(Awad et al., 2012). In order to study its effects as a pain management protocol in bariatric surgery patients, a retrospective chart analysis was completed of 285 bariatric surgery patients at a Midwestern hospital. Statistical analysis comparing surgical patients from October 1, 2015 to March 31, 2016 (Traditional Recovery) to patients from April 1, 2016 to September 30, 2016 (Enhanced Recovery) demonstrated a nonsignificant decrease in average pain scores (pre vs post, $p>0.05$). There was a statistically significant decrease in the length of stay in the enhanced recovery patients, compared to the traditional recovery group ($p<0.05$). While there was no statistically significant change in HCAHPS scores, there were noticeable increases in satisfaction for enhanced recovery patients. Due to the homogeneous nature of the samples, it is thought that much of the change was due to the protocol. However, there was no analysis of rates of chronic pain conditions between populations, which could have impacted the findings.

3E.3. Cognitive Behavioral Therapy for Spinal Cord Injury Patients with Chronic Neurogenic Pain

Judith Salazar BSN, RN, CHPN-BC. *Rancho Los Amigos National Rehabilitation Center*

The incidence of neuropathic pain after spinal cord injury (SCI) has been estimated at 75%. A common treatment for this pain is often ongoing opioid prescription medication despite limited evidence that these medication are effective for neurogenic pain. Recognizing the need to decrease the number of patients with SCI on continuous opioid medications, the often overlooked approach of Cognitive Behavioral Therapy (CBT) was tested in a group of six patients.

METHODS

A pilot group was started with 6 SCI patients, these patients were chosen due to their history of frequent requests for escalating doses of opiates and early refills. Outbursts of verbal abuse and threats against staff were common. The group met every two weeks and was led by a Pain Resource Nurse and Physician Assistant. Activities included guided imagery, meditation, and education about pain, pain medications, and other non-pharmacological pain management techniques.

RESULTS

Requests for early refills still occurred however, the patients handled this in a more appropriate manner by calling ahead of time and and discussing the issue with the Pain Management Nurse, this intervention provided an outlet to discuss the reasons for the need for the early refill and develop a plan for managing the pain without the early refill. Episodes of behavioral outbursts aimed at staff decreased and self-management of chronic pain symptoms was evident. Data from the Brief Pain Inventory assessment tool showed improvement in “pain at its worst in the last 24 hours” from an average of 9.75 at group initiation to 7.2 at four months post. Conclusions CBT is a beneficial tool for management of chronic pain in a small group of patients with SCI. It may not be as effective with larger groups.

4A Patient and Prescriber Anxiety about Benzodiazepines Combined with Opioids: Alternatives for the Non-Psychiatric Practitioner

June E. Oliver RN-BC, MSN, CCNS, APN/CNS. *Swedish Covenant Hosptial*

With the rise of public and professional attention on opioid overdose deaths, benzodiazepines (BZDs) have emerged as a significant risk factor for fatal overdose when combined with opioids. Studies vary in calculating a 4 to 10 fold increase in risk of death with combined opioids and benzodiazepines. At the same time, anxiety is a common comorbidity in chronic pain patients- as well as in many patients recovering from acute pain episodes. Side effects and risks of BZDs alone and in combination with opioids is explored in this session, along with recommendations for anxiety management including non-pharmacologic interventions and pharmacologic therapy with non-BZD medications. Understanding these principles can aid the pain management practitioner in communicating BZD risk and safer alternatives to patients and in discussion with other healthcare prescribers to foster a safe and effective team approach addressing the patient's physical and psychological needs.

4B Chronic Opioid Therapy in Persistent Pain: Patient Selection and Risk Reduction Strategies

Michelle M. Lavelle-Henry RN-C, MSN, APRN, CNP. *Fairview Ridges Hospital*

The aim of the presentation is to review safe opioid prescribing in the patient population of persistent chronic non-cancer pain within the CDC Guidelines for Prescribing Opioid. The method utilized is a convenience sample of subjects in a community based Comprehensive Pain Clinic. During the initial interview all patients were screened for comorbid conditions that increase the risk of unintended opioid overdose. In addition, current opioid analgesia, current medication list and prior pain therapies were reviewed. All patients, if on opioids, were assessed for dose lowering strategies. A particular emphasis was placed on patients at risk for adverse events related to opioid use, those with a morphine equivalent dose (MME) greater than 80 mg per day and patients that were pain treatment naïve. Patients with substance use disorder were excluded and referred for treatment. Patients agreeable for opioid lowering strategies were tapered at 10-15 % every 1-2 weeks while incorporating multimodal analgesia, physical reconditioning and cognitive behavioral therapy as indicated. The results of the study suggest that patients whose opioids were tapered to goal of less than or equal to 80 mg MME demonstrated an improvement in pain control and quality if life. In conclusion, patients with chronic persistent non cancer pain on opioid therapy, have better quality of life and less pain with opioids at less than or equal to 80 MME. The risk of unintended opioid related events are further reduced while incorporating strategies that look at patient selection with and implementing non opioid treatment strategies Opioid tapering at 10-15 % is safe, effective and well tolerated. Future studies to replicate these results should continue. Application of this study, can not be generalized to the primary care. Future study within primary care that targeting early intervention to prevent high dose opioid therapy should be considered.

4C Reducing Unintended Variation in Discharge Opioid Prescribing in a Pediatric Hospital Setting

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BACKGROUND AND AIM

In 2017, Children's Hospital Colorado finalized a clinical pathway to reduce unintended variation in opioid prescribing for pediatric patients with acute pain. Subsequently, the team aimed to analyze baseline prescribing data for Orthopedic Surgery inpatients and to design an improvement project to implement the pathway's recommendations. The improvement project will launch in early 2018 to increase compliance with the clinical pathway's recommendation to limit discharge prescriptions to a maximum of 7 days.

METHODS

A multi-disciplinary team conducted a retrospective review of prescribing data from January to December 2017. Based on the data, the team designed an improvement project to facilitate implementation of the clinical pathway at the bedside. Improvement strategies included dissemination of the pathway, enhanced substance use risk screening by nurses, EMR-based clinical decision support tools, education materials for patients/caregivers and pharmacist review of discharge opioid prescriptions exceeding 7 days.

RESULTS

At baseline, 1190 Orthopedic Surgery patients were discharged with opioids. The median patient age was 11, 48% were female and 26% were Hispanic/Latino. Patients were discharged with an average of 7.75 days' supply of opioids, with a range of .04 to 58 days prescribed. 51% ($n = 602$) of discharge prescriptions followed the recommended 7-day maximum. The pilot project will launch in March 2018 and aims to increase compliance with the 7-day maximum to 75% by July 2018. Outcome data will be available to report at the conference.

CONCLUSIONS

The clinical pathway and improvement project are innovative strategies for appropriate utilization of opioids for acute pain in pediatric patients. The pilot will expand to other departments in 2018. The initiative also highlights lessons for other healthcare entities, including: (1) building an

EHR query of opioid prescribing data; (2) tools for engaging stakeholders across the system; and (3) example EMR tools that can inform prescriber decision-making.

4D Transitioning from Pain Initiation into Addiction Treatment: "They Just Want to Feel Normal"

Marian Wilson PhD, MPH, RN-BC. *Washington State University*

PURPOSE

The purpose of this grounded theory study was to examine the process involved when adults first use opioids to treat pain through their enrollment in an outpatient medication-assisted treatment (MAT) program to recover from opioid use disorder. Opioid use disorder among U.S. adults has increased in recent years with a concurrent rise in MAT program enrollment. Limited understanding exists regarding how and on what basis people with persistent pain enter MAT. This IRB-approved study reveals participants' unique perspectives concerning their initial use of opioids, living with pain, and their deciding to enroll in MAT. This session will describe how practice changes can be informed from the resulting theory.

METHODS

Experienced qualitative researchers used open-ended questions to elicit narratives from 10 participants chronicling their journey from initial opioid use through opioid use disorder recovery treatment. Inclusion criteria called for adults enrolled in a single outpatient MAT program reporting they initially used opioids for treating pain. Interviews were digitally recorded in a private room at the MAT facility and later transcribed. Corbin and Strauss' approach to data analysis and grounded theory development were followed.

RESULTS

A newly-developed theory, Living with Persistent Pain: From Opioid Initiation to Substance Use Treatment was supported by three predominant categories emerging from data: "addiction pathway," "becoming normal," and "relationship spectrum." The theory's overarching core category, "living with pain" was described as a complex and tumultuous process originating in a precipitating painful experience, advancing to the initial use of opioids, and culminating with ongoing recovery in MAT.

IMPLICATIONS

The decision to enter MAT for opioid use disorder was key to helping participants with pain recover a sense of normalcy, which ultimately was both helped and hindered by significant relationships. Healthcare providers who understand both pain management and the addiction process are essential for guiding recovery-oriented treatment approaches.

4E Bioethics and Pain Management: A New and Practical Application

Esther I. Bernhofer PhD, RN-BC, CPE. *Cleveland Clinic*

The field of Bioethics provides clinicians with a framework that combines ethics and empirical evidence to help them make the right decision when faced with complex clinical dilemmas. However, bioethics has not been widely applied to pain management situations even though treatment decisions frequently include moral/ethical considerations, especially in the current context of the opioid abuse epidemic. The aims of this presentation are to review the principles of ethics related to pain care, move practically from ethics to values-based decision-making, and apply the bioethical framework of ethical and empirical evidence to complex pain management issues. Methods used to support this discussion include a review of historical, bioethical, and empirical literature as well as real-world case studies. The results of the literature review reveals that there has always been a moral imperative to treat pain and suffering, yet those who reported suffering without visible evidence ("pain without lesion") were often suspect of ulterior motives, stigmatized, and poorly treated. The field of Bioethics developed as a philosophical and practical approach to providing moral/ ethical guidelines for patient care to decrease bias, stigma, and unfair application of medical treatment. Currently, advances in pain science with new treatment options abound, yet there is evidence that stigma continues and pain is still not well managed; a model of values-based pain management decision-making has emerged to partially explain this phenomenon. Combining the empirical evidence of pain management science with moral/ethics theory can help solve clinical issues in practical ways by informing better pain assessment, understanding patient autonomy, deciding whose risk vs. whose benefit takes priority in treatment decisions, and supporting ethics-driven pain management policies. In conclusion, it is the practical application of bioethics to pain management quandaries that will provide the answer to the ultimate pain care question: what is the right thing to do?

5A NSAIDs: Friend or Foe as Opioid Alternatives?

June E. Oliver RN-BC, MSN, CCNS, APN/CNS. *Swedish Covenant Hospital*

With the rise in public and professional concern over opioid overdose deaths, a growing emphasis is being placed on using non-opioid analgesics. Nonsteroidal anti-inflammatory drugs, while not new, are garnering new interest as opioid alternatives. Along with demonstrated analgesic efficacy for nociceptive pain, these medications carry significant risks of morbidity and mortality from multiple mechanisms, ranging from hypertension, GI ulcerations, bleeding, kidney injury and cardiovascular acute events. In using this class of medication, the pain practitioner needs to have a strong understanding of the pharmacology of the variety of NSAIDs, impact of dosing and length of treatment, indications and contraindications and monitoring for toxicities. Weighing the risk and benefits in choosing an NSAID, including newer combination medications with gastrointestinal protective agents, will be explored- and contrasted with an overview of opioid risk and benefits.

5B When Addiction Hurts: Managing Acute Pain in Patients Receiving Medication Assisted Therapy (MAT)

Michelle Meyer PharmD, BCPS, BCNSP,
Andrea M. Wetshtein PharmD, BCPS, CPE. *OhioHealth Grant Medical Center*

BACKGROUND

In 2016 over one-million Americans were receiving medication assisted therapy (MAT) for opioid use disorder (OUD). This trend is expected to only increase as the number of patients permitted to be seen by a buprenorphine-naloxone provider increased to 275 patients in August of 2016. With the advent of the depot-naltrexone injection, even more patients can receiving MAT. With the increasing availability of MAT, acute care providers are facing difficulties managing patients with acute pain on these complex treatment modalities.

PURPOSE

This presentation will include an overview of MAT: the components of MAT, the pharmacology of the medications (methadone, buprenorphine-naloxone, and naltrexone), clinical pearls of each medication, legal considerations for inpatient providers, and strategies for managing acute pain crisis in patients with OUD. Opioid dosing strategies as well as non-opioid management of acute pain crisis, including the use of ketamine, will be discussed. The learner will be able further their practice skills through participation in several interactive case studies focusing on each MAT medication.

5C Sedation and Factors Nurses Consider When Making Decisions to Medicate for Pain in the PACU

Danielle Dunwoody RN, MS, PhD. *Halton Healthcare*

PURPOSE

The purpose of this study was to examine how nurses working in the Post-Anesthetic Care Unit (PACU) identify and describe excessive sedation and what criteria they use to make decisions about medicating patients for pain.

METHODS

Utilizing Heideggarian Hermeneutics methodology, approximately 20 individuals were interviewed using open-ended questions that focused on capturing the expert nurses' lived experiences while working in the PACU. Interviews were audiotaped, transcribed, and analyzed using an interpretive team and a modified seven-stage process for interpretation by