



Complete Summary

GUIDELINE TITLE

Pain management in the long-term care setting.

BIBLIOGRAPHIC SOURCE(S)

American Medical Directors Association (AMDA). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA); 2003. 36 p. [22 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: American Medical Directors Association. Chronic pain management in the long-term care setting. Columbia (MD): American Medical Directors Association; 1999. 39 p.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- [December 12, 2007, Carbamazepine](#): The U.S. Food and Drug Administration (FDA) has provided recommendations for screening that should be performed on specific patient populations before starting treatment with carbamazepine.

COMPLETE SUMMARY CONTENT

** REGULATORY ALERT **

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INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT

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SCOPE

DISEASE/CONDITION(S)

Acute or chronic pain

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Risk Assessment
Treatment

CLINICAL SPECIALTY

Family Practice
Geriatrics
Internal Medicine
Nursing
Pharmacology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Dietitians
Health Care Providers
Nurses
Occupational Therapists
Pharmacists
Physical Therapists
Physician Assistants
Physicians
Social Workers
Speech-Language Pathologists

GUIDELINE OBJECTIVE(S)

- To improve the quality of care delivered to patients with acute or chronic pain in long-term care settings
- To guide care decisions and to define roles and responsibilities of appropriate care staff

TARGET POPULATION

Elderly residents of long-term care facilities with acute or chronic pain or who are at risk of pain

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis/Assessment

1. Regular and systematic assessment for presence of pain
2. Observation for nonspecific signs and symptoms that suggest pain
3. Use of Minimum Data Set (MDS) as a tool to aid in pain assessment.
4. Identification of characteristics and causes of pain
5. Use of a standardized scale to quantify the intensity of the patient's pain
6. Identification and addressing of risk factors for pain
7. Assessment of impact pain has on function and quality of life
8. History and physical examination
9. Diagnostic testing, as indicated
 - Laboratory testing, such as fasting glucose, blood urea nitrogen, creatinine, liver profile, urinalysis, uric acid, alkaline phosphatase;
 - Radiologic testing, such as spine x-rays, computed tomography (CT) or magnetic resonance imaging (MRI) scan
10. Consultation with pharmacist and pain specialists, as needed

Management/Treatment

1. Interdisciplinary care planning
2. Environment support to promote comfort (temperature control, minimization of background noise, clean & dry skin, comfortable positioning in bed or chair, reassuring words and touch, back rub, hot or cold compresses, whirlpool, services of a chaplain or other appropriate pastoral counselor, comforting music)
3. Pharmacologic treatment
 - Non-opioid analgesics, such as acetaminophen, aspirin, and nonsteroidal anti-inflammatory drugs (NSAIDs), cyclooxygenase-2 (cox-2) inhibitors and tramadol. NOTE: The NSAIDs indomethacin, piroxicam, tolmetin, and meclufenamate are considered but not recommended for chronic use. Propoxyphene, meperidine, pentazocine, butorphanol, and other agonist-antagonist combinations are considered but not recommended.
 - Opioid analgesics (oxycodone; morphine; transdermal fentanyl; hydromorphone; methadone; combination opioid preparations, such as codeine, hydrocodone, oxycodone)
 - Other classes of drugs (corticosteroids, anticonvulsants, clonazepam, carbamazepine, anti-arrhythmics, intravenous local anesthetics, baclofen)
4. Complementary (nonpharmacologic) therapies
 - Education, cognitive/behavioral therapy, exercise
 - Other physical therapies (physical and occupational therapy, positioning, cutaneous stimulation, neurostimulation, chiropractic, magnet therapy)
 - Other nonphysical therapies (psychological counseling, spiritual counseling, peer support groups, alternative medicine, aromatherapy, music, art, drama therapy, biofeedback, meditation, other relaxation techniques, hypnosis)
5. Evaluation of response to treatment, monitoring of patient's pain, and adjustment of treatment as needed

MAJOR OUTCOMES CONSIDERED

- Pain intensity
- Pain relief
- Mood, function, sleep, and quality of life
- Safety and side effects of medications

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Interdisciplinary workgroups developed the guidelines, using a process that combined evidence- and consensus-based approaches. Workgroups included practitioners and others involved in patient care in long-term care facilities. Beginning with a general guideline developed by an agency, association, or organization such as the Agency for Healthcare Research and Quality (AHRQ), pertinent articles and information, and a draft outline, each group worked to make

a concise, usable guideline tailored to the long-term care setting. Because scientific research in the long-term care population is limited, many recommendations were based on the expert opinion of practitioners in the field.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

All American Medical Directors Association (AMDA) clinical practice guidelines undergo external review. The draft guideline is sent to approximately 175+ reviewers. These reviewers include AMDA physician members and independent physicians, specialists, and organizations that are knowledgeable of the guideline topic and the long-term care setting.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The algorithm [Pain Management in the Long-Term Care Setting](#) is to be used in conjunction with the clinical practice guideline. The numbers next to the different components of the algorithm correspond with the steps in the text. Refer to the "Guideline Availability" field for information on obtaining the full text guideline.

CLINICAL ALGORITHM(S)

An algorithm is provided for [Pain Management in the Long-Term Care Setting](#).

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The guideline was developed by an interdisciplinary work group using a process that combined evidence- and consensus-based thinking.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- This guideline recommends processes that, if followed, will help to ensure that pain among long-term care patients is adequately recognized, assessed, treated, and monitored.
- By implementing the steps described in this guideline, health care providers can meet the expectations of patients, their families, advocates, and policy makers for adequate, compassionate management of pain in the long-term care setting.

POTENTIAL HARMS

- See Table 9 in the original guideline document for a listing of possible adverse effects associated with non-opioid analgesics commonly used in the long-term care setting.
- See Table 17 in the original guideline document for a listing of possible adverse effects associated with non-analgesic drugs sometimes used for analgesia in the long-term care setting.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- This clinical practice guideline is provided for discussion and educational purposes only and should not be used or in any way relied upon without consultation with and supervision of a qualified physician based on the case history and medical condition of a particular patient. The American Medical Directors Association and the American Health Care Association, their heirs, executors, administrators, successors, and assigns hereby disclaim any and all liability for damages of whatever kind resulting from the use, negligent or otherwise, of this clinical practice guideline.
- The utilization of the American Medical Director Association's Clinical Practice Guideline does not preclude compliance with State and Federal regulation as well as facility policies and procedures. They are not substitutes for the experience and judgment of clinicians and care-givers. The Clinical Practice Guidelines are not to be considered as standards of care but are developed to enhance the clinician's ability to practice.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The implementation of this clinical practice guideline (CPG) is outlined in four phases. Each phase presents a series of steps, which should be carried out in the process of implementing the practices presented in this guideline. Each phase is summarized below.

- I. **Recognition**
 - Define the area of improvement and determine if there is a CPG available for the defined area. Then evaluate the pertinence and feasibility of implementing the CPG.
- II. **Assessment**

- Define the functions necessary for implementation and then educate and train staff. Assess and document performance and outcome indicators and then develop a system to measure outcomes.
- III. **Implementation**
- Identify and document how each step of the CPG will be carried out and develop an implementation timetable.
 - Identify individual responsible for each step of the CPG.
 - Identify support systems that impact the direct care.
 - Educate and train appropriate individuals in specific CPG implementation and then implement the CPG.
- IV. **Monitoring**
- Evaluate performance based on relevant indicators and identify areas for improvement.
 - Evaluate the predefined performance measures and obtain and provide feedback.

IMPLEMENTATION TOOLS

Clinical Algorithm
 Personal Digital Assistant (PDA) Downloads
 Tool Kits

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

End of Life Care
 Getting Better
 Living with Illness

IOM DOMAIN

Effectiveness
 Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

American Medical Directors Association (AMDA). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA); 2003. 36 p. [22 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003

GUIDELINE DEVELOPER(S)

American Medical Directors Association - Professional Association

SOURCE(S) OF FUNDING

American Medical Directors Association

GUIDELINE COMMITTEE

Steering Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Not stated

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

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This guideline updates a previous version: American Medical Directors Association. Chronic pain management in the long-term care setting. Columbia (MD): American Medical Directors Association; 1999. 39 p.

GUIDELINE AVAILABILITY

Electronic copies: None available

Print copies: Available from the American Medical Directors Association, 10480 Little Patuxent Pkwy, Suite 760, Columbia, MD 21044. Telephone: (800) 876-2632 or (410) 740-9743; Fax (410) 740-4572. Web site: www.amda.com.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Guideline implementation: clinical practice guidelines. Columbia, MD: American Medical Directors Association, 1998, 28 p.
- We care: implementing clinical practice guidelines tool kit. Columbia, MD: American Medical Directors Association, 2003.

Electronic copies: None available

Print copies: Available from the American Medical Directors Association, 10480 Little Patuxent Pkwy, Suite 760, Columbia, MD 21044. Telephone: (800) 876-2632 or (410) 740-9743; Fax (410) 740-4572. Web site: www.amda.com.

The following is also available:

- PDA application: pain management. Available in Palm/PDA and PocketPC formats from the [American Medical Directors Association \(AMDA\) Web site](http://www.amda.com).

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on July 6, 2004. The information was verified by the guideline developer on August 4, 2004. This summary was updated by ECRI on January 12, 2005 following the release of a public health advisory from the U.S. Food and Drug Administration regarding the use of some non-steroidal anti-inflammatory drug products. This summary was updated on April 15, 2005 following the withdrawal of Bextra (valdecoxib) from the market and the release of heightened warnings for Celebrex (celecoxib) and other nonselective nonsteroidal anti-inflammatory drugs (NSAIDs). This summary was updated by ECRI on June 16, 2005, following the U.S. Food and Drug Administration advisory on COX-2 selective and non-selective non-steroidal anti-inflammatory drugs (NSAIDs). This summary was updated by ECRI Institute on January 10, 2008, following the U.S. Food and Drug Administration advisory on Carbamazepine.

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