior and the resulting harm or risk of harm.
 - To be responsible for determining the outcome of a case.
- Education regarding pain management – boards may provide information for nurses and employers regarding the accountability of nurses, including any specific duty to report violations. Boards may offer information when law enforcement and prosecutors confuse appropriate nursing activities with overmedicating patients. Boards can reach out to patients regarding what they should expect as recipients of nursing care.
- Resources for further information about pain management – boards may share materials and resources related to the regulatory implications of pain management (see Appendix).

Conclusion

It is vital that boards of nursing understand the roles of licensed nurses in pain management and controlled substance administration, as well as the other complexities of this aspect of nursing care. The role of the RN is to first identify pain and assess the patient’s condition. The RN implements the pain regimen by safely and accurately administering pain medications treatment as ordered and on time. The RN is a patient advocate and provides a patient safety net by seeking clarification of unclear orders and questioning inappropriate treatment. RNs can recognize when pain strategies are not effective, and then collaborate with other providers to modify the pain management plan. They play an important role in educating patients, families and the public regarding pain management. The role of the LPN/VN is to monitor patient conditions and implement ordered pain treatment. The LPN/VN assists in providing a patient safety net by recognizing condition changes and reporting observations to the RN or physician. The LPN/VN also contributes to planning, assists in educating patients and families, and can advocate for patient needs.

Boards can undertake proactive activities, such as educating nurses, identifying pain management resources, and developing guidelines regarding the regulatory implications. And while it is the responsibility of the individual nurse to pursue ongoing education appropriate to his/her practice setting and patient population, when violations of the Nurse Practice Act are proven, boards of nursing are responsible for holding nurses accountable.

Boards may obtain feedback regarding proactive strategies from the many stakeholders interested in the regulatory aspects of pain management. The ideal result is the nursing regulation that functions as a support, not a barrier to the implementation of pain management by nurses who uphold standards of care and quality. When these conditions coexist, the public optimally benefits from the unique skills and knowledge of nurses.

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SECTION ELEVEN:

Regulatory Implications: the Advanced Practice Registered Nurse in a Pain Management Primary Care Role

The scope of practice of the APRN is unique in the nursing profession. The APRN practices as an independent primary care provider in a majority of states, with nearly all states conferring controlled substances prescribing authority upon APRNs, in conjunction with the DEA. In the role of primary care provider or licensed independent provider (LIP), the APRN is held to a high standard of education and practice in patient care.

In providing treatment for pain, the APRN is charged with the responsibility to diagnose the causes of pain, intervene with a variety of therapies, and evaluate the effectiveness of pain treatment being prescribed. The APRN is responsible for appropriate, accurate and complete documentation of assessment, treatment plan, informed consent and ongoing review of efficacy.

Introduction to Specific Regulatory Aspects

The Federation of State Medical Boards stated in *Model Policy for the Use of Controlled Substances for the Treatment of Pain*, that the following circumstances contribute to the prevalence of under-treated pain:

- Lack of knowledge of medical standards, current research, and clinical guidelines for appropriate pain treatment;
- The perception that prescribing [or administering] adequate amounts of controlled substances will result in unnecessary scrutiny by regulatory authorities;
- Misunderstanding of addiction and dependence; and
- Lack of understanding of regulatory policies and processes. (FSMB, 2004)

Several boards of nursing have addressed expectations regarding pain management. The Arizona and Alaska Boards of Nursing have published Advisory Opinions regarding the use of controlled substances for the treatment of chronic pain by APRNs, providing guidance regarding assessing and treating pain with controlled substances, including clear expectations regarding how the APRN is expected to comply with laws and regulations. (AZ BON, 2004; AK BON, 2006). The California Board of Registered Nursing adopted a standard of care for California RNs of assessing pain and evaluating response to pain interventions using a standard pain management scale, using patient self-report and documentation of pain assessment each time that vital signs are recorded for each patient. (CA BORN, 1999) The Oregon Board of Nursing developed a pain management position statement in 2004, addressing the distinct roles of both the RN and APRN in assessment of pain and administration of relief measures, as well as the APRN role in prescribing opioid analgesics and other interventions (see Appendices).

APRNs need to be knowledgeable about the regulation of advanced practice nursing and the significant variations in APRN scope of practice from state to state.

Professional Standards and Practice Expectations

Promoting pain relief, while at the same time preventing abuse of pain medications, becomes a balancing act. Preventing drug abuse is an important societal goal, but there is consensus by law enforcement agencies, health care practitioners, and patient advocates alike, that it should not hinder patients' ability to receive the care they need and deserve. (Joint Statement of the DEA et al., 2001)

The APRN, like all primary care providers, must work collaboratively with the patient for the best outcome. It is important for the patient to be fully informed concerning side effects as well as realistic expectations for pain relief. There are settings and situations where standards of pain management are unique, i.e. end-of-life care or disaster management.

The APRN treating acute or chronic pain is responsible for understanding the physiology of pain; treatment options, including surgical, physical therapy, pharmacologic and non-pharmacologic interventions; the pharmacokinetics, adverse effects and interactions of the medications selected for treating pain; and the appropriate documentation of treatment choices. While the use of opioid analgesics to treat pain is a legitimate medical use, there is additional responsibility for understanding the complex pharmacokinetics of these medications. Optimal pain management encompasses the correct medication, available in the correct dose, via the correct route of administration, at the correct time, with minimal and manageable side effects.

The field of pain management is rapidly evolving, with improved interventions and greater knowledge of the pharmacokinetics and molecular biology of medications. The APRN must be aware of pain treatment options, which may include aspirin, morphine, antidepressants or anticonvulsants and others, reversible interventions (such as local anesthetics, steroids, nerve blocks, trigger point injections), and irreversible interventions (such as surgery, nerve destruction). Many alternative interventions may be used in conjunction with other therapies, including acupuncture, nerve stimulation, physical therapy, and psychology. Implantable nerve stimulators and infusion pumps may be used for chronic, intractable pain. New technologies

are continually being developed, which requires the APRN to be knowledgeable about the appropriate combinations of pharmacologic and non-pharmacologic treatments.

Acute Pain

Acute pain, resulting from injury or surgical intervention, typically lasts less than three months. The principles of pain relief include the importance of titrating medication to the desired effect of pain relief, taking into account the time needed for the medication to take effect, as well as factors affecting length of effect. Co-morbidities can prolong or shorten pain relief onset and/or duration.

Chronic Pain

Chronic pain is generally defined as lasting longer than three months. Medications, opioid and nonopioid, are frequently used to treat chronic pain. Ineffective pain management may be the outcome when concerns regarding potential addiction impact decisions on the use of opioids.

Opioids are not always the first line of treatment for chronic pain. Some chronic pain syndromes do not respond to opioid medications. APRNs treating chronic pain require knowledge of a variety of categories of medications that can relieve pain. For example, neuropathic pain may respond better to antidepressants, anticonvulsants, or alpha-2 adrenergic agonists. Non-pharmacologic interventions may be helpful. Notwithstanding, the best efforts on the part of clinicians; not all patients will experience optimal relief from chronic pain, despite the appropriate use of analgesic interventions.

Some Guidelines for Documentation of Assessment and Care

There is no objective measurement of pain (MGH Handbook of Pain Management). However, appropriate assessment of history and physical findings, coupled with an understanding of pain pathophysiology guides rational, appropriate treatment. Documentation of assessment, treatment outcomes and ongoing follow-up is important for patient safety and communication with other health care providers.

Consistent with accepted standards (FSMB), accurate, legible and complete records include:

- Pain history that includes:
 - The onset and character of the pain, such as description, quality, intensity, duration, and impact of the pain on function;
 - Treatment history;
 - Relevant psychological history (including screening for anxiety, depression, somatoform disorder, coping style, and personality traits);
 - Vocational and medical legal issues;
 - General medical history;
 - Patient's perception about the cause of the pain; and
 - Patient's goals and expectations.
- Physical examination that includes an appropriate examination for the symptoms. This may be a more thorough examination in the case of acute pain or initial evaluation for chronic pain. A directed examination in ongoing chronic pain management would include:
 - Musculoskeletal;
 - Neurological;

- Skin; and
- Psychological.
- Psychological evaluation should be included in initial evaluation, with regular reassessment, addressing:
 - Screening for depression, anxiety, substance abuse;
 - Prior psychological evaluation and treatment review; and
 - History of alcohol or other drug addiction, including treatment by addiction specialists.
- Functional status – self-reported and/or objective evaluation.
- Laboratory testing and imaging as appropriate.
- Diagnosis, including contributing medical and psychiatric co-morbidities.
- Treatment plan, including:
 - Specific, measurable, realistic goals;
 - Rationale for interventions;
 - Documented discussion with the patient of risks, benefits, and alternatives;
 - Medications selected, with dose and quantity prescribed;
 - Patient education;
 - Patient agreements or contracts;
 - Plan for consultation, when needed; and
 - Plan for re-evaluation.
- Outcomes, including:
 - Pain reduction;
 - Physical function changes;
 - Psychosocial function changes;
 - Work status;
 - Medication use; and
 - Ability to self-manage pain with non-pharmacologic interventions.

In the management of chronic, nonmalignant or malignant pain,⁹ a written agreement between the APRN and the patient may be helpful when opioid analgesics are prescribed. Typical elements of a medication management agreement are:

- Regular office visits at a prescribed interval;
- Informed consent, outlining the potential risks, benefits and alternatives of the medications being prescribed;
- Limit prescription to one prescriber only;
- Limit refills to only a specified number and frequency, with no early refills;
- Use one pharmacy only, giving the name of that pharmacy;

⁹ Malignant pain refers to pain caused by metastatic growth.

- Random drug screens, urine or serum, when requested;
- Pill counts, when requested;
- Permission to speak with family members about the effects of the medications being prescribed;
- Psychological counseling as deemed necessary by the APRN; and
- Potential of discontinuation of controlled substance prescriptions.

A written agreement may not be necessary in the management of acute pain, anticipated to last less than three months. This is appropriately determined on a case-by-case basis, taking into account the individual's physical and psychological history.

Periodic review of the effectiveness of the treatment plan is critical. The APRN should reassess the appropriateness of the current plan, altering it as necessary. The treatment of chronic pain is complex and often consultations and referrals are needed for additional evaluation and treatment.

Specialized Knowledge and Skills of the APRN

The treatment of malignant and non-malignant chronic pain, as well as acute pain, is complex, requiring increased awareness and specialized education by the treating APRN. Education must include how to solicit pain level from patient, the phenomena of addiction, pseudo-addiction, tolerance, and dependence, the variety of treatment options, which include non-pharmacologic therapies, and the safe use of controlled substances and other medications.

Specialized education in pain management is the responsibility of the individual practitioner to pursue, appropriate to their practice. Graduate education and preceptors/mentors can work together to assure that graduate students, novice, and experienced APRNs are exposed to current standards and expectations regarding pain management, the latest research and clinical guidelines, the whole range of therapeutic interventions available to manage pain, and the distinctions between drug dependence and drug addiction.

Education is needed to equip APRNs to understand regulatory policies and processes and their implications for day-to-day practice. In addition to expertise in the pain management modalities, APRNs must develop competence in the expected standards of pain management. The state of Oregon has implemented statute requiring a one-time pain management continuing education course for all healthcare providers in the state.

The Role of the Board of Nursing

Many health care practitioners, including APRNs, fear being investigated for over-administering or over-prescribing controlled substances for pain. This fear can pose a barrier to effective pain management. Regulatory boards must consider the balance of promoting appropriate pain management against deterring inappropriate use of pain medications. Under-treatment of pain decreases patient functional status, safety, and quality of life.

The APRN may feel pulled in different directions by expectations of the employer, licensing board, legal requirements of the Drug Enforcement Agency (DEA), expectations of other health care team members, and the optimal care for the patient. APRNs who effectively manage pain contribute to improved quality of life for individuals, while those who fail to provide adequate pain interventions may be subject to disciplinary action for failing to meet professional standards.

Boards need to be aware that patients, family members, and other members of the lay community may not understand the need for pain management, which adds to the complexity of effective treatment. Patients may fear addiction or being thought of as an addict. They may fear that pain, especially the need for opioid medications, means that their

condition is worse. Patients may think that reporting pain will distract from the treatment of the underlying disease, so they may try to be a “good patient” who does not complain. They may be reluctant to take medications, expecting serious side effects. Sometimes those with chronic pain think that using the medication now will limit its effectiveness in the future, “when really needed.” As a result, patients may still be in pain. Caregivers are afraid of causing harm and may be conflicted between wanting to ease the patient’s pain but also being worried about addiction and side effects.

There have been situations when a prosecutor becomes alarmed because of high and increasing doses of controlled substances for a group of patients, not understanding that this is a pattern that might be expected in a hospice or palliative care setting and in some patients with persistent pain. Boards of nursing can be effective educators related to the implementation of pain management by APRNs, while upholding standards of care and quality.

If a board has identified that an APRN has failed to meet the expectations of pain management standards, the board must determine the appropriate course of action.

- Boards of nursing are charged with public protection and recognize that this protection includes access to effective patient care and assurance of the competency and accountability of nurses, including APRNs.
- Boards of nursing need to have knowledge about the complexity of pain management, understanding that:
 - Under-treatment of pain is a critical public health problem;
 - Standards of practice for pain management have been articulated;
 - An array of therapies and tools are available for use in pain management;
 - APRNs and other health care practitioners may fear scrutiny by regulators; and
 - APRNs and other health care practitioners may fear disciplinary action for administering too much or too little pain medication.
- Boards of nursing have an opportunity to collaborate with graduate program educators and preceptors to support pain management practice through education about the:
 - Standards of pain management; and
 - APRN authority to prescribe, including:
 - Prescribing controlled substances.
- Guarding against misuse of prescription forms:
 - Balance between promoting pain relief and preventing drug abuse; and
 - Regulatory process and disciplinary implications when an APRN fails to meet expectations for managing patients pain effectively.
- Boards of nursing expect APRNs to:
 - Maintain their knowledge of the complexities and challenges of pain management;
 - Implement pain management treatment standards, including pain assessment, intervention, documentation, and evaluation;
 - Appropriately consult with specialists;
 - Comply with state and federal Controlled Substances Law and Regulations;
 - Advocate for patient needs; and

- Collaborate and cooperate with other health team members in addressing patient pain.

Conclusion

As independent primary care providers, APRNs are responsible for providing compassionate, evidence-based healthcare. When statutes and regulations permit, APRNs may accept the additional responsibility for prescribing controlled substances for pain management. To assure competence, APRNs are accountable for acquiring and maintaining the knowledge and clinical expertise to provide this type of healthcare.

Boards of nursing are charged to protect the public through the regulation of safe nursing practice. It is vital that boards of nursing understand the complexities of pain management and controlled substance prescribing. The ideal result is implementation of nursing regulation that function as a support, not a barrier, to the implementation of pain management by APRNs, while upholding standards of care and quality. When these conditions coexist, the public optimally benefits from the unique skills and knowledge of APRNs.

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SECTION TWELVE:

Appendices

- A. Links to Member Board Pain Resources
- B. Summary of Literature Review
- C. Characteristics of Alternative Programs Compared to Characteristics of Disciplinary Process
- D. Regulatory Implications of Pain Management: Critical Questions
- E. Pain Management Questions for Board Policy Discussions

F. Other Resources

Appendix A:

Links to State Board of Nursing Pain Management Resources

A number of boards of nursing have developed resources related to the regulatory implications of pain management. This list identifies those Member Boards and provides the link to their resources.

Alaska Board of Nursing Advisory Statement:

The Use of Controlled Substances for the Treatment of Pain by Advanced Nurse Practitioners

<http://www.dced.state.ak.us/occ/pub/nur1808.pdf>

Arizona State Board of Nursing Advisory Opinion:

The Use of Controlled Substances for the Treatment of Chronic Pain

http://www.azbn.gov/Documents/advisory_opinion/AO%20Controlled%20Substances-Use%20for%20Treatment%20of%20Chronic%20Pain.pdf

California Board of Registered Nurses

The Nurse's Role in Pain Management

<http://www.rn.ca.gov/pdfs/regulations/npr-i-32.pdf>

Kansas Board of Nursing (with Board of Healing Arts and Board of Pharmacy)

Joint Policy Statement of the Boards of Healing Arts, Nursing and Pharmacy on the Use of Controlled substances for the Treatment of Pain

http://www.ksbn.org/positionstatements/joint_policy_statement.pdf

Maryland Board of Nursing

Pain Management Nursing Role/Core Competency – A Guide for Nurses

www.MBON.org/practice/pain_management.pdf

Michigan Board of Nursing

Guidelines for the Use of Controlled Substances for the Treatment of Pain

http://www.michigan.gov/documents/mdch_nurseguidelinesusecpain_139444_7.pdf

Minnesota Board of Nursing (with Boards of Medical Practice and Pharmacy)

Joint Statement on Pain Management Minnesota Boards of Medical Practice, Nursing and Pharmacy

http://www.state.mn.us/mn/externalDocs/Nursing/Joint_Statement_on_Pain_Management_091704014840_Jointstatement.pdf

New Mexico Board of Nursing

Administrative Rule 16.12.9 Management of Chronic Pain with Controlled Substances

<http://www.bon.state.nm.us/pdf/nmacpart9.pdf>

North Carolina Board of Nursing (with Boards of Medicine and Pharmacy)

Joint Statement on Pain Management in End-of-Life Care

<http://www.ncbon.com/content.aspx?id=888&terms=Pain+management>

North Dakota Board of Nursing

Role of the Nurse in Pain Management Practice Statement

<http://www.ndbon.org/opinions/role%20of%20nurse%20in%20pain%20mgmt.shtml>

Oregon State Board of Nursing

Position Statement for Pain Management

http://www.oregon.gov/OSBN/pdfs/policies/pain_management.pdf

Utah Board of Nursing

Rules for all practitioners with prescribing authority: Subsection 58-1-502 (6) it is

unprofessional conduct for failing, as a practitioner, to follow the FSMB Model Policy for the Use of Controlled Substances for the Treatment of Pain.

Wisconsin Board of Nursing White Paper

Pain Management

<http://drl.wi.gov/boards/nur/pap/pap14.pdf>

APPENDIX B

Literature Review

Much has been studied and written about the topic of pain – there are textbooks and many books on the subject. Some of the articles reviewed by the NCSBN Disciplinary Resources Committee were published in academic journals; others were in the popular press and more on the internet. Selected article abstracts, grouped by specific aspect of pain management, are below.

Pain Background

- In the early 1990s, the Agency for Health Care Policy and Research, Public Health Service, and the U.S. Department of Health and Human Services conducted expert panels to develop a number of clinical guidelines on a variety of health topics, including pain management. The guidelines describe principles of patient care derived from a systematic analysis of the scientific literature and from opinions of expert panels. In addition to the clinical guidelines, AHCPR developed a quick reference for clinicians and a patient and family practice guideline. Although dated, these references are included because of the process used for development and the historical value of the documents (a snapshot of pain management 20 years ago).
- A Robert Wood Johnson Foundation article stated that untreated or inadequately treated pain is one of the worst medical problems in the U.S. and that we face an epidemic of untreated and inadequately treated pain. While the tools are available to treat most pain effectively, many people continue to suffer. The article discusses reasons for this, and discusses the results of a 1999 Gallup survey about Americans and pain.
- The Joint Commission (2001) presented an institutional approach to pain assessment and management. It addresses issues of under-treatment; the rights and ethics of pain management; pain assessment, care, and education; and how to improve organizational performance. How pain assessment and management is addressed in Joint Commissions surveys and case studies.

Pain Management Nursing

- McCaffery and Pasero's *Pain: a Clinical Manual* is a classic textbook on nursing pain management. Content ranges from reasons for the under-treatment of pain; the anatomy and physiology of pain; types of pain; harmful effects; pain assessment; pharmacological treatment-how different analgesics work;non-pharmacological approaches to pain; pain in different age groups; selected pain problems; pain and addiction; and how to build institutional commitment to improving pain management.
- Compton and Mcaffery (2001) responded to a question about treating acute pain in addicted patients that one should never withhold opioids from someone in acute pain who suffers addictive disease. No scientific evidence exists to show that providing opioid analgesia to these patients worsens the addiction. Acute pain should be treated immediately with opioids and with analgesia around the clock to maintain blood levels. The authors note that a patient tolerant to opioids will likely need more pain control than someone who is not. As acute pain decreases, plan with the patient to taper the analgesic gradually.

- Mcaffery, Grimm, Pasero, Ferrell and Uman (2005) investigated the term “drug seeking” and found that nurses believed that term was likely to mean the patient was addicted, was abusing drugs or was manipulative. Their findings indicated there is a high level of confusion and stigma likely to be present in the care of a patient who is labeled “drug seeking.” A better description would be “concern-raising behaviors. They recommend a differential diagnosis be done when questionable behaviors occur during the course of pain management.
- Wisconsin Cancer Pain Initiative (1995) developed competency guidelines for cancer pain management in nursing education and practice. The following competency areas are identified: knowledge of basic principles, assessment, intervention, and side effects/risk management.

Advanced Practice Registered Nurses and Pain Management

- Starck, Sherwood and McNeill (2003) identified factors in the mismanagement of pain, effective tools and best practices for pain management, including guidelines, assessment tools, report cards, and managing interactions with patients and families.
- Lazarus and Downing (2003) discuss elements related to pain management and regulatory factors that affect the treatment of pain. They provide an overview of the evolution of advanced practice nursing and research results about nurse practitioners in Alabama, including perceptions about prescriptive practices and pain management. They related experiences of the Alabama Board of Nursing in monitoring and investigating nurse practitioners for compliance with prescriptive authority. The study confirmed the belief that lack of prescriptive authority has delayed pain treatment. However, almost half of the Alabama nurse practitioners did not feel adequately prepared for prescribing controlled substances.

Pain Policy

- In 1999, researchers at the University of Wisconsin-Madison Medical School conducted a study of state law and regulatory policies that may promote or impede the use of morphine and other controlled substances for pain relief. Researchers at the Pain and Policy Studies Group at Wisconsin identified law and policies in 16 states and the District of Columbia that could affect pain management. They recommended that “balance” should be the central principle of policies related to pain relief (government policies to prevent abuse of controlled substances should not interfere with the use of controlled substances for the relief of pain).
- The Pain and Policy Studies Group of the University of Wisconsin School of Medicine and Public Health, Paul P. Carbone Comprehensive Cancer Center has issued three progress reports (including the 1999 work described above) on Achieving Balance in State Pain Policy, the third edition in 2007. They emphasize the need for balance between practitioners’ ability to provide adequate pain management with the need to prevent drug diversion and abuse. States are rated on eight criteria that identify policy language with the potential to enhance pain management and eight criteria that identify policy language with the potential to impede pain management.
- Chan and Fishman reviewed the regulatory and legal aspects of the use of opioids in pain relief, concluding that the environment is in a state of flux. The article also looks at future trends concerning the regulation of chronic opioid treatment.
- Bolen discussed the role of law in medical decision making in opioid treatment and how to put legal and regulatory materials to work for the practitioner.
- Martino argued that a complex “ethic of under-prescribing” underlies the reluctance of many physicians to use opioids to treat chronic pain. She contends that the state medical boards are positioned to promote a new ethic for pain control, and that

success hinges on boards being able to change their approach to pain management and persuade a skeptical medical community that under-prescribing not only puts patients at risk, but that physicians can be disciplined for not meeting pain management standards. Effective pain management will better serve patient needs as well as assuring that the physician is meeting expected standards of care.

- Gilson and Joranson wrote about likely under-treatment of pain among patients with addiction disease as well as laws and regulations that pose barriers to effective treatment.
- Foley discussed how to dismantle the barriers so that practitioners can improve palliative and end-of-life care. These barriers include health care provider's fears and lack of knowledge (major medical and nursing texts devote only a few pages to pain and symptom control) as well as misguided legislation in some jurisdictions.
- Gilson, Joranason and Maurer (2003) state that since 1989, 41 states had adopted policies relating to controlled substances, written from multiple perspectives and largely inconsistent. In 1997, the Federation of State Medical Boards (FSMB) recognized the need for more consistency in state pain policies and convened a panel of experts to draft a model policy. The FSMB adopted the guidelines in 1998 and sent it out to state medical boards and asked them to consider adopting. As of the writing of this article, 21 states had adopted all or part of the statement. Two additional states endorsed the policy. Many state medical boards have exhibited a willingness to promulgate board policy that encourages treatment of pain and work to remove barriers to pain management. Once a board adopts such a policy, it must be implemented. The authors suggest a three tiered process for implementation: the training of investigators about the current standards of pain management, disseminating the policy to licensees, and using radio and television to reach the general public.

Pain Statements and Positions

- American Nurse Association (ANA) and the American Society for Pain Management Nursing (ASPMN)
ANA and ASPMN published *Pain Management Nursing: Scope and Standards of Practice* in 2005. These are discussed in the Standards section of this paper.
- American Society for Pain Management Nursing (ASPMN) and the American Pain Society
This consensus statement encourages institutions to develop policies that provide practical information about pain management and promotes education for staff to facilitate competency and safety. Policies should not include explicit dosing recommendations nor should medical orders be open-ended (e.g., titrate to comfort). A pain medication order should specify an appropriate dose range and frequency of administration based on the pharmacokinetics of the opioid, the patient characteristics and the situation.
- American Society for Pain Management Nursing (ASPMN)
ASPMN published a 2002 position statement on pain management in patients with addictive disease that emphasized the importance of the nurse advocacy role in pain management. ASPMN adopted a 2003 position statement on pain management at the end-of-life, stating the importance of the nurse to advocate for pain relief and symptom management to alleviate suffering, increase the quality of life and possibly prolong life.
- The American Society of PeriAnesthesia Nurses (ASPAN)
ASPAN's position statement on pain management supports a collaborative plan between the anesthesia department and perianesthesia nurses to address pain management in the perianesthesia setting, with goals of relieving pain to allow activity, relaxation, complication prevention, and promotion of healing and optimal health.

- The Academy of Medical-Surgical Nurses (AMSN)
AMSN recognizes freedom from pain as a basic human right, thus is committed to the identification of pain management as a patient care priority, and affirms that every patient will have access to the best level of pain relief that may be safely provided.
- Oncology Nurses Society
ONS issued a 2006 position on cancer pain management, focusing on the cancer patient's right to optimal pain relief; the need for education of patients, families, and the public about therapies available to treat cancer pain; the need to eliminate regulatory, legislative, economic, and other barriers to effective cancer pain management; and the ethical responsibility of all healthcare providers to use evidence-based pain management guidelines. ONS states the need for a multidisciplinary and collaborative approach for addressing the physical, psychological, spiritual, and socio-cultural effects of unrelieved pain.
- Federation of State Medical Boards
Model Policy for the Use of Controlled Substances for the Treatment of Pain provides guidelines for evaluating the patient in pain and developing a treatment plan. It discusses the need for informed consent for treatment, periodic review of the course of pain treatment, consultation, and medical records. The importance of complying with controlled substance laws and regulations is stressed. Originally adopted in 1998, the policy was revised in 2004 with an added emphasis on the concern that pain is often untreated. A number of medical licensing boards have adopted the model policy.

Pain Management Standards

- The American Nurse Association (ANA) and the American Society for Pain Management Nursing (ASPMN) published *Pain Management Nursing: Scope and Standards of Practice* in 2005. Pain is the most common nursing diagnosis, thus is important for the practice of all nurses standards for the RN address assessment, identification of pain problems (nursing diagnosis), outcomes identification, and developing a pain management plan. In addition, there are standards of professional performance, addressing the quality of nursing practice, education, professional practice evaluation, collegiality (interaction with and contribution to professional development of others), collaboration with patient, family and others – to involve them in planning and implementation of pain management and leadership (coordination of care and oversight of licensed and unlicensed staff). The same standards apply to APRN and there are additional measurement criteria for the APRN. In addition, a standard for prescriptive authority and treatment is provided for the APRN.
- The Joint Commission on Accreditation of Healthcare Organization's (now the Joint Commission) 2001 pain management standards state that every patient has a right to have his or her pain assessed and treated. These standards were the product of a two-year collaboration between the Joint Commission and the University of Wisconsin – Madison Medical School. PC.2.04.0 states that The [organization] assesses and manages [patient]s for pain.
- The Joint Commission published *Pain Assessment and Management: an Organizational Approach* in 2000. This book discusses the Joint Commission's expanded requirements for pain management in hospitals, long term care facilities, behavioral health care facilities, ambulatory care, and health care networks. It provides a step-by-step approach for achieving the organizational commitment needed to improve pain management by identifying and breaking-down organizational barriers to effective pain control.
- Chapman (2000) wrote in anticipation of the new standards for pain assessment and management expected to appear in the 2000-2001 Joint Commission standards manual

that require healthcare organizations to recognize the right of patients to appropriate pain assessment and management. The author, President of the American Pain Society, observes that healthcare professionals in a wide range of facilities need guidance and instruction about pain and its management. He advocated seizing the moment and stepping forward to help.

- Chapman (2000) presented a session at the 19th Annual American Pain Society Annual Meeting, reviewing the requirements for healthcare facilities and how they can be implemented. She described 10 steps to compliance and discussed how to implement the standards in the real world, providing examples from the hospital setting, ambulatory surgery, and a behavioral health setting.

Pain and Addiction

- Ziegler wrote about safe treatment of pain in patients with a substance abuse problem and describes the challenge to clinicians as how to help patients manage pain without exacerbating or reactivating the addictive disorder. She says for the acute pain caused by surgery, trauma, or extensive dental work, opioids may be indicated to control severe pain. The treating physician or dentist may reduce the dosage of opioids administered, but this is contrary to the effective approach of giving as large a dose needed to achieve good pain control. She emphasized that untreated pain can be as big a trigger as exposure to an intoxicant. She discusses in depth two case studies.
- Scholl and Weaver state that pain is often under-treated and provide tools for addiction screening. They addressed the psychological and behavioral consequences of chronic pain treated with opioids and present guidelines for prescribing opioids.
- Grant et al., state that providers tend to under-treat pain in the population with addictive disease due to biases, misconceptions, and systems issues. Inadequate pain relief is more apt to cause relapse than the use of opioids. They discuss a number of complications that can arise when pain is under-treated in the patient with addictive disease, as well as ways to improve pain control for this population.
- Markel describes a rigorous substance abuse treatment program for health care providers in Ann Arbor, Michigan. He stated the need for such a program to have a linkage to credible sanctions.
- Webster identified risk factors for an increased abuse potential in pain patients.
- Leavitt (2004) noted that pain and addiction share some common physiologic pathways in the brain, especially those involving opioids; hence the presence of pain may influence the development and course of opioid addiction and vice versa. The undertreatment of pain is an important concern for addicted persons. Some of the barriers to effective treatment include misguided institutional practices, inadequate physician training, reluctance to provide adequate pain medications to chemically dependent persons, clinician fears of regulatory sanctions, and a reluctance by these patients to seek care because of fear of drug relapse. The author encourages better communication between pain treatment specialists and addiction treatment specialists.
- Maher-Brisen (2007) described addiction as an occupational hazard in nursing and noted work-related factors that might be associated with the use and abuse of drugs, including: working nights or rotating shifts; critical care work; excessive overtime; musculoskeletal injuries and pain; and knowledge of medications. The author states that little attention is paid to addiction in schools of nursing, and that stereotypes and stigma persist. She discussed the legal and professional discipline implications of drug diversion.

Cognition and Neuropsychological Evaluation (NPE)

- Malik and McDonald describe types of NPE, who and when to refer patients for NPE, test selection, technical issues, and examples of testing.
- Ersek et al., (2004) wrote about the cognitive effects of opioids. This article reviews the empiric literature on opioids and cognitive functioning. In general, research reflects minimal to no significant impairments in cognitive functioning. Despite subjective experiences of mental dullness and sedation, objective tests of cognitive functioning do not always demonstrate marked changes following opioid administration.
- Brown et al., conducted a study on a sample of 1,009 patients treated by 235 primary care physicians. Patients on daily opioids experienced more side effects than those taking the medication intermittently. The authors suggest that psychological measures and pain severity are more predictive of decrements in cognitive function and advise physicians to closely monitor patients for adverse effects and adequacy of pain control.

Pain Education

- Robert Wood Johnson Foundation (2002) funded an effort led by the City of Hope National Medical Center to improve nursing education in pain and end-of-life issues. Project staff reviewed and critiqued 50 nursing textbooks, surveyed members of key nursing organizations, met with nursing licensure leaders, created and distributed resources, and sponsored a national conference. The textbook analysis revealed that just two percent of textbook content addressed end-of-life issues. A follow-up examination of the 50 textbooks previously reviewed showed that 40 percent of the authors and publishers had made changes or were in the process of doing so.
- The American Geriatrics Society Foundation for Health in Aging (2002) has developed an online Patient Education Forum on Persistent Pain. Presented in a question and answer format, it provides basic information about pain, over-the-counter medications, advises how to keep a pain diary, and other suggestions for making the most of time with health care providers.
- The American Medical Association (2007) offered online continuing education modules on pain. 12 modules cover topics that include pathophysiology of pain, pain management, and pain in several specific patient populations.

Media Coverage of Pain

Most of the major periodicals in the U.S. have looked at pain at one time or another. Here are some samples:

- Schrof, writing for *U.S. News and World Report* (March 17, 1997), told the story of a physician who lost his medical license after he prescribed narcotics for hundreds of patients. His medical board found that the physician's practice was too risky and his monitoring of patients was inadequate. He was treating patients from other states because doctors there would not prescribe narcotics. After the physician stopped practicing, two of his former patients committed suicide. The article suggests that drug regulators don't know about the latest scientific data on treating pain. Some states are beginning to develop policies that support vigorous pain treatment. The physician in this story is still pursuing his case.
- Meier, writing for the *New York Times*, looked at the "delicate balance of pain and addiction." He observed that for much of the 1900s, doctors believed that patients could easily become addicted to drugs resulting in many patients in pain were denied relief. Over the past decade, "doctors specializing in pain treatment and drug companies eager to broaden the market for such drugs" championed the view that drugs posed scant risk to pain patients. This too may have had unfortunate

consequences because physicians and patients may have developed a false sense of security about the use of drugs to control pain. Now, the focus is right in the middle of these two extremes. Medical experts agree that most pain patients can use narcotics without consequences. However, the addiction risk for chronic pain patients has not been studied and the long term results are really unknown.

- Kalb, writing for *Newsweek* magazine (May 19, 2003) did a cover story on “Taking a New Look at Pain,” observed that patients are demanding that pain be seen as a condition in and of itself, not just a byproduct of injury, illness, or surgery. Congress has declared this the Decade of Pain Control and Research. New imaging technology allows researchers to begin to detangle the pain system at its molecular level. Medical scientists are developing new, targeted treatments. The author also addresses the spiritual, cultural, and emotional aspects of pain.
- Wallis, writing for *Time* magazine (Feb. 28, 2005), explored the right and wrong ways to treat pain. Presenting actual cases, looking at the cause of the pain, the patient’s age, and how they are being treated, the author looked at the causes of chronic pain and the holistic approach being taken at leading pain management centers.
- Brody, writing for the *New York Times* (Nov. 6, 13 and 20, 2007), did a series on chronic pain, observing that pain that doesn’t quite change a person. Delving into the causes of chronic pain the effects on families, she presents some ideas adapted from the American Chronic Pain Association’s Family Manual, about what patients and families can do to cope. In the third article, she outlines medications and other non-drug approaches that can ease chronic pain.

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APPENDIX C

Comparison of Alternative Programs and Disciplinary Actions

There are two common approaches for regulatory management of nurses in pain, or chemically dependent nurses who have the additional challenge of pain. Many boards offer alternative or non-disciplinary programs for nurses who meet specified criteria. Whether a nurse can be referred to an alternative program or continue in an alternative program if already enrolled depends on the program's criteria for participation, the circumstances of the nurse's situation and the scope of the alternative program.

According to the *2007 NCSBN Member Board Profiles*, 43 boards reported having non-disciplinary alternative programs available for chemically dependent nurses who meet entry criteria. 13 of those programs also accept individuals with physical or health problems. The advantages of an alternative program include earlier identification, intervention, and treatment for a nurse with chemical dependency and pain issues. Nurses able to continue or return to nursing practice are monitored to assure compliance with program requirements. Nurses who comply with program expectations and complete the terms of an agreement/contract avoid having a disciplinary history associated with the nursing license. Nurses who do not comply with program agreements/contracts are referred to the board of nursing for disciplinary action.

Boards that do not offer alternative programs use the disciplinary process to manage a nurse's chemical dependency and pain issues. Discipline is also used in situations where a nurse does not meet a program's requirements for participation or does not comply with the terms of the alternative program agreement/contract. Although the discipline process takes longer, the board has the full force and effect of administrative law supporting their orders.

Figure 1 provides a comparison of important characteristics of most alternative programs and the discipline process. The major advantage of alternative programs is how quickly nurses are identified, undergo treatment, and have their practice monitored if working in a nursing role. There is an agreement executed between the nurse and the alternative program that can be accomplished in a short period of time, so the nurse's practice is monitored almost immediately.

The nurse's license to practice is considered a property right and boards must provide due process of law for the nurse who is under board scrutiny for possible violations of the Nurse Practice Act. This means the nurse must be provided proper notice of the allegations against her/him, an opportunity to challenge charges, and an objective decision maker. States vary a great deal in the details of the disciplinary process and each board must abide by the jurisdiction's Nurse Practice, Nursing Administrative Rules, the State's Administrative Procedures Act, and other state and federal statutes and rules relevant to the regulation of nursing. The time required for completing an investigation for a board of nursing ranges from a few months to a year or more. During the time of the investigation, the nurse's license is unencumbered and the nurse retains the authority to practice until the board takes disciplinary action.

Often, the terms of discipline orders require the same type of drug testing and monitoring of recovery and practice that are typically elements in alternative program agreements/contracts. Instead of a private, non-public agreement/contract with an alternative program, public disciplinary actions are taken against the nurse's license. Such administrative actions are required to be reported to federal databanks and agencies.

Figure 1. Comparison of Characteristics of Alternative Programs and Board Discipline
(NCSBN, 2004)

Characteristic	Alternative Programs	Board Discipline
Identification of problem	Some nurses refer themselves; others are referred by employers, family members, et al.	Usually via a complaint to the BON, can be from employer, patient, other nurse, law enforcement, et al.
Legal basis	Individualized agreement between program and nurse	Board discipline authority in Nursing Practice Act (NPA) and rules.
Classification of nurse's information	Not public ¹⁰ – only persons who need to know are informed	Board actions are public and required to be reported to national databanks. States vary on status of information during investigation and prosecution.
Communication with nurse	Nurse may make first contact when self-reporting; alternative program staff may contact nurse first	Varies by state, first contact can be letter from board, call from investigator, or a notice of allegations.
Collecting information	Interview with nurse, review of treatment records and other available information	Investigation varies with nature of allegations and state process; typically involves interviews with witnesses, interview with nurse, review of available records and other related information.
Evaluation	Either recommended to nurse or may be required for participation	Some states can order evaluation with cause; other states may request an evaluation during the course of an investigation.
Treatment	Nurse expected to comply with pain management plan and any CD treatment recommendations (to avoid or recover from relapse caused by pain or pain treatment)	Nurse may be ordered to comply with pain management plan (if has not already done so) as a condition for continuing or returning to nursing practice.
Time frame for beginning monitoring	In a matter of hours to a few days – as soon as nurse signs agreement	May be a few months, a year, or more – time is required to complete investigation, prosecution, or negotiation.

¹⁰ Many programs classify information as "confidential," however, a "not public" classification is recommended in the NCSBN Model Nursing Practice Act (because some people do need to know) as more descriptive of actual practice. (NCSBN, 2004)

Characteristic	Alternative Programs	Board Discipline
Can the nurse practice nursing?	Some programs may recommend a temporary period away from nursing, at least during early recovery. Specifics depend on nurse's situation, point in recovery, and other issues. Other nurses may continue to practice under monitoring.	Nurse has unencumbered license during investigation unless emergency action is taken or the nurse is willing to voluntarily surrender license during investigation. Board may determine that separation from practice until nurse meets specified requirements needed to protect the public, or if nurse is already in recovery, a board may restrict or put conditions on license or other discipline as authorized in NPA.
If out of practice, how does the nurse resume nursing practice?	Agreement may specify when the nurse may return to practice; timing may depend on nurse's progress toward recovery	Complies with requirements specified in order.
Monitoring Requirements		
Drug screening	YES	YES
Reports from self	YES	YES
Reports from pain management health care provider	YES	YES
Reports from employer	YES	YES
Reports from counselor or other CD treatment/ aftercare	YES	YES
Reports from AA or other support group attendance	YES	YES
Reports any prescribed medications	YES	YES
Periodic telephone interviews	Likely	Maybe
Periodic face-to-face interviews	Maybe	Not Likely
Return to work		
Work site	May be limited	May be limited
Hours	May be limited	May be limited
No overtime	Sometimes	Sometimes
Must inform supervisor of requirements	YES	YES
No access to controlled substances	Often for a designated period of time	Usually, with requirements to meet to regain access

Characteristic	Alternative Programs	Board Discipline
In case of Relapse		
Relapse plan	Encouraged to have in place	May be in order requirements
Effect of relapse on ability to practice	Serious relapse must be reported to board	Serious relapse by nurse under board order may result in additional action
Duration	2-5 years depending on program	Varies
Mobility – (Nurse’s ability to move to another jurisdiction)	Ability to move to a different state depends on states and programs	Depends on elements of order and the boards involved

Conclusion:

Alternative programs offer a non-disciplinary approach for regulators addressing situations involving a nurse in pain, or a chemically dependent nurse in pain. The advantages include earlier identification and much earlier monitoring of the nurse who is continuing or returning to practice. The legal basis is the voluntary agreement between the program and the nurse. Board disciplinary action may be needed when a nurse does not meet alternative program entry requirements or chooses not to participate in a program. Disciplinary action is the approach used in states that do not have alternative programs. Nurses who do not meet the terms of their alternative program agreement are referred to the board for possible disciplinary action. Although the discipline process takes longer, the board has the force and effect of administrative law supporting their orders.

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APPENDIX D**Regulatory Implications of Pain Management: Critical Questions**

These questions have been developed for use by board of nursing staff, investigators and attorneys when dealing with a discipline case involving one of the four pain issues identified in the *2007 Statement Regulatory Implications of Pain Management*. These questions could be useful when screening complaints, planning an investigation, holding a pre-hearing conference or other informal proceeding, or preparing for an administrative hearing.

The Nurse in Pain

- Where does the nurse work and what is his/her practice role?
- What is the nature of the nurse’s pain?
- Is she/he being treated for pain?
- What is the pain management plan?
- Does the nurse have insight into his/her situation?
- Does the nurse recognize how pain or the treatment for pain may compromise his/her ability to practice safely?

- Are there familial, financial or employer issues that compel the nurse to work in spite of potential compromise to safety?
- Is there a need for a professional evaluation of the nurse's pain?

The Chemical Dependent Nurse in Pain

- Where does the nurse work and what is his/her practice role?
- Does the nurse acknowledge being chemically dependent?
- Is the nurse already in a monitoring program?
- Is the nurse presenting with dual diagnoses of CD and pain?
- What is the nature of the nurse's pain?
- Is she/he being treated for pain?
- What is the pain management plan?
- Does the nurse have insight into his/her situation?
- Does the nurse recognize how pain or the treatment for pain may compromise his/her ability to practice safely?
- Does the nurse understand how unrelieved pain can increase the risk of relapse?
- Does the nurse understand how being prescribed drugs with addictive potential can increase the risk of relapse?
- Are there familial, financial or employer issues that compel the nurse to work in spite of potential compromise to safety?
- Is there a need for a professional evaluation of the nurse's pain?
- Does the nurse have support systems in place to assist her recovery?

Nurse Role in Pain Management

- Where does the nurse work and what is his/her practice role?
- Does the nurse work with patients in pain?
- Is the nurse concerned about regulatory scrutiny of his/her practice and the administration of controlled substances?
- Is the nurse familiar with the standards of pain management nursing?
- Is the nurse familiar with the policies and procedures of the facility or agency relating to pain management?
- What professional development activities has the nurse pursued? Are any related to pain management?
- What is the nurse's attitude toward patients in pain?
- Does the nurse understand the difference between tolerance, dependence and addiction?
- Is the nurse knowledgeable about the laws and rules that govern the use of controlled substances?
- How does the nurse advocate for patients who need additional intervention for pain?

APRN Role in Pain Management

- Where does the APRN work and what is his/her practice role?
- Does the APRN work with patients in pain?
- Does the APRN have prescriptive authority and a DEA number for prescribing controlled substances?
- Is the APRN concerned about regulatory scrutiny of his/her practice and the prescription of controlled substances?
- Is the APRN familiar with the standards of pain management nursing and the additional standards for APRNs?
- Is the APRN familiar with the policies and procedures of the practice, facility or agency relating to pain management?
- What professional development activities has the APRN pursued? Are any related to pain management, pharmacology, and other treatment options for pain?
- What is the APRN's attitude toward patients in pain?
- Does the APRN understand the difference between tolerance, dependence, and addiction?
- Is the APRN knowledgeable about the laws and rules that govern the use of controlled substances?
- Does the APRN collaborate with other health team members to develop, evaluate, and adjust/change the pain management plan?
- How does the APRN advocate for patients in pain?

APPENDIX E

Pain Management Questions for Board Policy Discussion

1. Unrelieved pain is a serious public health problem in the U.S. Do you agree with this statement?
2. Do you think that pain management is recognized as an important part of nursing practice?
3. The *2007 Achieving Balance in State Policy*¹¹ describes a central principle of balance – that drug control and professional practice policies and their implementation should be balanced so that efforts to prevent diversion do not interfere with the medical/ nursing use of opioids and other analgesics. Do you think that your state has achieved a good balance between practice expectation and drug control efforts?
4. There have been many pharmaceutical and technical developments in the last 25 years but the use of this knowledge in practice has been slow and is still incomplete. Why do you think there is this significant gap between what is known and what is done by all types of healthcare providers?
5. Do you think that nurses are concerned about regulatory scrutiny in your state? Why or why not?
6. As board members, do you believe you have a clear understanding of the difference between physical dependence, analgesic tolerance, and addiction?

¹¹ Pain & Policy Studies Group. (2007). *Achieving balance in state pain policy: A progress report card* (3rd ed.) Madison, WI: University of Wisconsin School of Medicine and Public Health, Paul P. Carbone Comprehensive Cancer Center. Readers can check the report for specific jurisdictions by going to: http://www.painpolicy.wisc.edu/Achieving_Balance/PRC2007.pdf

7. Do you believe that opioids should be used as the pain treatment of last resort?
8. Should a nurse in recovery for chemical dependency be given opioids after surgery or serious injury? Why? Why not?
9. Do your state nursing practice statutes have any pain-specific (directly addressing pain management) statements? If so, where do they appear?
10. Do your state nursing administrative rules have any pain-specific statements? If so, where do they appear?
11. Do your state nursing practice statutes have any pain-related (do not directly address but contain provisions that could affect pain treatment) statements? If so, where do they appear?
12. Do your state nursing administrative rules have any pain-related statements (e.g., provisions for APRN prescriptive or controlled substance prescriptive authority)? If so, where do they appear?
13. Has your board developed a position statement, paper or guidelines to educate nurses and the public about the nurse's role in pain management? If so, how has it been used?
14. If your board has not developed a position statement, paper or guidelines, why not? Possible reasons include: no need identified, board does not have authority, limited resources, not on policy agenda, and other.
15. Does your board consider failure to provide appropriate pain management as grounds for professional discipline? Has your board ever decided such a case?

APPENDIX F

Other Resources

There are many organizations addressing pain issues. Many of these groups have developed resources with emphasis on different perspectives on the pain issue. Contact information is provided below:

American Chronic Pain Association

PO Box 850
Rocklin, CA 95677
Toll Free: 800.533.3231
Fax: 916.632.3208
e-mail: ACPA@pacbell.net

American Nurses Association

8515 Georgia Ave., Suite 400
Silver Spring, MD 20910-3492
Phone: 301.628.5000
Toll Free: 800.274.4ANA (4262)
Fax: 301.628.5001

American Pain Society

4700 W. Lake Ave.
Glenview, IL 60025
Phone: 847.375.4715
www.ampainsoc.org

American Society for Pain Management Nursing

PO Box 15473
Lenexa, KS 66285-5473
Phone: 913.895.4606
Toll Free: 888.34A.SPMN (342.7766)
Fax: 913.895.4652
e-mail: aspmn@goamp.com

American Society for PeriAnesthesia Nurses

10 Melrose Ave., Suite 110
Cherry Hill, NJ 08003-3696
Phone: 856.616.9600
Toll Free: 877.737.9696
Fax: 856.616.9601
e-mail: aspan@aspan.org
www.aspan.org

The AGS Foundation for Health in Aging

The Empire State Building
350 Fifth Ave., Suite 801
New York, NY 10118
Toll Free: 800.563.4916
www.healthinaging.org

American Pain Foundation

201 E. Charles St., Suite 710
Baltimore, MD 21201-4111
Toll Free: 888.615.PAIN (7246)
www.painfoundation.org

Arthritis Foundation

1330 W. Peachtree
Atlanta, GA 30309
Toll Free: 800.283.7800
www.arthritis.org

Federation of State Medical Boards of the U.S., Inc.

PO Box 619850
Dallas, TX 75261-9850
Phone: 817.868.4000
Fax: 817.868.4099

International Association for Pain and Chemical Dependency

101 Washington St.
Morrisville, PA 19067, USA
Phone: 215.337.6104
Fax: 215.337.0959
e-mail: info@iapcd.org

Institute for Healthcare Improvement

20 University Rd., 7th Floor
Cambridge, MA 02138 USA
Phone: 617.301.4800
Toll Free: 866.787-0831
Fax: 617.301.4848

Joint Commission

One Renaissance Blvd.
Oak Brook Terrace, IL 60181
Phone: 630.792.5000

601 13th St., NW
Suite 560 South
Washington, DC 20005
Phone: 202.783.6655
Fax: 202.783.6888

National Chronic Pain Outreach Association (NCPOA)

7979 Old Georgetown Rd., Suite 100
Bethesda, MD 20814-2429
Phone: 301.652.4948

National Headache Foundation

5252 N. Western Ave.
Chicago, IL 60625
Toll Free: 888.NHF.5552 (643.5552)
www.headaches.org

Oncology Nursing Society

125 Enterprise Dr.
Pittsburgh, PA 15275
Phone: 412.859.6100
Toll Free: 866.257.4ONS (4067)
Fax: 412.859.6162
Toll Free Fax: 877.369.5497
e-mail: customer.service@ons.org

Pain & Policy Studies Group

University of Wisconsin
Paul P. Carbone Comprehensive Cancer Center
World Health Organization Collaborating Center for
Policy and Communications in Cancer Care
406 Science Dr., Suite 202
Madison, WI 53711-1068
Phone: 608.263.7662
e-mail: ppsg@med.wisc.edu