Clinical Note

The Benefits of Authorized Agent Controlled Analgesia (AACA) to Control Pain and Other Symptoms at the End of Life

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Abstract

Context. Eliza Coffee Memorial Hospital is a community hospital with a palliative care unit providing inpatient symptom management and end-of-life care. The palliative care unit provides authorized agent controlled analgesia (AACA).

Objectives. The objective of this study was to determine if an AACA system improves control of pain and other end-of-life symptoms adequately and if it provides families with satisfactory involvement in the care of their loved ones.

Methods. Data on demographics, pain assessments, length of stay before and after consult, drugs used, mortality, discharge disposition, and family and staff satisfaction were collected by chart review of all 2013 consultations.

Results. There was a total of 318 consults in 2013. Of the 118 patients (37% of total) who used the AACA system, 112 (95%) died in hospital; morphine was used by 77% and the others used hydromorphone. Following the patient's death, of the 70 AACA families contacted, 100% were satisfied with the pain/symptom control. Staff also were overwhelmingly pleased with the system.

Conclusion. An AACA system has been highly satisfactory for patients, families, and staff, meeting the goals of 1) allowing patients with a terminal condition to die peacefully and 2) enabling families to share in the patients' care, providing them with a more favorable memory at the end of life. J Pain Symptom Manage 2015;50:371–374.

Key Words
Authorized agent controlled analgesia, AACA, authorized agent, end of life, pain control, symptom management

Introduction

Dr. Eric Cassell noted that one of the most fundamental goals of medicine is the relief of suffering.[1] The Institute of Medicine report, *Dying in America*,[2] highlights the need for health care professionals to improve palliative practices at the end of life.

Since 2006, the Eliza Coffee Memorial Hospital (ECM) Palliative Care Service (PCS) has provided authorized agent controlled analgesia (AACA) as an essential element of palliation for patients needing constant pain/symptom control but lacking the mental or physical capability to act in their own behalf. Surprisingly, little published information exists on the subject. A search of PubMed using the term "authorized agent controlled analgesia" found only three articles, two of them published by the American Society for Pain Management Nursing (ASPMN),[3–5] whereas a search for "patient-controlled analgesia" (PCA) yielded several 1000 articles.

The most support comes from the 2013 "ASPMN Position Statement with Clinical Practice Guidelines: Authorized Agent Controlled Analgesia,"[3] which states that although the literature since their initial review in 2007[5] relates to the use of AACA mostly in pediatrics, the low incidence of complications and adverse events allowed the ASPMN to strongly support the use of AACA for other vulnerable populations because it offers timely and effective pain management.

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It must be emphasized that AACA is *not* PCA by proxy and that the ASPMN does not endorse PCA by proxy. The distinction is that AACA requires licensed hospital staff to instruct competent individuals identified as the "agent" to administer pain medication using the dose button, whereas PCA by proxy means someone other than the patient indiscriminately doses medication without authorization or consent.

In 2013, we reviewed palliative care (PC) patient/family surveys and found results similar to the ASPMN: AACA is simple, safe, and satisfactory as a comfort measure at the end of life. This article reports a review of our cases, hoping that more hospitals will initiate this practice and publish additional research.

Background

ECM is a 240-bed, privately owned, community hospital in Florence, Alabama, offering a full spectrum of primary and secondary subspecialty care. For 2013, the hospital had 11,130 discharges, with an average length of stay (ALOS) of 4.5 days and an average daily census of 140 patients.

The PCS was initiated in 2005 for inpatient consultations and subsequently added a four-bed Palliative Care Unit (PCU) in 2006. In 2013, there were 318 consultations. The PCS is a team-based activity, but its core is one board-certified consultant, with Education in Palliative and End-of-life Care (EPEC) certification, and one registered nurse (RN) certified by End of Life Nursing Education Consortium (ELNEC), with Bachelor of Science in nursing, who serves as service coordinator; the RN is also our Grief Support Counselor and has a Certificate in Thanatology. Interdisciplinary team (IDT) meetings are held twice weekly and include the physician consultant, coordinator, a case manager/social worker, chaplain, pharmacist, the patient's RN, dietician, and respiratory and physical therapists.

Although the PCU is an "open" unit, meaning any physician may admit and treat their own patients, physicians are required to use the PCS Standing Order Set (with AACA as an option) and have an Allow Natural Death/Do Not Resuscitate order in place. A PC consultation is not mandatory; however, because our program (including AACA) follows clinical practice guidelines, the PC medical director maintains oversight (In 2013, there were 80 admissions to the PCU without a formal consult.). AACA can only be performed on the PCU floor and by RNs who have completed our two-day, ELNEC-based "certification" course.

ECM's PCS earned The Joint Commission (TJC) Certification in December 2012 and recertification in 2014; to date, it remains the only hospital with such certification in Alabama.

Methods

Data Collection

The authors reviewed all 318 charts from the 2013 consultations. Data included gender, age, lengths of stay before and after consult, diagnoses, use of AACA, drug used, pain scores, family satisfaction, date of death (survival days, when known), and discharge disposition.

Measures of success for pain and symptom management were taken from our plan for TJC certification ("Symptom Control Using Authorized Agent Controlled Analgesia"), where the goal was that 90% of patients with AACA would have their pain controlled satisfactorily.

Assessments were conducted using a three-way verification process: 1) electronic medical record (EMR) pain scores by the RN (0–10 using a Numeric Rating Scale (NRS), the Wong-Baker FACES® Pain Rating Scale, or the Behavioral Observation Pain Rating Scale, resulting in a "mild," "moderate," or "severe" rating, which correlated with ECM's 0–2 Pain Scale guide for families[6] (Fig. 1); 2) real-time verbal feedback on daily rounds; and 3) post-death phone calls to the family.

To rate family satisfaction, the PCS physician attempted to telephone every family within a few days of a patient's death for feedback: was pain controlled adequately; were they satisfied with the PCS; and was the information provided easily understandable.

Eligibility for AACA

During a patient/family consultation, the physician discussed options regarding symptom management (usually pain, dyspnea, or terminal delirium). Once AACA was accepted, the mechanics of pump use, dosing (pushing the button), and the role of the authorized agent was explained by the physician, reinforced in greater detail by the PCS coordinator and again by the patient's PCU nurse. Additionally, a PC educational folder (information plus references to the first author's PC website: *comfortcarechoices.com*) and handouts explaining AACA were given to each family: 1) "Controlling Pain using an Analgesic Infusion Pump"; 2) "Pain/Symptom Diary"; and 3)

0 = No sign of pain/discomfort
1 = Sign of pain observed but quickly ends
2 = Sign of pain observed and continues (>than 5minutes) ***CLICK BUTTON***

Fig. 1. ECM's pain scale guide for families.