

Problem Statement

- Pain significantly affects quality of life of oncology patient and is often under-treated.
- Inconsistent pain assessment documentation prevents providers from evaluating pain medication effectiveness and adjusting treatment plans
- Inadequate pain assessment documentation hinders treatment optimization, risking under-treated pain.
- Inadequate adherence to unit and hospital standard protocol/policy for pain assessment and reassessment documentation.
- In a community hospital oncology unit, 5% of patients lacked initial pain assessments, and 43% had no documented pain reassessment

Purpose and Goals

Purpose statement: The purpose of this quality improvement initiative is to increase the documentation of pain assessment and re-assessment among nurses working in an oncology unit of a medium-sized community hospital through the application of visual reminders, chart audits, and feedback.

Process Goals

- 100% documentation of initial shift pain assessment in the EHR once a shift according to the organization's policy.
- 100% documentation of pain re-assessment in the EHR within 60 minutes of administering as needed (PRN) pain medication per organization policy.

Methods

Setting: The oncology unit of a medium-sized community hospital.

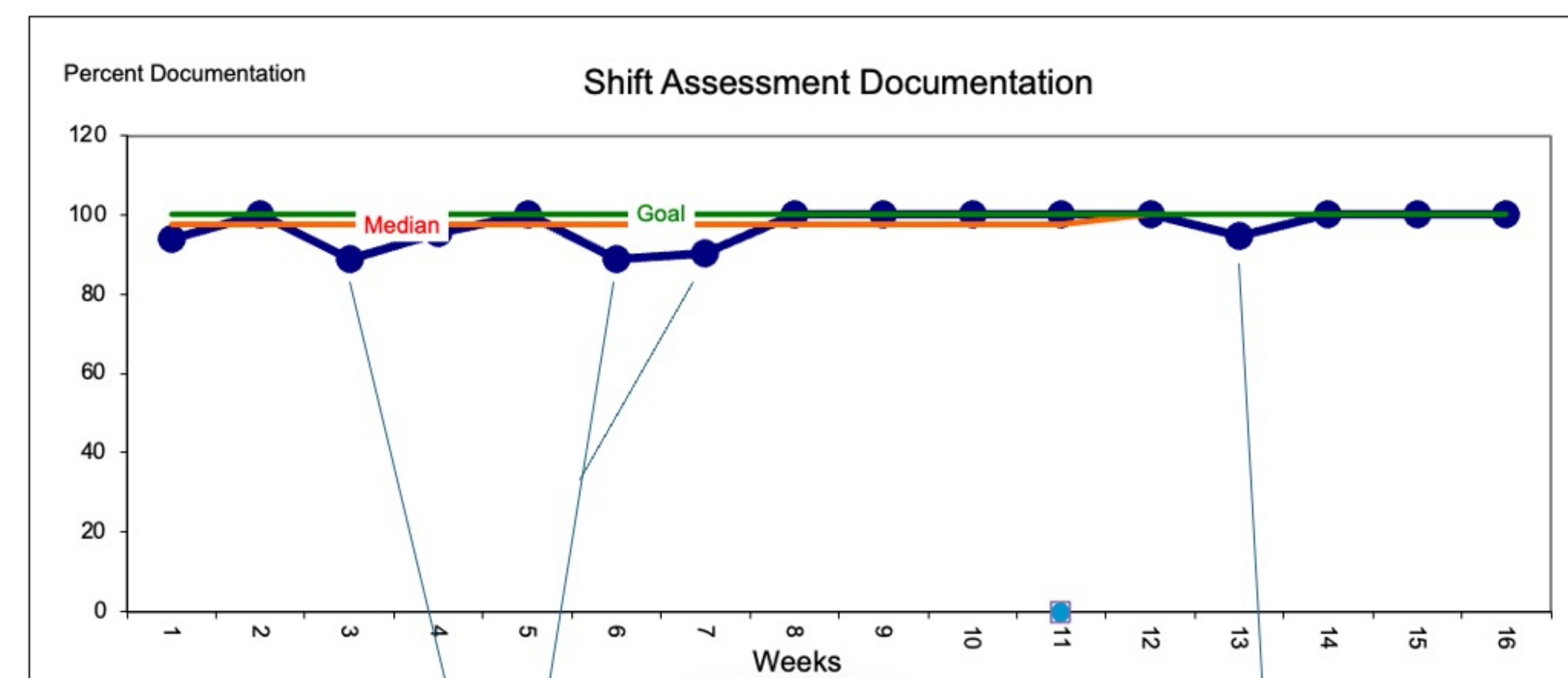
Population: All registered nurses employed on the oncology unit

Intervention: Visual reminders, regular chart audits, and staff feedback

Implementation Strategies and Tactics: Obtained buy-in with unit leadership, obtained staff work email address, obtained access to electronic health record, completed staff education, provided printed and laminated visual reminder posted in patient rooms and at nursing documentation stations, constructive feedback provided to staff members with missing pain documentation via work email.

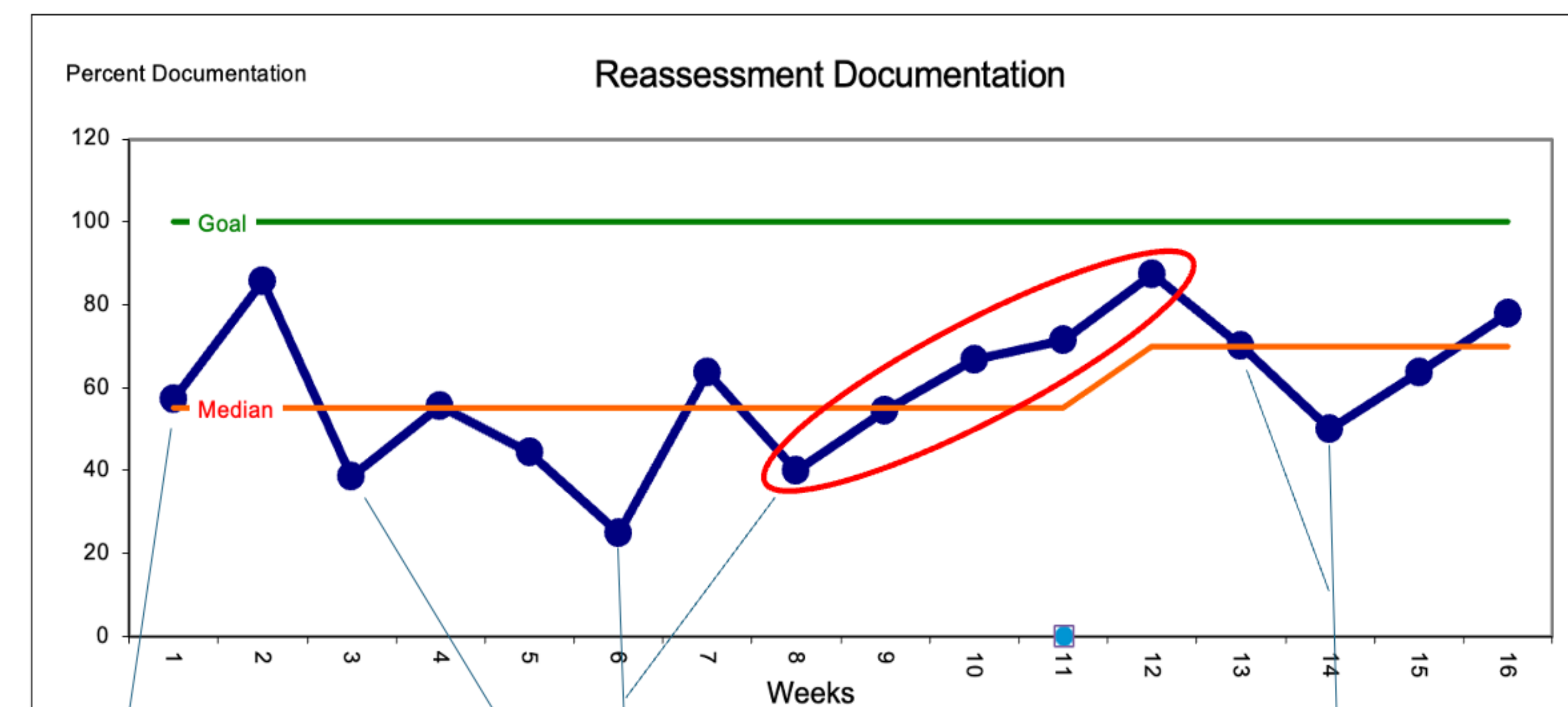
Data Collection: Weekly chart audit to assess unit progress on pain documentation. All project-related data was stored on REDCap.

Results



Email feedback sent to nurses to encourage adherence to pain evaluation documentation

Presence of temporary/float staff on the unit who did not receive education and unable to receive feedback email.



Staff education and knowledge re-enforcement

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Discussion

- The process goal of 100% shift pain assessment documentation was achieved.
- A 100% documentation of pain re-assessment documentation was not achieved.
- However, an upward trend in pain reassessment documentation can be observed in weeks 8 to 12 and weeks 14 to 16.
- Email feedback/documentation reminders was sent to staff to encourage documentation which eventually led to a consistent rise in documentation compliance starting in week 8 and again in week 14.

Limitations

- Staff resistance to change
- The tendency to revert to familiar routines
- Presence of temporary float staff

Conclusion

Usefulness and implication for practice

- Visual reminders, chart audit and email feedback are simple evidence-based intervention to improve pain evaluation documentation on an oncology unit.
- Cost-effective and can be implemented without advance training

Sustainability and Spread

- Visual aids should be left in place at the documentation stations to continue to serve as a cognitive reminder for
- Staff re-education to reinforce the importance of pain evaluation and documentation.
- Low cost and can be adopted in other areas of the organization where frequent pain assessment and reassessment is necessary for optimal patient care, and areas with limited electronic health record.

Next Steps

- Monthly staff education
- Assign unit documentation champions and chart reviewers
- Implement quarterly documentation feedback to nurses on unit progress with pain evaluation documentation
- Future quality improvement initiative should focus on implementing automatic electronic pain re-assessment reminders that auto populate when a pain medication is scanned or documented as given.

References



Visual Aid

