Pharmaceutical care of people with chronic pain

Course Information

Contents of pack

Your pack contains:

- *Pharmaceutical care of people with chronic pain – Course information*
- *Pharmaceutical care of people with chronic pain – Course activities*
- *Pharmaceutical care of people with chronic pain – Course resources*

Set of pharmaceutical care needs assessment tools for chronic pain (10)
Patient pain diary (5)
Universal pain assessment tool
NAPP Pharmaceuticals *Challenge pain* (1)
Pain Association *Managing pain in ten easy steps* (1)
Plan & record form
Freepost envelope
CD-ROM *Video presentation*

Acknowledgements

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Special thanks to Deborah Paton for the video lecture ‘Pharmaceutical Care of people with Chronic Pain’ provided for the CD-ROM enclosed.

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CD-ROM

The CD-ROM with Debbie Paton’s presentation will work on a PC which runs Windows 98 or later and has:

- a CD-ROM drive
- a Windows Media player version 9 or later
- a soundcard with speakers or headphones
- a web browser, such as Internet Explorer 5.0 or later, or Netscape Navigator 7 or later.

Insert the CD-ROM in your computer and wait a little
while. The CD-ROM starts automatically and will show the opening page in the browser window. (You may be prompted to download some additional software.) Click on ‘play’ to run the presentation.

If the CD-ROM doesn’t work in ‘autostart’ mode (or if you want to run it on Apple Macintosh), open the CD-ROM and double-click on the file ‘CHRONIC PAIN D Paton.htm’.

Introduction

Pharmaceutical care of people
with chronic pain

This course offers Scottish pharmacists training on how they can contribute to the care of people with chronic pain as part of their normal working practice by applying the principles of the pharmaceutical care model schemes (PCMS). This invaluable training for community pharmacists will help prepare them for the future and can be seen as a therapeutic addition to the NES/PCMS frail elderly medication review training.

The evening will start with a lecture on the management of chronic pain. This will be delivered by a practitioner with a special interest in chronic pain. This will cover aetiology, diagnosis, management and common pharmaceutical care issues. The workshops will take the form of very practical patient assessments followed by group discussion.

To help with integrated care this course is of interest to pharmacists working within all care settings.

Aim

To update pharmacists on the current management of chronic pain and explore ways to identify and meet the pharmaceutical care needs of this patient group.

Objectives

At the end of the session pharmacists should be able to

1. define the current therapeutic management of chronic pain
2. identify pharmaceutical care issues and respond to patient scenarios and identify appropriate management solutions
3. explore how to implement the pharmaceutical care needs assessment tool in practice.

Pre-course reading

Future Prescriber – “Management of chronic pain: current and future options”

DTB – “Using NSAIDS in Cardiovascular disease”
Background

Chronic pain has been defined as pain that continues a month or more beyond the usual recovery period for an illness or injury, or pain that goes on over months or years as a result of a chronic condition\(^1\). It may be continuous or come and go. Often a period of three months is chosen and early intervention can stop pain becoming chronic.

In a recent Scottish study\(^2\) examining pain in the community, 50% of respondents reported suffering from chronic pain. One third of those aged between 25 and 34 reported suffering from chronic pain, two thirds of people over the age of 65 were affected. The two most common reasons for chronic pain were back pain and arthritis. One in four people over the age of 65 suffer chronic pain due to arthritis. Chronic pain sufferers use health services up to five times more frequently\(^3,4\) and take more days of sick leave than the rest of the population.

The management of chronic pain includes medication, exercise, physical therapy and surgical intervention. The World Health Organisation (WHO) provides a basic pain ladder as guidance for the treatment\(^5\). The optimum management of pain in primary care is difficult to achieve. The use of formal pain assessment tools is recommended. Guidelines recommend using the safest non-steroidal anti-inflammatory drug at the lowest dose possible, for the shortest period of time, to reduce the risk of adverse effects\(^6\). Medication should be used in a logical stepwise manner, with drug choice tailored to the severity and type of pain. It is important to review patients regularly.

With the withdrawal of co-proxamol and safety concerns relating to COX-II inhibitors and NSAIDs, there is a need for multi-disciplinary strategies for
alternative therapeutic management. A multi-professional approach is required to optimise the management of pain.

The Clinical Resource and Audit Group (CRAG) (1999) Framework for clinical pharmacy practice in primary care provides a definition of pharmaceutical care needs which include; concordance, advice, medication review, and health promotion. To fulfil clinical governance and best practice recommendations, it is advisable that pharmacists document their patient interventions.

Implementing the pharmaceutical care needs assessment tool

A pharmaceutical care needs assessment tool for chronic pain has been developed to help pharmacists apply their learning, develop their assessment skills and help their patients get the most out of their medication and reduce any associated risks. It incorporates a simple pain assessment and follows the same systematic inquiry as the other chronic condition PCNA tools by suggesting questions that will allow you to confirm the person's understanding of their condition and or how their medication works, effectiveness (sub-optimal dose or additional medication required), safety (adverse drug reactions, interactions or toxicity) and intentional or non-intentional non-compliance.

As people present with their prescriptions for medication used in the treatment of chronic pain, confirm their diagnosis and as part of the normal clinical check and counselling process ask if they would like to answer some more in depth questions about their condition. This will help to ensure that they are getting the best from their medication and that they are not at risk of any adverse effects.

You can then work through the assessment tool as a single intervention or it can be completed as the person visits the pharmacy with a repeat prescription over subsequent weeks or months. The assessment tool has been designed with direct patient contact in mind and will help pharmacists to speak with patients in a more systematic and focused way. You can adapt the questions to your own style and the needs of your patients. Use it in conjunction with your computerised pharmacy medication records to identify patients you would like to actively target e.g. people over the age of 65.
prescribed regular NSAIDs.
The aide memoire suggests ways to optimise information provision and drug treatment by summarising key points to help pharmacists support and advise the patient or carer and suggests when it may be appropriate to refer to their GP or nurse. Pain diaries can help some people to identify what makes their pain worse or better and helps them to manage their pain. If you advise them to take their medication in a more optimal way, e.g. taking analgesia regularly rather than when required, they can use the diary to note the changes. You also have spare diaries included in the pack. We have included one copy of a pictorial pain assessment tool which can be shown to patients to help them describe and record their pain. Using this tool will help you to further develop your patient assessment skills and more therapeutic relationships with your patients and medical and nursing colleagues.

References

7 Clinical Research and Audit Group (CRAG) Clinical Pharmacy Practice in Primary Care: a framework for the provision of community-based pharmaceutical services, 1999.
Teaching plan

**Lecture**
50 minutes and 5 minutes discussion

**Chronic pain**
This talk will cover:
- definition and diagnosis
- symptoms
- epidemiology and statistics
- guidance on management
- pharmaceutical care.

**Comfort break**
15 minutes

**Workshops**
60 mins
Training groups should be divided into groups of between 12 and 15 participants. One facilitator should be assigned to this group which will then be further subdivided into smaller groups of three to five.
- Case 1, 2 and 3: volunteers for each case, one participant chosen to play the patient and one to play the pharmacist who completes the case using the pharmaceutical care needs assessment tool. Remaining participants will observe. The group will identify care issues at the end of the role play (10 minute role play with 5 minutes discussion). Each group should do all three cases, if possible.
- Workshop: the small groups work through this together (10 minutes with 5 minutes discussion)

**Questions/discussion/answers**
10 minutes in large groups.
Answers should be provided at the end of the session.

**Summary**
10 minutes
- CPD-action (recording), evaluation and identification of further training needs.
- Using the spare assessment tools to explore how to implement the tool in practice.
- Local pain services and support.
- Course assessment.

**Aide memoire**
To be used in conjunction with the *British National Formulary* and national or local clinical guidelines and in light of any co-morbidities and over-the-
counter medication.

1 **How long have you experienced chronic pain?**
Chronic pain has been described as pain or discomfort that persists, continuously or intermittently, for longer than three months. The longer the person has suffered the pain, the more it will affect their general health and well being. About one quarter of those suffering pain will co-present with depression. The length of time someone has suffered can affect their belief in the health care system and they may accept a poorer quality of life as a result.

2 **Can you tell me what caused the pain in the first place and what word(s) would you use to describe your pain and what part(s) of your body are sore?**
To manage pain effectively it is important to identify the cause as this in turn will help to ascertain whether the pain is likely to be neuropathic, nociceptive or of mixed or unknown aetiology. If the pain is caused by arthritis, confirm if this is osteo or rheumatoid? Enquire if there is any inflammation (redness or swelling) present and if they are stiff or sore in the morning or evening? Detail about the cause or name given to their pain or condition will help identify the best management plan for the person. Three sub-divisions can be described as:

- **Nociceptive pain**: The aetiology is usually stimulation of peripheral or visceral nociception by noxious stimuli with information transferred centrally to the brain by an intact, normal functioning nervous system e.g. inflammation or headache. This type of pain is managed by analgesics, NSAID’s and opioids.

- **Neuropathic pain**: Usually results from damage to or dysfunction in the nervous system. The term usually refers to pain caused by a primary abnormality in the peripheral nervous system, e.g. post-herpetic neuralgia, diabetic neuropathy, pain following trauma, compression or infiltration of peripheral nerves. Patients may require adjuvant therapy with anti-epileptic or anti-depressant medication. This is often an unlicensed indication.

- **Mixed pain**: pain of mixed origin.

The following list from the Abbreviated McGill Pain Score summarises the terms commonly used to describe or differentiate pain of neuropathic and
nociceptive origin.

<table>
<thead>
<tr>
<th>Neuropathic descriptors</th>
<th>Nociceptive descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shooting</td>
<td>Tender</td>
</tr>
<tr>
<td>Sharp</td>
<td>Heavy</td>
</tr>
<tr>
<td>Hot-burning</td>
<td>Splitting</td>
</tr>
<tr>
<td>Stabbing</td>
<td></td>
</tr>
<tr>
<td>Gnawing</td>
<td></td>
</tr>
<tr>
<td>Aching</td>
<td></td>
</tr>
</tbody>
</table>

**Action**

Note answer and consider if their current therapeutic plan reflects the type of pain reported e.g. is there a neuropathic component? If yes, are they or have they been prescribed adjuvant therapy at the appropriate dose?

3. **What is (are) the name(s) and strength of your pain medication(s) (all routes), how do you take it (them) and how many on average/day?**

This helps to identify any issues relating to the person’s understanding of what they are taking for pain management and if they are taking it as prescribed or optimally. Note what the patient is actually taking and how many per day. They may be taking too much or too little, due to ineffective therapy or fear or presence of side-effects or fear of addiction. If they are experiencing pain at the moment ensure the patient is aware of the need to use pain relief medication on a regular basis, e.g. Paracetamol regularly 2 QDS and explain the possibility of using NSAIDs as pulse therapy in the presence of inflammation e.g. hot, swollen or burning and benefits of taking analgesia before activity.

There are some conditions where continuous NSAID therapy may be required, e.g. ankylosing spondylitis or rheumatoid arthritis. It is important that you confirm what the condition is and what the person has been advised to do by their GP. NSAIDs should be prescribed at the lowest effective dose.

People may be prescribed medication three times daily and can manage by taking it once. If their repeat prescription assumes full dose, they might be requesting their medication monthly along with other medication, this can lead to waste.

**Action**

Note if there is a difference between prescribed medication dose and what the person is actually doing and explore why and offer appropriate advice and support. Synchronise prescription quantities etc if appropriate.

Ask if they ever take pain relief medicines bought from the pharmacy or supermarket with, or
instead of your prescription medicine?
People with chronic pain frequently self medicate, and therefore run the risk of duplication, overdose and adverse effects (e.g. by combining two NSAIDs). Thus this can be a safety issue. However, the need to do this may indicate poor control with prescribed medication (effectiveness), difficulties in obtaining prescriptions or personal preference.

**Action**
Note name and dose of non-prescribed medication name and explore why. Provide appropriate advice to reduce any associated risks.

4 Are you satisfied with your pain control? If no, ask questions 4a-c.
If yes, go straight to question 5.
If they are pain free, explore if they would they be open to reducing their medication? If they have no inflammation and they are taking NSAIDs, is it possible to reduce or stop taking them for a trial period and introduce as ‘pulse’ therapy if inflammation is present? A pain diary could be offered to support the trial reduction.

Questions 4a-c are a simple pain assessment and will help to identify any effectiveness issues resulting from sub-optimal dose or need for additional or different medication or non-compliance.

4a Using the following 0-10 pain score, describe your worst pain in the last 24 hours where 0 is no pain and 10 is the worst pain imaginable. Note pain score.
Read the descriptors. Complete pain relief is not an achievable goal for the majority of people. The ability to manage their pain rather than their pain managing them is a reasonable goal for the majority of people. Pain scales can be used to determine the severity of pain and to assess effectiveness of treatment interventions. This will be a very helpful baseline for you and the patient to work from if you recommend any changes as you can compare scores at follow up.

<table>
<thead>
<tr>
<th>Score</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = No pain</td>
<td>No action required, continue to monitor for pain escalation and explore reducing medication.</td>
</tr>
<tr>
<td>1 – 3 = occasional mild pain</td>
<td></td>
</tr>
</tbody>
</table>
Confirm optimal therapy and self-management and compliance, monitor for pain escalation.

4 – 5 = moderate pain-limits some activity
Confirm optimal therapy and self-management and compliance. Continue to assess pain. If persistent make recommendations and refer to their GP.

6 – 10 = severe pain often markedly affecting activities
Confirm as above and for persistent severe pain, which distresses the patient refer to GP urgently for review of analgesia as appropriate.

**Action**

Note the pain score in detail column.

**4b Is there a time of day when your pain is worse?**
The person’s experience of pain can vary throughout the day or over time and can be associated with different activities. It may also be linked to the cause of the pain. Some people suffer from morning stiffness in their joints due to inflammation. OA related pain tends to get worse at night and RA in the morning. If the person has RA an increase in the duration of morning stiffness may indicate their RA is worsening. Consider the following points are they prescribed a NSAID, if so when and how are they taking it? If it is a long acting NSAID is it better to take at night rather than in the morning or would an immediate release medication give more flexibility and management? Are they taking their analgesia regularly? Consider dosing times of analgesia especially modified release preparations and formulations and aim for pain free at night as the first step.

**Action**

Note when the pain is worse and confirm if timing or frequency of medication is optimal. Offer a pain diary of the person is not sure when the pain is worse.

**4c Does anything make your pain worse or better?**
Is the patient describing movement-related pain, check that the patient has a suitable “when required” analgesic and is taking it before movement. If pain is well controlled at rest, and only worsened by movement an increase in the dose of regular (modified-release) opioid, if prescribed, is not appropriate. If certain tasks exacerbate the pain, explore pacing the tasks as described in the Pain
5 **Have you had a stomach ulcer, a gastric bleed or experienced an allergy with your pain medication?**

If so, if the person prescribed a traditional NSAID are they co-prescribed the appropriate type and dose of gastro-protectant i.e. proton pump inhibitor/misoprostol? Or are they prescribed COX-II to reduce the risk? If they are co-prescribed aspirin with a COX-II, this negates the proposed reduced GI risk of the COX-II. Carry out a risk benefit assessment to explore what the optimum management plan is for this patient. Increased risk of gastric adverse effects with NSAIDs and COX-II is associated with people over 65 years of age, co-prescribed (or buying aspirin), warfarin, Plavix®, long-term prednisolone (>3 months) and SSRI antidepressants. The risk is greatest if they have had a previous GI bleed or ulcer. This identifies any **safety** issues.

**Action**

Note any co-prescribed/bought medication that may increase risk. If the person is at risk of a GI bleed then the need for continued use of a NSAID requires review. If a NSAID is required then use an appropriate gastro-protectant.

6 **What side effects, if any, do you attribute to your medication?**

Check that any adverse effects can be attributed to their medication. Some people erroneously link symptoms or adverse effects to medication and this can affect their adherence. If prompting required with respect to their pain relief medication ask about constipation, drowsiness, GI upset, and bloody stools. Identifying adverse effects is important, many can be managed and if not, the patient should be involved in a risk benefit assessment. You are in a position to advise people on long term NSAIDs how to manage dyspepsia (take with food etc.) and identify signs of GI bleeds. If there is no obvious link to the reported signs or symptoms this may require a clinical review by their GP. If the person is prescribed disease modifying anti-rheumatoid drugs (DMARDs) confirm that they appropriate monitoring is being
carried out. NSAIDs are used with caution with cardiovascular disease. COX-II are not recommended in people with cardiovascular disease. Carry out an interaction check if person has other medication and co-morbidities. This identifies any safety issues.

**Action**

Take appropriate action.

7. **Do you ever forget or choose not to take your pain medication? If yes, note how often.**

Many patients with long-term medical conditions forget or choose not to take their medicines as advised. The reasons for choosing not to take medication are varied; some patient may not be fully aware of the reasons for taking medicines, or the benefits or consequences of not taking medicines or they may fear or be experiencing side effects or they may fear becoming addicted. Choosing not to take medication is the right of the patient and should be based on an informed choice. Simple compliance solutions may help.

**Action**

Explore the patient’s reasons, discuss their fears or experience and provide the appropriate advice, compliance solutions (linking to meal times, medication charts etc) and information.

**Issue and actions**

At the end of the assessment, review their medication and how they are taking it in light of the answers provided. Offer advice and support as appropriate. Tick the box that most accurately describes the issues or problems identified and note any follow up required and any outcome of your intervention in the care plan section. There may be no care issues and this should also be noted. Action taken may involve providing information, clarifying points, providing compliance solutions, undertaking a review of their medication in light of the information available and offering a pain diary. Refer any effectiveness or safety issues to their GP practice with suggestions and recommendations. Consider referral to national or local patient support groups. Find out what local pain services are available and how to refer people to them.