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The Development of Standardized Patient Controlled Analgesia Documentation to Improve Patient Care

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The Development of Standardized Patient Controlled Analgesia Documentation to Improve

Patient Care

Collyn L. West

NURS 653 CNL Role: Synthesis

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Clinical Leadership Theme

This project focuses on the clinical nurse leader (CNL) leadership theme of Clinical Outcomes Management. The CNL role functions are clinician and educator. As the CNL on this project, I will use appropriate teaching principles to facilitate the learning of nurses in the microsystem to improve healthcare outcomes.

Through the work on this project, I aim to standardize the documentation of patient controlled analgesia (PCA) medication administration on 3 East to improve post-operative pain management, improve patient satisfaction, and improve patient safety. The process begins with the order to administer medications via PCA and ends with documentation of the discontinuation of medication administration via PCA. This project is important to implement now because we have identified the need to improve pain assessment and reassessment documentation and to ensure the changes made to our post-operative pain regimen have made an improvement in patient care.

This project meets the American Association of Colleges of Nursing (2013) clinical nurse leader competencies to “collaborate with healthcare professionals, including physicians, advanced practice nurses, nurse managers, and others to plan, implement, and evaluate an improvement opportunity” (p. 11) and of leading change initiatives to decrease or eliminate discrepancies between actual practices and identified standards of care.

Statement of the Problem

During this last year, our unit has undergone numerous changes to ensure we are providing our patients with a high standard of nursing care. One of these changes was the development of a pain service staffed 24 hours per day and seven days per week. With the

initiation of the pain service, the nurses on our unit now have access to a specialist that is dedicated to managing our post-surgical patients' pain regimen and effectiveness.

In less than one year, the pain service team has introduced new nerve blocks, epidurals, and new medications onto our unit with the intention of decreasing narcotic usage and improving overall pain management. Recently, the pain service attending requested a chart review to ensure the changes to the pain mediation regimens resulted in the desired outcomes, especially in a reduced amount of medication administered via PCA our patients. Unfortunately, when the chart review was conducted, missing and inconsistent documentation regarding the amount of medication administered prevented the determination if the changes to the pain regimens had improved patient outcomes. As a result, this project was initiated to standardize PCA documentation based on a performance gap to improve patient care.

Project Overview

To ensure patients are receiving an effective pain medication regimen, documentation of PCA pain medication, including the total used per shift and the effectiveness, will occur for 95% of the patients on 3 East receiving PCA therapy by May 1, 2016. The ultimate goal is to be able to ensure the pain medication regimen is effective for the patients. Without adequate documentation, it is challenging to keep track of the amount of medications patients have received and appropriately update their medication regimen. I will conduct chart reviews to ensure the documentation requirements have been fully implemented.

In order to educate the nursing staff on the requirements for PCA pain medication documentation, I will conduct in-services for 100% of the nursing staff by April 11, 2016 and provide handouts for future reference. After the in-services, I will conduct chart audits and provide specific feedback to nursing staff on their compliance or areas for improvement

regarding their completion of the required documentation by April 22, 2016. Through the in-services and feedback provided to staff, I will meet my aim statement to ensure patients on 3 East have thorough documentation of medications administered via PCA. Through my work on this project, I will help to improve post-operative pain management, improve patient satisfaction, and improve patient safety. A review of the evidence-based change in practice project checklist revealed this project is considered to be an evidence-based activity and Internal Review Board (IRB) review is not required.

Rationale

The macrosystem for this project is a 250 bed Veterans Affairs hospital in a metropolitan city of Washington State. The microsystem for this project is 3 East, a 28 bed acute post-operative inpatient unit that also accepts overflow medicine patients. The surgical specialties include orthopedics, cardiothoracic, neurology, general, otolaryngology, urology, gynecology, ophthalmology, podiatry, and vascular. On average, the patients on 3 East range in age from early 20s to late 70s with an occasional patient that is healthy enough for surgery in their 80s or 90s. The majority of patients are male but 3 East also cares for females and transgendered patients.

There are 44 registered nurses (RNs), five licensed practical nurses (LPNs), and four nursing assistants (NAs) working on 3 East. On average, each shift is staffed with a minimum of six licensed nurses. Supplemental staff, when needed, are provided from nurses floating from other units and agency nurses. The nursing experience ranges from new graduate to over 30 years of experience. Although all new graduate RNs are Bachelor's degree prepared, some of the experienced nurses are Associate's degree prepared. The percentage of Bachelor's degree prepared RNs on 3 East is 90%. The only Master's degree prepared nurse working on 3 East is

the nurse manager. The average years the RNs have been working on 3 East is 5.8 years; however, 8 of the 44 RNs (18%) are new graduates.

In an effort to evaluate the efficacy of PCA opioid medication administration on my unit after the implementation of changes to the pain medication regimens by the new pain service, I conducted a chart review and found a performance gap in documentation. I worked with pharmacy to obtain a list of patients that had received PCA therapy throughout the month of December 2015. When reviewing the charts of these patients, I found inconsistencies and incomplete documentation. Pain assessments were routinely being completed on admission and per shift; however, the pain assessments did not routinely include the amount of PCA medication used per shift and the effectiveness of the pain medication regimen. Only 26% of the charts reviewed had all of the documentation components and only 47% had one of the needed components documented.

Providing cost-effective care is becoming increasingly important as reimbursements for healthcare services are declining (Lee, Moorhead, & Clancy, 2014). The need to justify nursing interventions is even more urgent given that nurses “are the largest and most expensive group of hourly workers employed by hospitals” (Lee et al., 2014, p. 826). According to Warburton (2009), nurses should take a lead in evaluating costs and effects of implementing change. To provide a cost analysis that supports the project of improving PCA documentation it is important to consider multiple factors.

First, to calculate the costs, the hourly salary for the CNLs involved in training multiplied by the number of hours required to complete the training will need to be calculated. Next, the staff nurses’ salaries will need to be taken into account while they are attending the in-services. These projected cost will decrease after the first year when the training on proper PCA

documentation is included in orientation for all of the new nurses. The costs for the handouts will also need to be incorporated. This cost will also be higher the first year since the handouts will need to be made for every unit. After the first year, only replacement handouts will need to be made so this cost should also decrease. Lastly, the hourly salary of the CNLs conducting chart reviews to analyze the baseline and post-implementation data will need to be taken into consideration. The first year of project implementation will require more frequent chart audits; therefore, this cost will also decrease after the first year. See Appendix A for a breakdown of the projected cost analysis that includes rolling this project out to all of the inpatient units that utilize PCA medication administration.

In addition, the qualitative benefits could also be considered. Some of the qualitative benefits include increased patient satisfaction related to improved pain control, improved patient flow related to transitioning patients to oral pain control and discharging more timely, increased patient safety related to opioid administration, and meeting The Joint Commission (2012) guidelines for opioid administration and documentation. Through the focus on value-based healthcare, this project will improve patient care utilizing a sound business rationale (Perlin, Horner, Englebright, & Bracken, 2014). For a better understanding of the issues impacting the process of thorough PCA documentation, see the fishbone diagram in Appendix B and the flowchart in Appendix C.

When implementing change, it is also important to analyze internal strengths and weakness as well as external opportunities and threats that will impact the success of the change (Deisher, 2013; Pearce, 2007). Some of the strengths I have identified in implementing standardized documentation regarding medication administered via PCA are the desire by the nursing staff to provide optimal post-operative pain control, a standardized nursing progress note

for documenting nursing care, and a pain service team of physicians willing to implement change to improve pain control. The weaknesses that have been identified with the implementation of this project are the large unit size with three shifts providing care 24 hours per day and seven days per week, inconsistencies among ordering providers and pain service, and miscommunication passed between nurses on documentation requirements.

One opportunity for the implementation of standardized PCA documentation is improved interdisciplinary communication regarding the amount of PCA medication patients are utilizing. Our residents rotate through other hospitals in the Seattle area and report their practice is to review nursing documentation to determine the amount of pain medication the patients are utilizing. Without consistent documentation, the residents have to call and speak with the nurse over the phone to gather data. Additionally, through standardized documentation, the unit will have the opportunity to adhere to the Agency for Healthcare Research and Quality (AHRQ, 2015) guideline for pain management in older adults that states the intensity, character, frequency, pattern, location, duration, and precipitating and relieving factors of pain should be assessed and documented on admission. Furthermore, pain should be assessed and documented regularly and frequently, at least every four hours and after giving medication to determine the effectiveness (AHRQ, 2015).

One threat is the eventual transition to a new electronic charting system. The new charting system should be deployed in our facility within the next year and may require the recreation of our pain documentation template. Another threat is the lack of “universally accepted guidelines to direct effective and safe assessment and monitoring practices for patients receiving opioid analgesia” (Jarzyna et al., 2011, p. 118). Without a universally accepted protocol for assessment and reassessment, the physician orders vary and create inconsistent pain

assessment documentation. Additionally, patient satisfaction scores driving hospital ratings is a threat as well as the negative perceptions that exist surrounding healthcare at the Veterans Affairs hospitals. For a more thorough SWOT analysis, refer to Appendix D.

Methodology

One of the change theories that I found useful for the development of my project to improve documentation of PCA administration is Kotter's theory of change. Kotter's eight stage process for creating change is one of the leading theories in change implementation (Pollack & Pollack, 2015). The steps in Kotter's change theory are to establish a sense of urgency, create a guiding coalition, develop a vision and strategy, communicate the change vision, empower the change, generate short-term wins, consolidate gains, and anchor new approaches in the culture (King & Gerard, 2013; Pollack & Pollack, 2015).

Utilizing this change theory, I was able to create a sense of urgency with the staff regarding the potential patient safety issue associated with poor documentation of opioid administration, further develop my vision, and communicate my vision to empower change. I have developed my guiding coalition through gaining buy-in from key staff that will help to ensure spread of the documentation changes. Additionally, I will generate short-term wins by pointing out staff that are compliant with the new documentation requirements when conducting chart audits. As a result of their literature review, Pollack and Pollack (2015) discussed the theory that "the actual execution of a change [is] one of the key factors in determining success or failure" (p. 52). Utilization of this change theory helped me to organize the project and ensure steps were taken to determine successful implementation that is sustainable.

To implement my project on improving documentation of PCA administration, I will be providing in-services that outline the exact documentation requirements to the staff nurses on the

unit and speaking with nurses individually that are unable to attend the in-services. According to a study conducted by Yusufu (2008), education through in-services helps to train the new staff and re-orient experienced nurses so they both can keep abreast with the demands of nursing care. In-services are considered an acceptable educational tool for ensuring sustainable quality patient care and expertise (Yusufu, 2008).

Utilizing multiple teaching activities to match learning styles is one way to address learning barriers (McCrow, Yevchak, & Lewis, 2014). McCrow, Yevchak, and Lewis (2014) utilized a prospective cohort study design to determine the preferred learning styles of Registered Nurses (RNs) in acute care environments and found sensing and visual were the preferred learning styles. According to McCrow, Yevchak, and Lewis (2014), persons that favor a sensing learning style “prefer facts, data, and learning through practical and real world application” (p. 172) and persons that prefer a visual learning style “like pictures, diagrams, flowcharts, and reading books” (p. 172). Therefore, to meet the learning needs of all of the staff, I will provide a brief lecture, have handouts for the nurses to take that clearly outline the expected documentation criteria and the policies that govern the criteria, and allow time for questions.

To evaluate the effectiveness of my intervention, I will utilize data from a pre- and post-survey to ensure staff’s understanding and conduct chart reviews to ensure application of knowledge to practice. If the nursing staff report an increased understanding of the documentation requirements on the post-survey and apply their knowledge to practice, I will have reached my desired goal with this project. I predict the nursing staff will demonstrate an increased knowledge regarding thorough PCA documentation in the post-survey and will demonstrate application of their knowledge with thorough documentation.

Data Source/Literature Review

To conduct a thorough review of the literature supporting implementation of my project, I developed a PICO statement that was specific yet broad enough to ensure a return of relevant research articles. Riva, Malik, Burnie, Endicott, and Busse (2012) state when developing a strong PICO statement, it is important “to understand both the clinical area of investigation and the current literature that exists” (p. 170). The PICO statement I developed was: In post-operative adults (P), does standardized PCA medication documentation (I) when compared to non-standardized documentation requirements (C) show an improvement in pain management (O)?

After I developed my PICO statement, I was able to conduct a thorough review of the current literature to provide for the basis for my project. Riva et al. (2012) also suggest making sure the research question is well-thought-out and defines who will benefit from the research. Furthermore, Riva et al. (2012) reported, to ensure clinical significance, a PICO statement should “be one that is developed in conjunction with a diverse team” (p. 170). As the CNL in this project implementation, I collaborated with the healthcare team to ensure the literature search yielded the necessary results to demonstrate this project would result in improved patient care in the microsystem.

One of the articles returned during my literature search presented a study conducted by Abdalrahim, Majali, Stomberg, and Bergbom (2011) that sought to explore nurses’ knowledge of and attitudes toward pain before and after an educational offering on a surgical ward. Sixty-five nurses were surveyed and 240 patient charts were audited. The authors found a statistically significant difference between the nurses’ responses before and after the postoperative pain management education. Additionally, there was a statistically significant improvement in the documentation of patients’ pain assessment in 85% of the audited records.

In another article by Adamina, Kehlet, Tomlinson, Senagore, and Delaney (2011), the authors conducted a literature review on randomized, controlled trials comparing enhanced recovery pathways with traditional care for post-surgical patients and concluded enhanced recovery pathways were associated with improved pain control, a length of stay decrease by 2.5 days, and similar readmission rates. A random-effect Bayesian meta-analysis was performed on 6 randomized controlled trials with a total of 452 patients. The results indicate standardized pain control regimens followed by standardized documentation associated with the enhanced recovery pathway have a positive association with improved post-surgical pain.

In a study conducted on post-operative pharmacology, Hicks, Hernandez, and Wanzer (2012) describe the potential side-effects associate with PCA use; the potential errors with prescribing, transcribing, dispensing, and administering opioid medications via PCA; conclude PCA errors may be reduced through establishing standardized processes for perioperative nurses to safely administer, assess, reassess, and document pain medication administration. The authors assert some of the most effective post-operative pain medications are opioid analgesics, such as morphine and hydromorphone and PCA administration is commonly use post-operatively due to the quick onset and short half-life of intravenous opioids; however, the incidence of medication errors associated with PCA use is 5% higher than with other methods of opioid analgesia administration. Due to the increased potential for error, Hicks et al. (2012) recommends a standardized documentation process be established and staff education occur annually.

In another study, Samuels and Eckardt (2014) attempted to determine the impact of assessment and reassessment documentation routines on postoperative pain through analyzing the timing of pain and pain management documentation from 146 patients at three hospitals. The analysis of their data showed the presence of reassessment pain documentation within one hour

of the intervention was linked to patients' pain severity trajectory. This study will help to gain buy-in from the nursing staff through establishment of a link between documentation and the patients' pain level.

Samuels (2012) analyzed data gathered from pain management documentation reviews from three different hospitals to determine if consistent documentation practices were present at the different facilities. Due to the inconsistent documentation practices found at each facility, Samuels (2012) proposed standardized pain medication documentation to improve benchmarking efforts related to pain management among facilities.

Schreiber et al. (2014) conducted a quasi-experimental research study with a pre- and post-intervention on 341 medical/surgical nurse to evaluate an educational intervention created to improve pain management in the acute care setting. Data was collected at baseline and three months following intervention utilizing the Brockopp-Warden Pain Knowledge/Bias Questionnaire and found a 50% improvement in the nurses' assessment and documentation of pain post-intervention.

In a research project conducted by Purser, Warfield, and Richardson (2014), the authors gathered baseline data regarding pain assessment on the surgical and medical wards of a hospital in Northwest England, conducted education regarding a pain assessment tool that was placed at each bedside, and conducted follow-up chart reviews to determine the impact of the pain assessment tool education after eight months. The results of the study showed an increase in pain assessment documentation after the education intervention.

Saunders (2015) reviewed quantitative and qualitative data on practical interventions in patient care in order to develop a pain management care bundle that was integrated into the electronic health record in 15 medical/surgical units of nine hospitals. The pain management

care bundle documentation included assessing the patients' pain moving and at rest at least once per eight hours, treating the patients' pain when above tolerable level, and reassessing the patients' pain after each intervention for pain management. The pain management care bundle demonstrated an improvement in communication among the interdisciplinary team, increased standardization of pain management practices in the medical/surgical units, and increased quality of nursing documentation of pain management interventions. Through the conduction of this literature search, I was able to gather research that supports and will enhance the successfulness of the implementation of my project.

Timeline

To ensure successful implementation of my project, I developed a detailed timeline to outline the required steps and deadlines to ensure the project is completed in a timely manner. The Centers for Disease Control and Prevention (CDC, n.d.) recommends keeping the project timeline flexible to allow for modifications that arise as you are implementing your project. The CDC (n.d.) also recommends including start and completion dates, major deadlines, persons responsible for tasks, and any barriers that would prevent the project from moving forward.

The beginning of my project timeline starts with conducting the needs assessment for my unit. After I determined the need for education regarding thorough PCA administration documentation, I conducted a literature search which is the second step on my timeline. Utilizing the research I found during my literature search, I next developed standardized documentation requirements. To develop the documentation requirements, I worked with members of the Clinical Practice Committee. The Clinical Practice Committee is comprised of representatives from all areas of the hospital that are responsible for developing and updating all of the nursing policies and procedures. The collaboration of the Clinical Practice Committee

was essential to ensure the implemented changes would be able to successfully spread to the other units in the hospital that utilize PCA pumps.

Once the documentation requirements were developed, I presented them to the nurse managers of the acute inpatient units and obtained approval to go forward with the project implementation. Next, I worked on developing the handout that will be used during the in-services and will be maintained on the different inpatient units as a reference guide. During this time, I also administered the pre-survey to staff to gain an understanding of their baseline knowledge regarding the documentation requirements.

During the first week of April, I will be conducting in-services and one-on-one training with the nursing staff. Once the training is complete, I will also be administering a post-survey by April 16th to determine if there was an increase in knowledge related to documentation requirements. During the last two weeks in April, I will be conducting chart reviews for compliance and providing feedback directly to the employees and the nurse managers for follow-up with non-compliant staff. On May 1st, I will compile my data to determine if the project implementation was successful. For an outline of the project timeline including responsible persons and task completion dates, see Appendix E.

Expected Results

As a result of this project, I expect to find more consistent documentation of PCA pain medication, including the total amount of medication administered per shift and the effectiveness of the pain medication. I also expect to see an increase in the nursing staff's knowledge regarding pain medication documentation requirements. Furthermore, with the improved documentation, the physicians and pharmacists will have more readily access to the effectiveness of the patients' pain medication regimen and will be able to make adjustments as needed,

resulting in more effective post-operative pain management. If the expected outcomes are observed, it would be reasonable to conclude the nursing staff are eager to provide thorough documentation to improve interdisciplinary communication around the patient's plan of care.

Nursing Relevance

The significance of the implementation of this project to our present understanding is the reinforcement of the nursing staff's desire to provide optimal patient care. Without a thorough introduction to documentation requirements in orientation, misinformation or omitted information can lead to poor documentation practices and a gap in interdisciplinary care planning. As a result, the plan of care may not be effective or timely and the patient's discharge may be delayed. Furthermore, implementation of this project will demonstrate that nursing documentation can be improved with detailed guidelines, reference materials, and individualized feedback related to specific patient examples.

Summary Report

Through the work on this project, I aimed to standardize the documentation of PCA medication administration on 3 East to improve post-operative pain management, improve patient satisfaction, and improve patient safety. To implement this change, I worked with 44 RNs, five LPNs, and four NAs that care for patients on a 28 bed acute post-operative inpatient unit that also accepts overflow medicine patients. There are 10 surgical specialties and nine medicine teams that help to care for the patients on this unit. On average, the patients range in age from early 20s to late 70s and the majority of patients are male. Each shift is staffed with a minimum of six licensed nurses and their experience ranges from new graduate to over 30 years of experience.

To implement my project, I conducted chart reviews to establish the current documentation practices for patients with PCA pain medication. The chart review revealed only 26% of patients had the required components for PCA documentation and only 47% had at least one of the components. I then created a pre-quiz to determine the staff's baseline knowledge regarding facility policy requirements on documentation and the content of documentation. See Appendix F for the pre- and post-quizzes. The results of the pre-quiz showed none of the staff knew all of the required components for documentation or which policies to reference and on average, the staff were only able to answer 30% of the questions correctly. The results of the chart reviews and pre-quiz supported the need for this project.

To ensure staff would be able to retain the information I presented on thorough PCA administration documentation, I provided copies of the facility policy TX-35: Pain Management, the nursing policy Pain Reassessment, and copies of the PowerPoint used for the in-service. Additionally, I created quick reference guides on clearing the shift totals from the PCA pump and retrieving data that was cleared. The staff reported appreciation for the quick reference guides and the manager posted a copy on their unit. At the conclusion of the in-service, the staff completed a post-quiz to determine if there was an increase in knowledge. Additionally, the manager was appreciative of the copies of the policies and stated she was also unaware of them.

As a result of the focused in-services on standardized PCA administration documentation, the nursing staff, on average, were able to answer 84% of the post-quiz questions correctly and follow-up chart reviews revealed an increased documentation compliance of 60%. The results of the post-quiz demonstrated an increased awareness of facility policy and an increased knowledge of the required components of PCA documentation administration. The question most commonly missed on the post-test was true or false, pain is a complex, objective response with

several quantifiable features, including, duration, quality, impact, and personal meaning. The goal of this question was to remind staff that pain is subjective, not objective. I believe this question was missed because of the staff rushing to get back to their patients. When I pointed out the error as people turned in their quizzes, all of the staff stated they know pain is subjective and did not realize their mistake. The last question was designed to gain insight into the staff's confidence level with thorough pain documentation. After the in-service, 100% of the staff, a 50% increase, stated they were clear on the requirements of pain documentation.

The results of the follow-up chart reviews were not what I had anticipated. I had predicted a greater increase in standardized documentation compliance. Upon further reflection, I realize an increase in documentation compliance from 26% to 60% within a few week period should still be considered a success. One potential reason for this outcome was the inability to meet with every staff person. During the week of in-services, not all staff were on duty and did not receive the in-person training. In my future role as a CNL, I would consider this a mid-point review and continue to follow-up with staff that were not in attendance at the in-service. I would also continue to provide staff with overall unit compliance data and individual feedback to further support integration of standardized PCA documentation into their daily practice.

To increase the likelihood of sustainment of this project, I met with one unit champion from each shift to train them to be super users on the PCA pump and documentation requirements. In a review of the literature, Scheirer (2005) examined the extent of sustainability achieved and the different factors that contribute to greater sustainability. Two of the factors that were found to consistently influence the sustainability of a project were the presence of a unit champion and the perceived benefits to the staff members for sustaining the change (Scheirer, 2005). To solicit unit champions, I worked with the nurse manager to identify staff that are

perceived as leaders by their peers. I met with each of them, went over the usage of the PCA pump and the documentation requirements. I also worked with the nurse manager to go over the frequency of education and re-education for staff on the PCA pump, appropriate documentation, and the importance of staff feedback. French-Bravo and Crow (2015) found in their research that “the more buy-in employees demonstrate in support of the change, the more likely the change will be successful and sustained over time” (p. 1). Through the development of the unit champions and continual feedback for the nursing staff, I intend to make the work from my project a standard of nursing practice throughout the unit.

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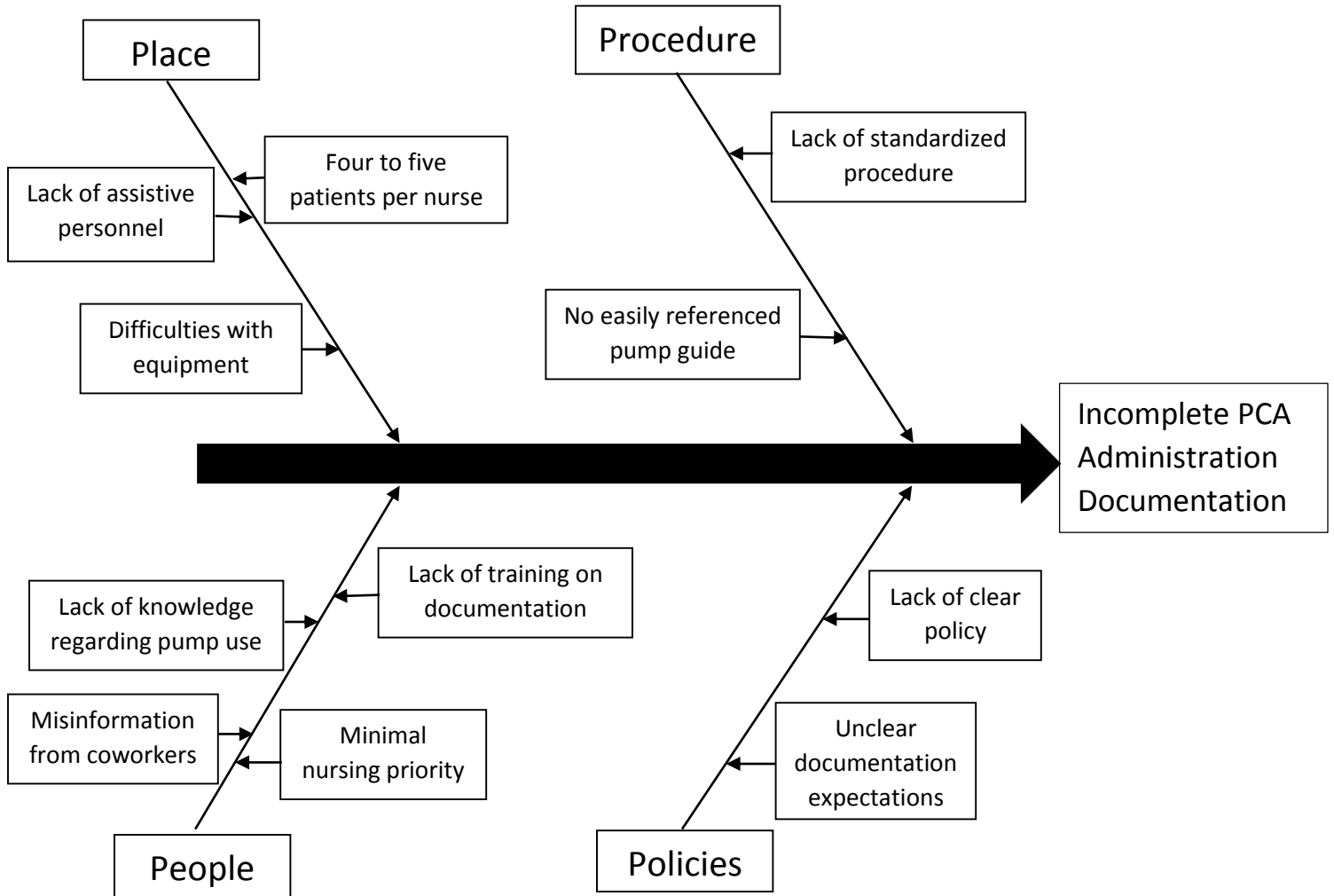
Appendix A

Projected Cost Analysis

Materials & Labor	First-Year Costs	Second-Year Costs
CNL and/or Nurse educator wages	\$45/hr x 0.5 hrs x 3 educators x 6 sessions = \$405	N/A
Staff nurse wages	\$25/hr x 0.5 hrs x 150 nurses = \$1,875	N/A
Educational handouts	\$0.50/handout x 60 handouts = \$30	\$0.50/handout x 20 handouts = \$10
Evaluation of policy implementation (CNL wages)	\$45/hr x 1 hr/wk x 52 wks = \$2,340	\$45/hr x 1hr/mo x 12 mos = \$540
Total	\$4,650	\$550

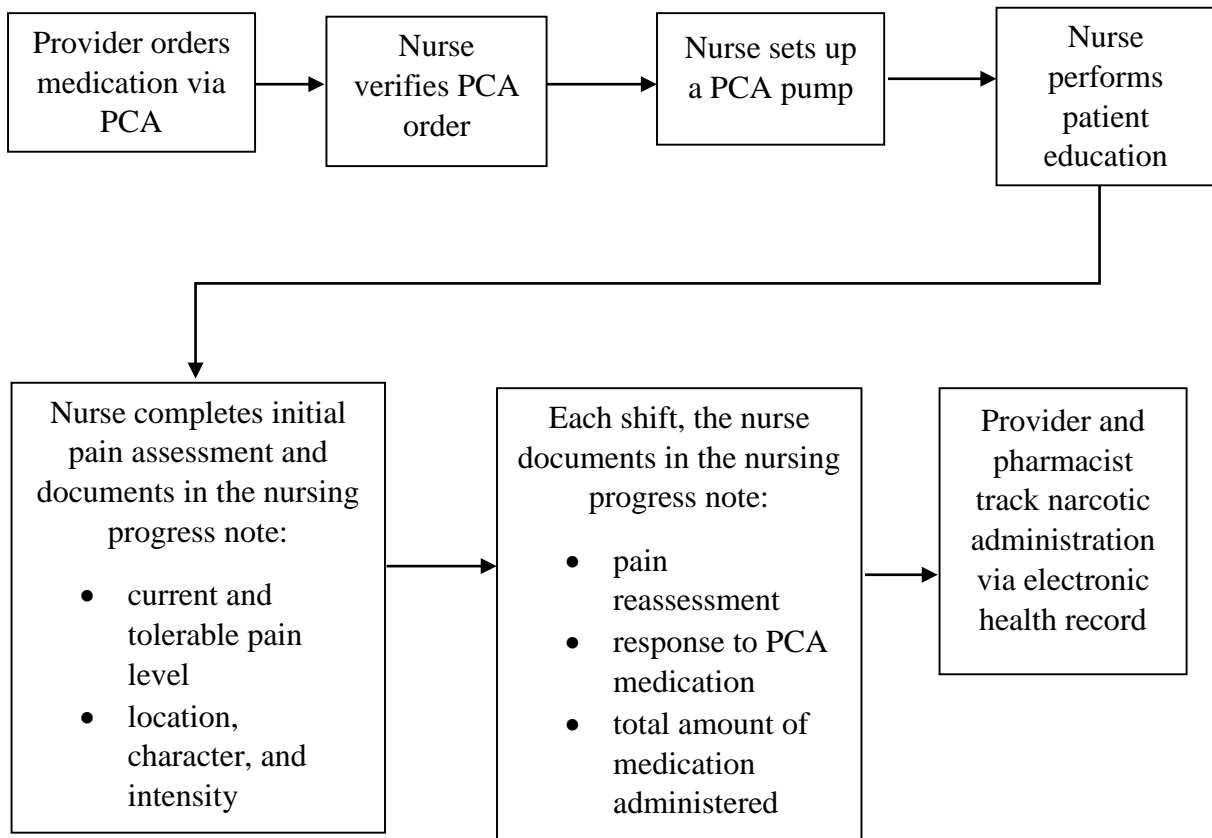
Appendix B

Fishbone Diagram



Appendix C

Flow Chart



Appendix D

SWOT Analysis

Internal or Present		Negative or Cost
<p>Strengths</p> <ul style="list-style-type: none"> • Desire by nursing staff to provide optimal post-operative pain control • Standardized nursing progress note for documentation • Physicians willing to implement change to improve pain control 	<p>Weaknesses</p> <ul style="list-style-type: none"> • Large unit with 3 shifts providing care 24 hours/day and 7 days per week • Inconsistencies among ordering providers and pain service • Miscommunication passed between nurses on documentation 	
<p>Opportunities</p> <ul style="list-style-type: none"> • New pain medications for patients • Improve patient's knowledge regarding pain medication after surgery • Teaching hospital provides opportunities to bring in new ideas in pain management and teach residents • Decrease narcotic use • Improve interdisciplinary communication regarding pain management • Adhere to AHRQ guidelines for documenting pain qualifiers with pain assessments 	<p>Threats</p> <ul style="list-style-type: none"> • Patient satisfaction scores as drivers • Negative perceptions about the care at VA hospitals • New charting system with new templates rolled out in next 2 years • Lack of universally accepted guidelines for pain assessment and reassessment documentation 	
External or Future		

Positive or Benefit

Appendix E

Timeline

	1/26-2/6	2/7-2/20	2/21-3/5	3/6-3/19	3/20-4/2	4/3-4/9	4/10-4/16	4/17-4/23	4/24-5/1
Conduct a Needs Assessment	CNL-Completed								
Conduct a Literature Search	CNL-Completed								
Develop Standardized Documentation Requirements	<i>CNL with Clinical Practice Committee-Completed</i>								
Obtain Approval	<i>CNL with Nurse Managers-Completed</i>								
Develop Handout	CNL-Completed								
Administer Pre-Survey	CNL-Completed								
Conduct In-Services	CNL-Completed								
Administer Post-Survey	CNL-Completed								
Conduct Chart Reviews	CNL-Completed								
Provide Individual Feedback	<i>CNL and Nurse Manager-Completed</i>								
Conduct a Final Chart Audit for Compliance	CNL-Completed								

Appendix F

Pre- and Post-Quizzes

Pre-Quiz

Please take this quick quiz so I can determine if this in-service was helpful for you.

1. The facility's policy on pain management is TX-_____.
2. True or False: I am familiar with all of the requirements for pain assessment, reassessment, and documentation outlined in Nursing Policy: Pain Reassessment.
3. Where are three locations we are required to document a patient's pain level?
 - a. _____
 - b. _____
 - c. _____
4. True or False: Pain is a complex, objective response with several quantifiable features, including intensity, duration, quality, impact, and personal meaning.
5. Proper pain medication documentation includes:
 - a. _____
 - b. _____
 - c. _____
 - d. _____
 - e. _____
6. Pain should be assessed _____
7. True or False: I am clear on where and how often I should document pain.

Post-Quiz

Please fill this in so I can make sure this in-service was helpful for you.

1. The facility's policy on pain management is TX-_____.
2. True or False: I am familiar with all of the requirements for pain assessment, reassessment, and documentation outlined in Nursing Policy: Pain Reassessment.
3. Where are three locations we are required to document a patient's pain level?
 - a. _____
 - b. _____
 - c. _____
4. True or False: Pain is a complex, objective response with several quantifiable features, including intensity, duration, quality, impact, and personal meaning.
5. Proper pain medication documentation includes:
 - a. _____
 - b. _____
 - c. _____
 - d. _____
 - e. _____
6. Pain should be assessed _____
7. True or False: I am clear on where and how often I should document pain.

8.