Fall 12-18-2015

Reinforcing Teach-back Method Regarding Pain Management for Non-verbal Patients and their Families

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Abstract

Pain has been known to have physiologic, psychologic and emotional consequences. Education in pain management has been part for standard care for nurses. The purpose of this study was to reinforce teach-back techniques with nurses when delivering pain management education with non-verbal patients in order to improve patient outcomes in the adult ICU. By using the teach-back method, the nurse will be able to hone a more collaborative approach in dealing with pain, encourage autonomy and include the patient/family in making informed decisions regarding treatment for pain. Reinforcement regarding teach-back was focused on teaching points, and rewording teach-back cues to better engage with the patient/family and acquire more data, not just for the education but for their routing cares as well. A family guide was used as a visual aid for the teaching. A survey was conducted, pre-/post-reinforcement whether or not the nurses do teach-back and observations and family interviews were done after the reinforcement of teach-back technique. The findings show that four out of five family interviews found the guide to be useful, and four out of five nurses found the guide to be useful.

Keywords: teach-back, pain management, critical care, non-verbal adults

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The Adult Intensive Care Unit cares for patients that normally have high acuity, present with co-morbidities and require constant monitoring. It is common to see patients who are non-verbal, motor and cognitively challenged, and ventilated on this unit. For non-verbal patients, this presents as a bigger challenge to assess and communicate with patients, especially for pain management. Pain is a common and distressing symptom in critically ill patients and uncontrollable pain places patients at risk for numerous adverse psychological consequences, some of which may be life-threatening (Stites, 2013). Some patients who present in the ICU describe their experiences as confusing or incomprehensible (Meriläinena, Kyngäsb, & Ala-Kokkoa, 2013). While some patients will have a low GCS score or is non-cognizant, studies have shown that these patients will remember sounds and sensations of being in the ICU. The charge nurse uses one patient experience story on the floor to remind the staff to communicate with their patients, even if they do not verbally respond, as this particular patient remembers the events of his ICU stay and only notes one nurse that explained what she was doing and the significance of her actions. According to this patient, that same nurse was the only one that helped keep his anxiety levels low. A study conducted by Zetterlund, Plos, Bergbom and Ringdal in 2012 found that the memories from the ICU were still the same five years after trauma (Zetterlund, Plos, Bergbom, & Ringdal, 2012). As nurses, it is important to continue to address the need for optimal interventions for pain management, especially for this vulnerable population in the ICU. Patient education is considered part of a nurse's daily care for patients, with multiple methods of delivery to incorporate the patient and/or their families in decision-making for care.

Clinical Leadership Theme

The clinical leadership theme for improvement focuses on interaction. The global aim is to improve the staffs' ability to perform teach back regarding pain management to non-verbal patients and their families in the adult ICU. The process begins with assessing staff's strategies for teach-back. The process ends with evaluation of the patient/family's understanding of the teach-back.

By working on the process, we expect (1) improve patient outcomes for pain management in the unit by 10% with the help of upward trend in compliance of pain management documentation using Critical-Care Pain Observation Tool (CPOT) and (2) promote a culture of safety. It is important to work on this now because there is yet to be studies to improve nurse-patient communication in the ICU for patients who are non-verbal.

The CNL competencies evident in this project are the ability to demonstrate professional and effective communication skills, including verbal, non-verbal, written, and virtual abilities, and using evidence to design and direct system improvements that address trends in safety (American Association of Colleges of Nursing, 2013).

Statement of the Problem

Pain can result in physical, psychological, and emotional consequeces. Pain can trigger the stress response and reduce tissue oxygenation and delay healing, for example. Psychologically and emotionally, uncontrolled pain has been associated with depression and anxiety. Many critically ill patients experience alterations in cognition or receive purposeful sedation, making pain assessment and subsequent treatment a challenge for the nurses who care for them (Makic, 2013). However, the inability to communicate verbally does not negate the possibility that the critically ill patient is experiencing pain and is in need of appropriate

treatment (Makic, 2013). The ethical principles of beneficence and nonmaleficence oblige health care professionals to provide pain management and comfort to all patients, including those vulnerable individuals who are unable to speak for themselves (Herr, Coyne, McCaffery, Manworren, & Merkel, 2011). A study in 2011 highlighted specific areas for improvement in communication between nurses and nonspeaking patients in the intensive care unit, particularly in communication about pain and in the use of assistive communication strategies and communication materials (Happ, et al., 2011).

Some institutions use the teach-back method as a form of patient education, mostly in heart failure or cardiac patients according to recent studies. The teach-back method as a strategy to confirm that the learner understands the education delivered by the health care professional (MacLeod, Eastwood, Struthers, Jennings, & Rodger, 2014). There is no current literature on its efficacy in pain management, let alone in non-verbal patients and their families. This project focuses on reinforcing the staff nurses' teach-back skills regarding pain management, both pharmacological and non-pharmacological to non-verbal patients and their families in attempt to improve patient outcomes through a more collaborative and interactive approach between the healthcare team and the patient and/or the family.

Project Overview

The microsystem of focus is the Adult ICU. One of the challenges in this unit is performing patient education on patients who are non-verbal – be it due to altered mental state, or physical compromise, or multiple tubes and/or ventilation. Tingsvik, Bexell, Andersson, & Henricson conducted a study in 2013 that described the ICU nurses' experience with lightly sedated patients and highlighted the need to reinforce the importance of communication in nursing care (2013). Proper education and adequate treatment of postoperative pain can also

result in positive emotional outcomes for patients, such as a decrease in anxiety and depression, an increase in coping skills, a greater sense of individual control, and an increase in a sense of well-being (Glowacki, 2015).

The project is supplemental to a new initiative by Palliative Care and Pain Management, as it focuses on teach-back to patients and their families regarding pain management, and a bigger teach-back initiative throughout the entire Health System. The project aims to explore the comfort levels of nurses performing teach-back, and improve their technique in its application to pain management education and create a more collaborative effort to manage the patient's pain between the healthcare team and the patient and/or the family. For this, I monitored the pain assessment flowsheets and patient education outcomes in the EHR, as well as observing the nurses do teach-back and interviewing patients and/or their families. By reinforcing teach-back on pain management for non-verbal patients and their families, the project aims to improve patient outcomes and better collaboration with both the patient/family and the other members of the healthcare team as evidenced by an increase of performing the teach-back from 66.7% to 75% by November 30, 2015, and positive feedback from patients and/or their families regarding the usefulness of teach-back guides for pain. This project enforces our roles as advocates and educators.

Rationale

Palliative Care and Pain Management conducted a seminar for the nurses as a system-wide intervention to incorporate the family in discussing prognosis, setting and understanding goals of care, and collaborating with physicians to achieve these objectives. One of the points of interest from the pre-seminar and post-seminar survey is conveying a family's communication needs to a physician, in which there was not much of a difference in improvement in bridging the

gap. Some themes identified focused on dealing with difficult families and setting realistic goals, both from the physician's perspective and the family's perspective.

The nurses and nursing leadership acknowledge that pain management education is easier with verbal, responsive patients. When it comes to non-verbal (e.g. intubated, sedated, altered level of consciousness, ventilated) patients, this teaching is more tedious and easily overlooked. Approximately 23% of the nurses do not perform teach-back on non-verbal patients/families. Out of 67% of the nurses that stated that they do the teach-back on non-verbal patients/families, only 22% use alternative methods of communication if the patient is cognizant (whiteboard, cellphone, charts, notebook). In a separate survey with 43 RN participants from the unit, 24% do not feel confident in their ability to contribute to discussions of prognosis and goals of care during family meetings.

According to hospital compare of the institution as a whole, only 79% of nurses "always" communicated well, 75% of patients reported their pain as "always" controlled, 65% of patients reported staff "Always" explained about medicines before giving it to them, and only 52% of patients "Strongly Agree" they understood their care when they left the hospital (CMS, n.d.). Patients that are readmitted after 30 days of discharge that present with pain could be associated with multiple diagnoses and disease processes. The unplanned readmission rate for the hospital as whole is 16.9%, which is higher than the national benchmark of 15.2%. From hospital compare, I found the following estimated costs: if a patient has a respiratory diagnosis and is vented for <96 hours, the cost is $87,116 and Medicare only reimburses $18,672. If a patient was admitted for chest pain, the cost is $24,889 and Medicare reimburses $4701. In 2010, the mean cost for a hospital stay is $9700 (AHRQ, 2013). Hospital stays that involved ICU services were 2.5 times more costly than other hospital stays (AHRQ, 2014). According to an article in 2013 by

Huynh, et al., over a 3-month period, the ICU has an estimated cost of $2.6 million for futile treatment, with approximately $4000 average cost per hospital stay per patient (Huynh, et al., 2013).

Assessment of a patient's pain requires that professionals become well educated in recognizing a patient's perception of pain, previous experiences with pain, current knowledge of pain, spiritual and religious beliefs, and sociocultural components. What a patient believes and understands about pain is critical in influencing the reaction to the pain therapy provided (Glowacki, 2015). Finding the best assessment tool for patients who cannot verbalize pain can be difficult. In the past, the unit has used its own tool to assess and document pain, however it has not been validated. Now they utilize CPOT as a way to assess this patient population, as its design fit both intubated and non-intubated patients. This assessment tool is now built into our EHR and serves as a tool for non-verbal patients, especially those who are intubated.

Pain education alone may be the most effective treatment provided by health care professionals (Glowacki, 2015). When nurses perform the teach-back as a method of teaching, the EHR now includes "teach-back" as an option to properly document the education that was done.

The pain champions on the unit consist of nine Clinical Nurses II, who meet once a month for 3 hours. The starting salary for a CN II is $43/hour, which amounts to $1161 a month. By having this team meet monthly, it reduces the risk of being short staffed for a shift, while having enough work force to facilitate and advocate pain management on the floor. By encouraging teach-back for pain management, patient outcomes would improve by reducing cost of care, depending on diagnoses and reducing possible futile costs for treatment in the ICU,

establishing better collaboration for patient care, and keeping an open channel of communication even if the patient is non-verbal.

Methodology

The project was implemented in the adult ICU. There were 34 participants, both from the day shift and night shift of varying levels of nursing experience, picked at random. The only inclusion criteria is that the RN had to be a full-time ICU nurse, and not a float.

Initial survey was gathered among the nurses, whether or not they do teach-back for non-verbal patients and their families in the adult ICU, and speaking with some of the family members present.

A one-page family guide pamphlet was developed by a different project (see Appendix I) to recognize non-verbal signs of pain, common causes of pain, and common non-pharmacological interventions that can help soothe pain. During the second PDSA cycle, I included another pamphlet that was being utilized in another project (see Appendix J) on the unit that included teaching points for the nurses and information for the patients and their families regarding alternative treatment modalities the hospital offers for the patient's stay.

Over the span of 1 month, I did one-on-one reinforcement with the unit's pain champions and the staff nurses to do teach-back and utilizing the pamphlet guide as an education tool to help families assist non-verbal patients with managing pain. Alternative communication methods (whiteboards, cellphones, picture charts for non-English patients) were part of reinforcement as well. After the reinforcement, I observed the nurse perform teach-back to either the patient if they are able to use the whiteboard to communicate, or to the family regarding pain. I filled out a teach-back observation data collection tool that both myself, and the unit needed. I also

interviewed the patient and/or family to obtain qualitative data regarding the RN's teach-back method and if they find this form of patient education helpful.

I will know I have reached my desired goal if patients/families are able to participate in the teach-back and collaborative effort to help manage the patient's pain together with the healthcare team (e.g. using the call light to notify the nurse of pain, using alternative pain management strategies like massage/hot pack/cold pack in addition to medication, understanding pain goals).

Data Source/Literature Review

There is no direct literature on reinforcing teach-back method for pain management education for non-verbal patients and their families in the adult ICU improve patient outcomes and patient experience after the teach-back seminar for staff nurses. I decided to breakdown the concepts and do a literature search on the teach-back method itself, nursing communication skills, and the experience of non-verbal and ventilated patients in the ICU.

Patient Experience and Pain

For patient experience, one article describes the level of awareness of patients during their stay in the ICU and their recollection of both positive and negative experiences. The authors used a descriptive, exploratory design, and it shows that there was a high level of awareness among patients to surrounding persons (82.2%) and relatives (90.3%). Although 58% of patients perceived pain as a negative experience during their stay, however, 82% still rated their care as good as it should be (Alasad, Tabar, & Ahmad, 2015). The authors stated that in nurses play a vital role in alleviating the negative experiences and facilitating positive feelings – trust, security, and orientation. It is imperative, however, that nurses understand

potential stressors in the ICU and are able to properly assess and identify early signs of distress in their patients.

Another article relating to patient experience enumerated the possible psychological risks a patient who has been on prolonged ventilation. The study noted multiple clinical implications such as the assessment of and interventions to relieve anxiety during and after hospitalization (Rose, Nonoyama, Rezaie, & Fraser, 2014). The researchers used a questionnaire that utilizes "trigger questions", rated by a 5-point lickert scale. They also used the Impact of Event Scale-Revised to measure PTSD symptomatology. It was noted that patients recall choking, pain, difficulty breathing, anxiety, and sleep interference with both an endotracheal tube and tracheostomy tube. The study expressed the need for further psychiatric help, as patients still experienced anxiety after 3 years following the experience. One of the limitations of the study, however, is that it had a small sample size (53) over the span of 7 years, from the initial 136 identifiable participants.

Communication

In regards to nursing communication skills, one study conducted a clinical trial called the Study of Patient-Nurse Effectiveness Associated with Assisted Communication Strategies (SPEACS). This trial tested the ICU nurses' ability to communicate using augmentative and alternative communication (AAC) techniques in patients who were intubated, awake, responsive, and unable to speak by using a quasi-experimental design. Phase 1 was the control phase, of which standard care was delivered. Phase 2 incorporated basic communication skills training, which the nurses received 4-hour training, and an AAC communication cart was supplied to the ICU. Phase 3 was the final phase, and had the same treatment as phase 2 with supplemental 2-hour AAC training, speech-language pathology (SLP) assessment, and

electronic communication device and low tech tools matched to patient ability (Happ, et al., 2014). This trial yielded positive results during phase 2 and 3. The authors cited that an area of concern for ICU nurses is that they receive little to no training in communication assessment or use of AAC. Another study was conducted in 2015 to include a wider range of patients and to assess quality of care delivered in patients who are mechanically ventilated in the different ICUs. The study reflected only 26.2% of the patient population that had pain scale documentation, despite the additional training of the nurses for AAC (Happ, et al., 2015).

Another study related to the SPEACS trial used a descriptive observational study to describe nurse-patient interactions and communication for non-verbal patients. The researchers highlighted specific areas for improvement in nurses communicating with nonverbal patients in the ICU. The study noted that 37.7% of patient communication regarding pain was unsuccessful. Patients noted 40% of the communication sessions were somewhat difficult and the use of alternative communication methods were of little to no use (Happ, et al., 2011).

Radtke, Tate and Happ used small focus groups and conducted an individual interview with six critical care nurses (2012). The authors illustrate ICU nurses' perception regarding various communication tools. The study focused on BCST and AAC training. Findings of this study showed these tools were valuable, and honing these skills may reinforce alternative ways of communicating with little to non-verbal patients in the ICU.

Teach-back Method

One study in 2011 explored the effectiveness of teach-back for learning in older heart failure patients. There were 276 participants, 153 of which were female. Within 30 days of hospital discharge 41 (14.9%) patients were readmitted and 52 (19%) died within 12 months.

Prior to hospitalization, 86 (31%) were independent with their activities of daily living. Following education using teach-back principles, 233 (84%) patients correctly answered three out of four (75%) of the teach-back questions. Upon follow-up at 6-8 days, 145 (77%) patients correctly answered 75% of the teach-back questions. (Howie-Esquivel, White, Carroll, & Brinker, 2011). Patients remembered more about the diet than reportable weight gain. The study revealed that teach-back was an effective method to assess and teach self-care learning in older heart failure patients.

To ensure comprehension, clinicians have been urged to use teach-backs - explicitly asking patients to repeat back key points of instruction - with every patient receiving new care management instructions (Jager & Wynia, 2012). One study explores which population is eligible for receiving this form of patient education, despite the recommendation of having all patients receive teach-back. For this study, the researchers utilized the Communication Climate Assessment Toolkit (C-CAT), a validated set of tools for measuring the communication climate in health care organizations, to determine whether patients in demographic groups with higher rates of low health literacy were more or less likely to report receiving a teach-back (Jager & Wynia, 2012). One of the highlighted results is that the native English-speaking Caucasian patients are those who received limited teach-back. The researchers recommend exercising universal precaution when doing teach-back, which in essence is to perform it with everyone, as teach-back proved to be beneficial in providing discharge instructions.

Another study that explored teach-back in hearth failure patients was conducted in 2014 by Brown, Mack, Guzzetta and Tefera to check its feasibility and comparing readmission rates between the control group (standard of care) and the teach-back group. Topics that were discussed prior to discharge included diet, diuretics, reportable weight gain, and reportable

signs and symptoms (Brown, Mack, Guzzetta, & Tefera, 2014). After performing the teach-back, the researchers compared 30-day readmission rates, however, their study proved to be inconclusive.

Timeline

Initial planning started in the 2nd week of September. Initial survey was supposed to be the last 2 weeks of September, however it extended to Mid-October. Teach-back pamphlets were made and disseminated beginning of October, during one-on-one reinforcement. Implementation was halted for 2 weeks due to unfortunate circumstances, however, the project continues to be carried out in my absence by the pain champions. Progress will be reassessed October 28, 2015 for adjustments in the project implementation. Final reassessment after intervention is set to be the last 2 weeks of November.

Expected Results

Granted that there is a limited time to do the study, I do expect small changes and slow progression, however the microsystem as a whole shows strong adaptability to change for the majority of the RN staff. One factor to consider is that the timeline that this project falls on is the onboarding of New Grad nurses and new experienced RN staff.

Nursing Relevance

Pain control in hospitalized patients is important to patients, families, nurses, physicians, and regulatory agencies (Paulson-Conger, Leske, Maidl, Hanson, & Dziadulewicz, 2011). There is a need for updated literature in using the teach-back method in other aspects of nursing care. In recent articles, it is limited to discharge planning and patients with cardiac issues. The nursing significance is focusing on holistic care, and continuing to hone non-verbal communication skills, especially in regards to pain. Pain affects not only a patient's physical well-being, but

mental and emotional as well. Adult ICU non-verbal patients may be technically non-cognizant, but the possibility of remembering the ICU experiences – intubations, healthcare team interactions, overhearing conversations, remains intact. It also reflects on keeping open communication channels for this vulnerable population, and reflects indirectly on how nurses communicate with this population.

Summary Report and Conclusion

In the adult ICU, I was able to observe five nurses perform teach-back on the families. I was able to speak to the families regarding their thoughts on the guide. Only one caregiver stated that the things mentioned in the guide (common causes of pain, pain management modalities and behavioral cues) were things they already knew, hence the guide was unnecessary. The other four families found the guide useful. One of the families I interviewed stated they kept a picture of the guide on their phones, just in case they lose the paper. From the nurse's perspective, only one found the guide to not be helpful because it was too "wordy". She suggested bullet points and making the guide more concise might help families better. The other nurses felt that the guide was helpful in delivering education. The original family guide that was used was from the Pain Management and Palliative Care unit, and the supplemental guide was what the unit had developed for the other project.

Upon doing the reinforcement prior to doing the teaching, I discovered that patients and/or their families have difficulty responding to some of the teach-back cues, and I had to adjust my approach in helping the nurses perform teach-back. The most useful part of my revision of the reinforcement, based on feedback from the nurses, were rewording the cues. An example of which, was, instead of asking the learner if they can enumerate alternative methods of pain management to "teach back" to the nurse, I had the nurse ask the learner after doing the

teaching if they have a preference for any of the alternative methods listed (pet therapy, hot/cold packs, massage, aromatherapy, music/tv, yoga/meditation). This also helps the nurses further tailor their pain interventions, and making the teaching more conversational and reducing the feeling of being "questioned like in class". The most common feedback among patients is that they were not aware of pet therapy or aromatherapy, but did opt for one or both after the teach-back. Two nurses also commented that when patients requested for both pet therapy and/or aromatherapy, they experienced the benefits of a reduction in their stress levels. I also made sure that the nurses were documenting the education correctly on the patient's chart.

One of the initial barriers I have come across at the beginning was that some of the nurses did not feel the need to do pain management teach-back in the absence of pain and/or pain medication ordered. By the end of the implementation of my project, doing the teach-back became mandatory for the unit, however, the frequency of utilization of this method and how nurses determine the appropriateness to perform the teach-back may be suited for another project, or a deeper dive, which was beyond the scope of my project. I would have hoped that there were more families I could have observed, however, timing and language/literacy levels were also barriers. I did also note, it is harder to do teach-back at night compared to the day, because the hospital has a "quiet at night" curfew from 10 PM-5 AM.

A common theme I did notice after this discovery is that the nurses always start with asking the patient (if alert) or the family member (if sedated or not fully cognizant) if they are currently in pain. To move forward with the teach-back, I shared another reworded statement to achieve better flow into giving the teaching which was "if you do experience pain, while waiting for the medications, we have alternative methods to help treat your pain in the meantime, such as…" and to review how to use the call light to notify the nurse.

I shared my findings with the CNS, pain champions and teach-back champions, as well as the key points of my approach to reinforcing teach-back techniques. They found my reworded cues to be helpful, not just for the purpose of educating but improving the delivery of care. Since there is cross-over between my project and two other ongoing projects, the unit will be able to utilize some of the data I have gathered for their audits. Moving forward, they will be taking my data and taking some of my techniques into consideration for the next round of teach-back topics, as they will have one new topic approximately every few months.

In order to properly acknowledge authorship of the pamphlets, I have been granted permission to include both guides in my prospectus – the non-verbal family guide, which was developed for another nursing graduate project by Suzanne Graf, MSN, RN, PHN under the supervision of Jeanette Meyer, RN, MSN, CCRN, CCNS, PCCN, ACHPN – CNS for Palliative Care, and the pain teach-back pamphlet created by both Jeanette Meyer, RN, MSN, CCRN, CCNS, PCCN, ACHPN and Jill Scherrey MSN, CCRN, RN-BC – Nursing Professional Development Specialist .

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APPENDIX A

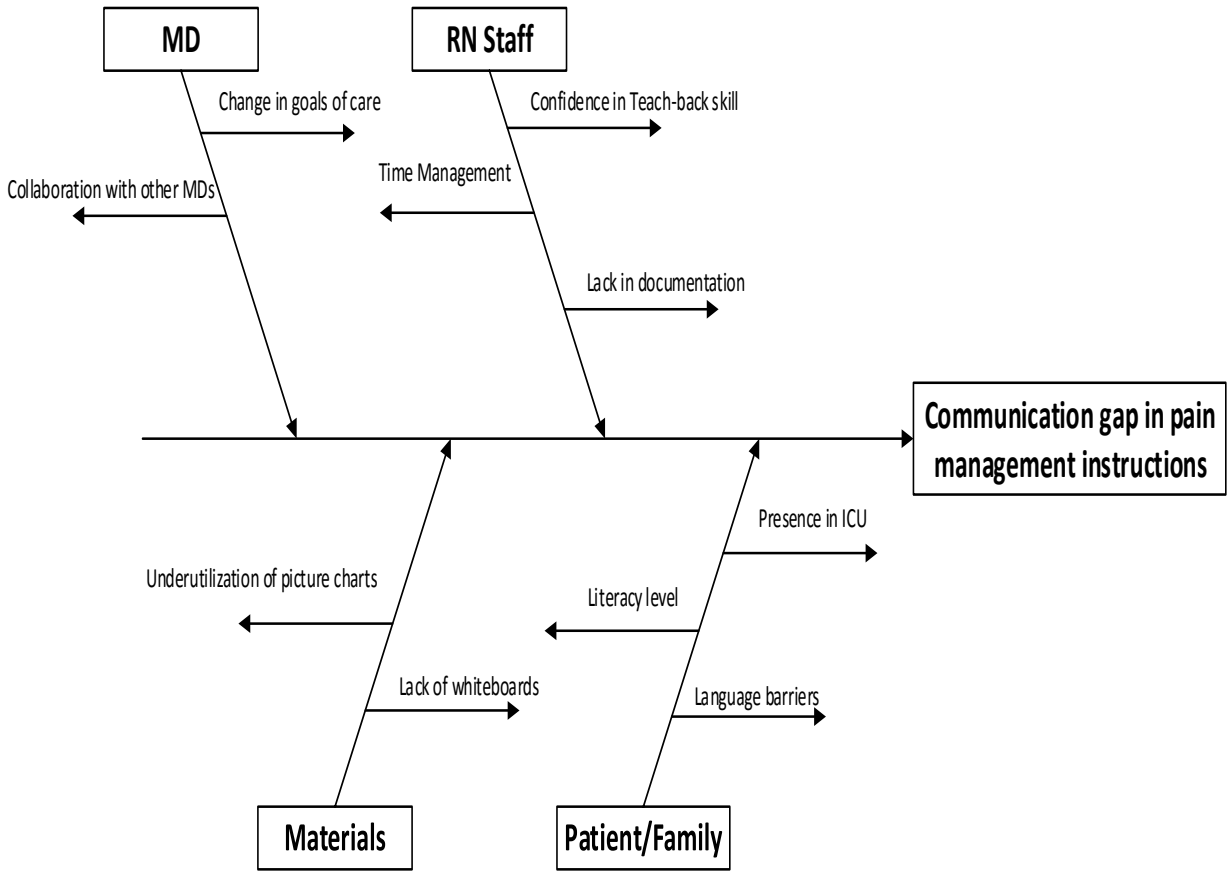


Fig 1. Fishbone diagram

APPENDIX B

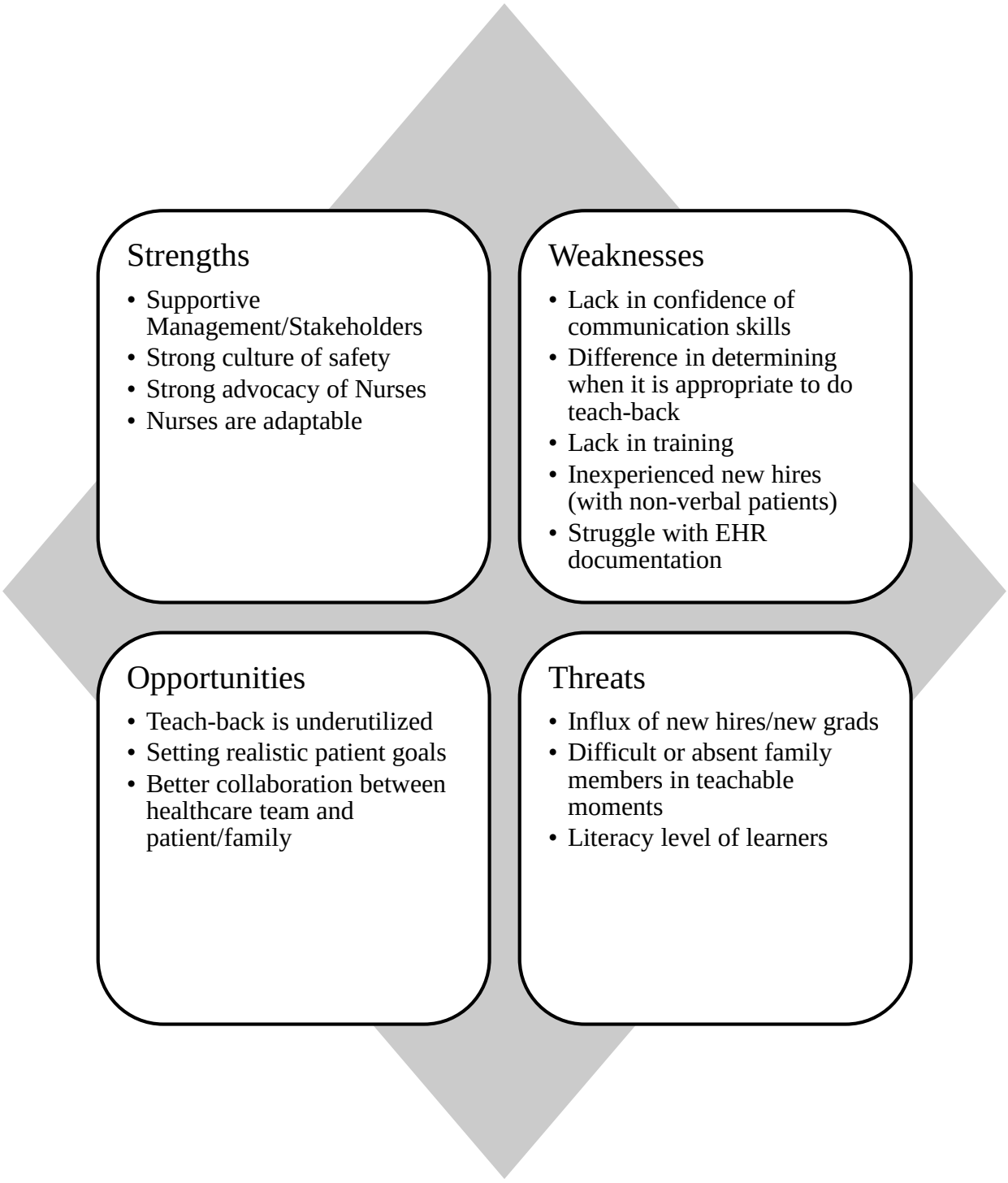


Table 1. SWOT Analysis

APPENDIX C

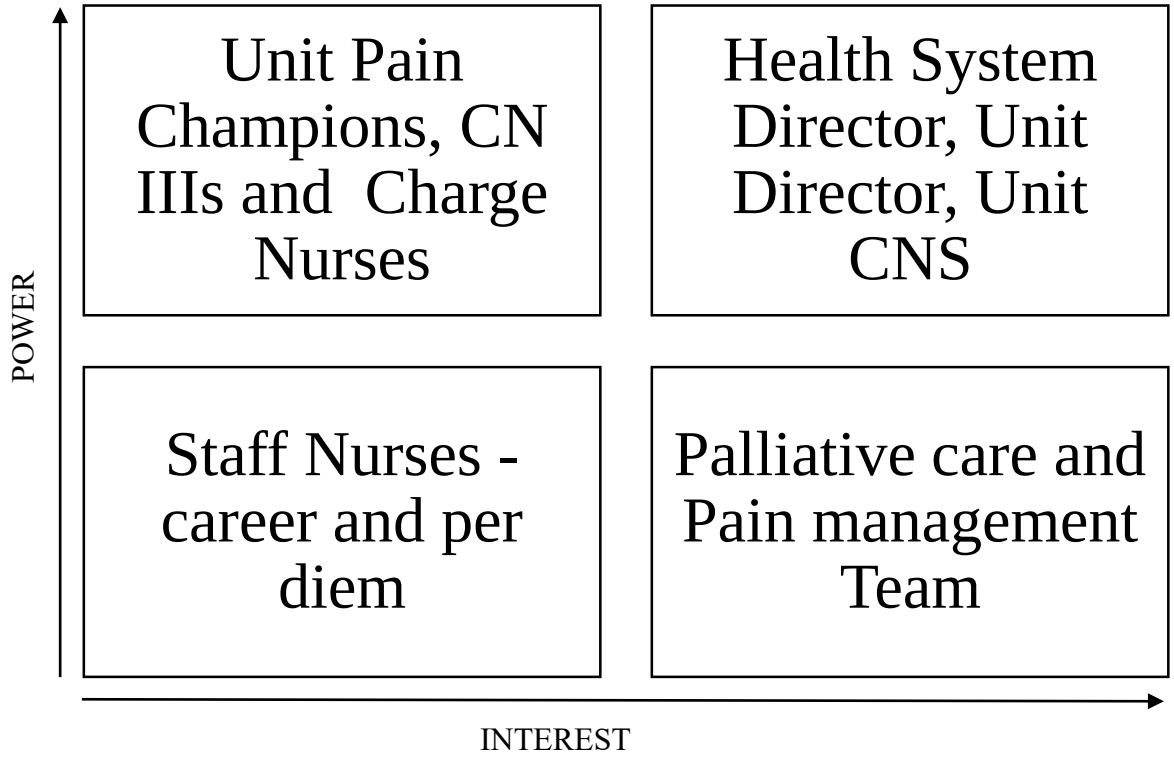


Table 2. Stakeholder Analysis

APPENDIX D

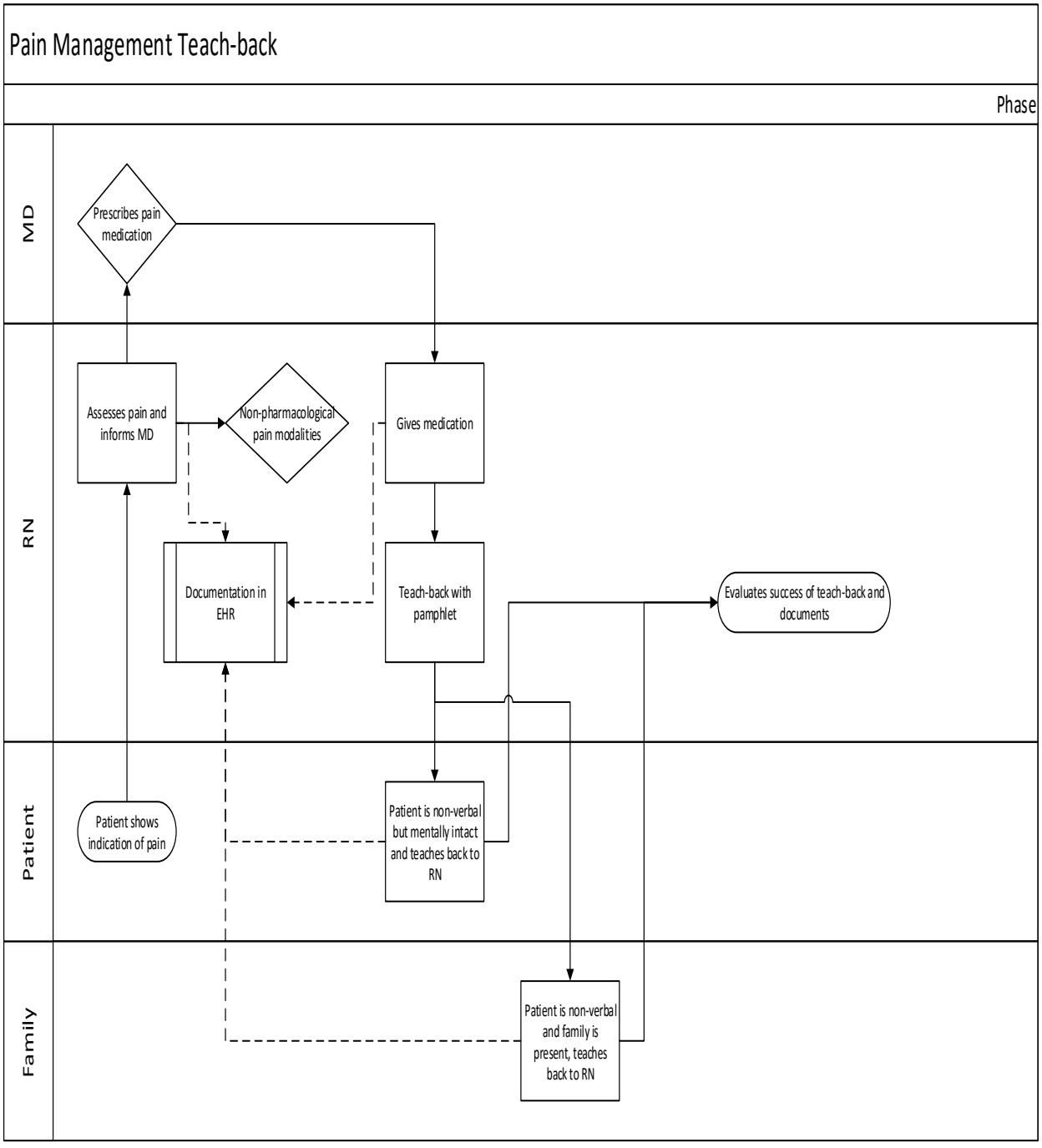


Fig 2. Process Map

APPENDIX E

ACTIVITY	PLAN START	PLAN DURATION	ACTUAL START	ACTUAL DURATION	PERCENT COMPLETE
Project Formulation	09/16/15	7	09/16/15	7	**100%**
Data Gathering	09/21/15	14	09/23/15	21	**100%**
Implementation	10/05/15	21	10/09/15	5	**100%**
Reassessment	10/26/15	1			**0%**
Revision Implementation	10/29/15	2			**0%**
Evaluation	11/16/15	14			**0%**

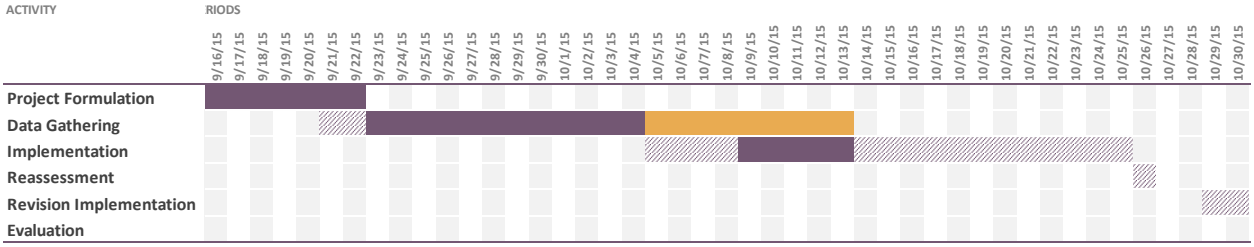


Fig 3. Gantt Chart

APPENDIX F

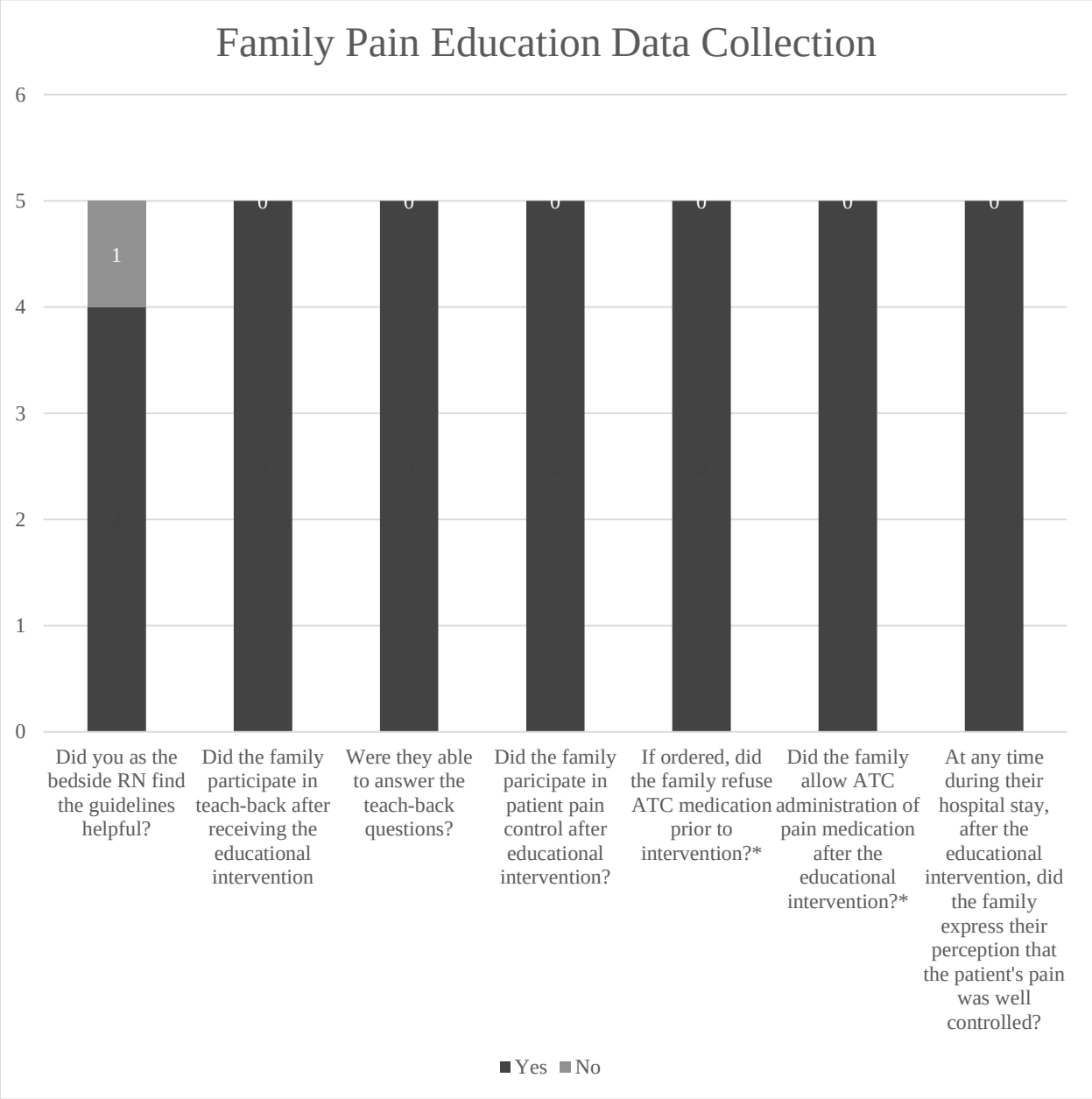


Table 1. Family Pain Education Data Collection

*ATC or around the clock

APPENDIX G

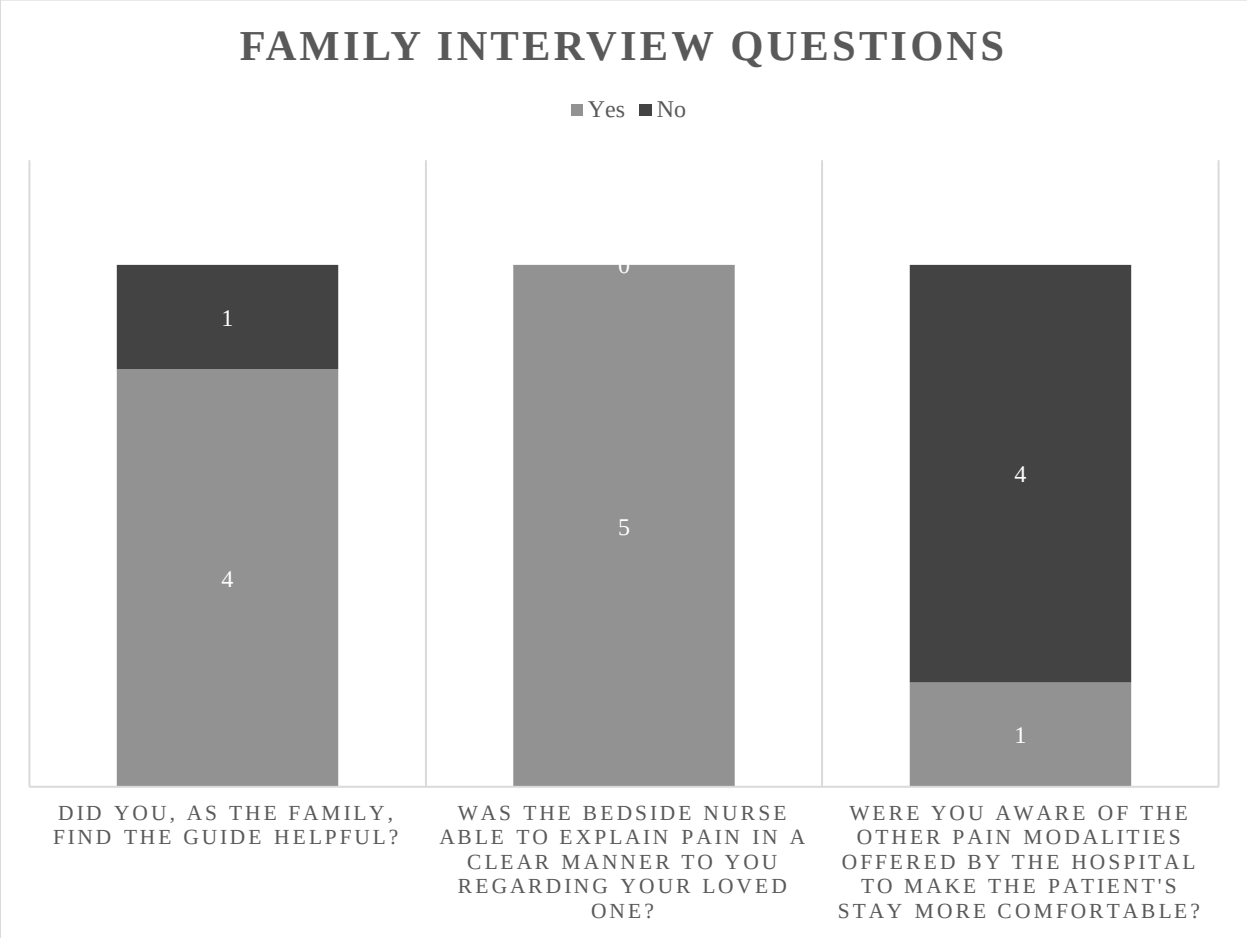


Table 2. Family Interview Questions

APPENDIX H

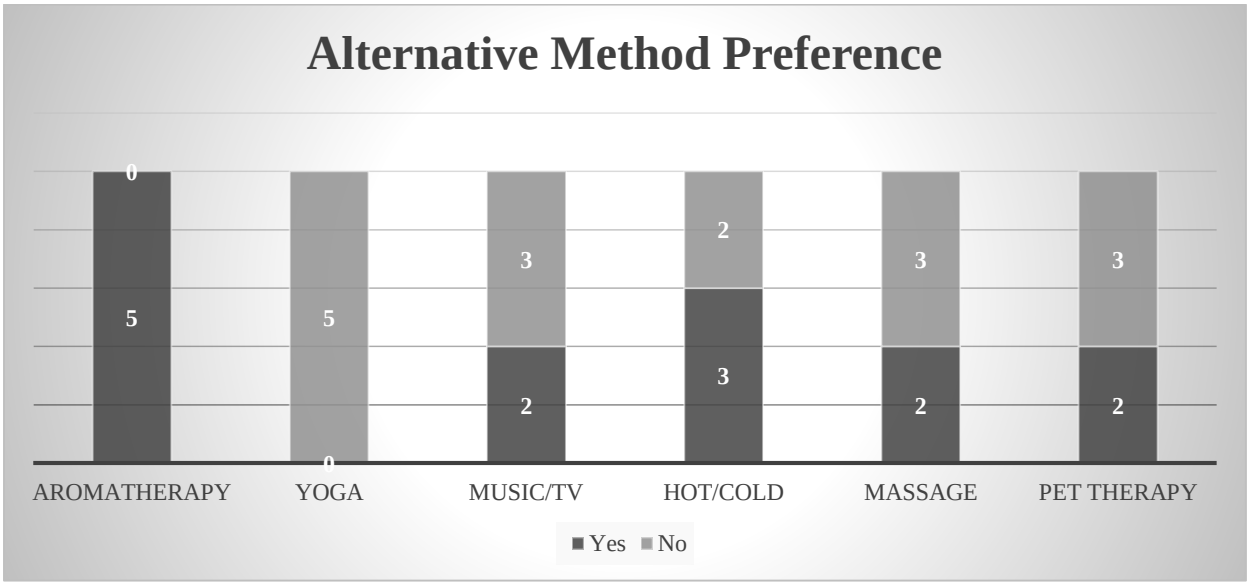


Table 3. Alternative Method Preference

APPENDIX I

UNDERSTANDING PAIN CONTROL

A FAMILY GUIDE

Created by Suzanne Graf, MSN, RN, PHN and Jeannette Meyer, RN, MSN, CCRN, CCNS, PCCN, ACHPN

How do we know your loved one is in pain if they cannot tell us with words?

We can use the way a person acts to tell us if they are in pain when words cannot. The areas we look at are:

1) *Breathing* - Is it easy for them to breathe or do they appear to be working very hard to get enough oxygen? Is their breathing faster or slower than normal? Pain can make you breathe like you are running even while lying still in bed.
2) *Sounds* - Are they moaning, groaning, or crying out?
3) *Face* - Are they smiling, frowning, grimacing, look sad or scared?
4) *Body* - Are they relaxed, moving around, or very stiff and making fists with their hands?
5) *Do they appear at rest* or do they need to be soothed by a calm voice or light touch? What if nothing helps them to be *calm?*
6) *Whatdo you know?* - If you know what type of actions mean your loved one is in pain or you know what has helped them with pain in the past, please let us know.

Things We Know That Cause Pain: Arthritis, infections (example: cough from pneumonia, or burning with urination), hernias, stomach ulcers, diverticulitis, hemorrhoids, fractures, open wounds, contractures, or surgery. From research with people who have had these health problems, we know that they are painful. If your loved one cannot tell us they hurt, we still believe they are having some pain if they are suffering from one or more of these listed conditions.

Why do we give pain medication on a schedule instead of when you ask for it?

Some illnesses, procedures, or conditions create pain that we cannot safely 'take away completely. The best way we can help control this kind of pain is with medication on a schedule we call *around-the- clock.* This is long-acting pain medication given at

certain times in a 24-hour period. However, we may also have to give a fast-acting pain medication for immediate pain as needed (example: during activity). We call this *breakthrough pain*. Both are important for the best possible control.

Other Things That Help With Pain: Pet therapy, ice or heat, music, or

changing positions. Remember, being in pain .....

- Can make it hard to breathe
- Puts the body under stress
- Interrupts sleep/rest
- and.....slows healing

Thank you for helping us control your loved one's pain

References:

AGS Panel on Pharmacological Management of Persistent Pain in Older Persons. (2009). Pharmacologica l management of persistent pain in older persons. *Journal of American Geriatrics Society, 57*, 1331-1346. doi: 10.l 111/j.l 532-5415.2009.02376.x

American Pain Society 6th Edition Panel. (2008). *Principles of analgesic use in the treatment of acute pain and cancer pain* (6th ed.). Glenview, IL: American Pain Society.

Herr, K., Coyne, P. J., McCaffery, M., Manworren, R., & Merkel, S.(2011). Pain assessment in the patient unable to self-report: Position statement with clinical practice recommendations. *Pain Management Nursing, 12(4),* 230-250. doi:doi:10.1016/j.prnn .2011..10.002

UCLA Pain Management Policy HS 1341

APPENDIX J

FAMILY PAIN EDUCATION DATA COLLECTION

- Did you as the bedside RN find the guidelines helpful?
  Yes Somewhat No
- Did the family participate in teach-back after receiving the educational intervention?
  Yes No
- Were they able to answer the teach-back questions?
  Yes No
- Did the family participate in patient pain control after educational intervention?
  Yes No
- In what ways did the family participate? (Check all that apply)
  - ☐ Informed RN of other modalities that have worked in the past
  - ☐ Agreed with RN assessment of presumptive pain indicators
  - ☐ Pointed out pain behaviors of patient to RN
  - ☐ Assisted with/requested non-pharmacological modalities

Free Text: _____

_____

_____

_____

- Ifordered, did family refuse ATC pain medication prior to intervention?
  Yes No
- Did family allow ATC administration of pain medication after educational intervention?
  Yes No
- At any time during their hospital stay, after the educational intervention, did the family express their perception that the patient's pain was well controlled?
  Yes No

Teach-back Qs: Name two things we look at to tell us someone is inpain ifthey cannot speak?What are some known painful conditions/procedures?

APPENDIX K

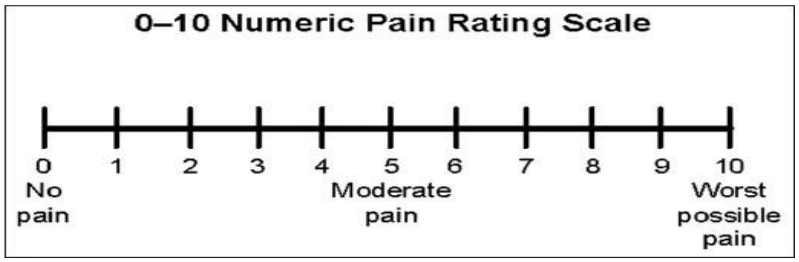
Partnering with U to manage your Pain

Created by Jill Scherrey, MSN, CCRN, RN-BC and Jeanette Meyer, RN, MSN, CCRN, CCNS, PCCN, ACHPN

At UCLA HealthSystem we always strive to keep your pain managed and at an acceptable level for our patients. Please take a few minutes to review this card with your nurse, to help us have a better understanding of your pain.

1.) Are you in pain right now?_____

On a 0-10 Scale pick the number that describes how you feel



2) We'll try, but we may not be able to get rid of 100% of your pain. Considering that, would you be willing to set a goal for your pain level on the 1-10 scale?

_____

3) What has worked to treat your pain in the past for you?

_____

We want to partner with you to keep your pain at or below the goal level.

It's better to stay ahead of the pain- Please call your nurse when your pain begins to increase so we can keep in the goal range. Ways to contact your nurse if you are in pain:

Use the cell phone numbers listed on the whiteboard to contact your nurse directly.

Use the call light to let your nurse know you are in pain.

Partnering with U to manage your Pain

We want to work together to come up with the best plan for your care. Here are a few options to treat your pain.

Alternative therapies (Circle all that apply):

Massage **Hot/Cold Pack** **Music Therapy**

Urban Zen: Urban Zen therapists offer yoga, reiki, aromatherapy, and breath work to help with anxiety, pain, general relaxation and or nausea.

This service is free to patients

Nursing: To submit a request for Urban Zen use form #16029 found in Forms Portal.

Pet Therapy–Patient Animal Connection (PAC)-*Nursing order in Care Connect*

Pet Pal –your own animal may visit you if you have patio privileges-*Nursing order in Care Connect*

Plan

_____

_____

_____

_____

_____

***Most importantly we want to keep you safe, please always use your call light for any assistance ☺**

Notes

_____

_____

_____

_____

_____