

Implementing the use of a patient-reported satisfaction metric was intended to complement the pain screening and associated follow-up by a licensed independent practitioner (if applicable) occurring at every ambulatory visit. This coincided with an evidence-based practice initiative related to routinely offering interventions for needlestick pain to both adult and pediatric ambulatory patients. In March 2013, a new Ambulatory Pain Committee began collaborating with the Office of the Patient Experience on this initiative. The available customized questions from the vendor, who sponsors the institution's patient satisfaction surveys, were reviewed. The group recommended the inclusion of a new survey item, Our Sensitivity to Your Pain. In May 2015, final approval and sign-off was obtained from the Chief Nursing and Medical Officers. To date, no other organization has chosen to use the same customized question, preventing external benchmarking. However, internal benchmarking between the 44 ambulatory areas in the organization is occurring and "best practices" are shared between areas. Quarterly pain-related patient satisfaction updates have been provided to the Ambulatory Pain Committee since the survey item was added and an annual update is reported to the Department of Nursing Pain Committee. The addition of this item to the survey has resulted in an increase in free text pain-related comments by patients and family members. Since May 2016, these comments have been shared on a weekly basis to highlight positive patient experiences or additional opportunities to improve pain-related care.

Posters

C1 Transforming Pain Management from the Perspective of a Neurobiopsychosocial Pain Practice

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The purpose of this paper is to reflect on our present-day knowledge about the nature of pain in order to better inform pain assessment and management. Pain has been well defined as a neurobiopsychosocial experience. Evidence supporting this classification has emerged from a multidisciplinary collective, including neuroscience, medicine, nursing, psychology, and a lesser-known component, somatic therapy. Pain, whether acute or chronic, is a phenomenon that elicits an intricate perceptual process and a complex affective response. That pain is an experience of one's entire being is borne out in a continuum of evidence extending from patient narratives to fMRI images. The benefit of integrative strategies to address pain management is well documented, including therapies utilizing exercise and interoception-focused somatic movement, meditation, breath work, psychotherapy, and pharmacology. A numerical rating scale alone has been found to be an inadequate measure of pain and is poorly correlated to patients' satisfaction with overall pain management. And yet, pain assessment continues to primarily reflect a biomedical paradigm, with emphasis on a unidimensional measurement of pain intensity obtained either by numerical or image-based tools. Assessment based on components such as patient narrative tends to be devalued. As a result, pain management continues to primarily reflect a pharmacology-centric model in which multidisciplinary strategies able to modulate the pain experience occur only as alternative and secondary interventions rather than as equally indispensable components that support a well integrated pain management plan of care based on patients' unique attributes and histories. Reconfiguring pain assessment to better match patient characteristics with treatment modalities will require a cultural transformation inclusive of clinician education, methods of pain assessment and skills for effective patient engagement. This paper thus queries the cultural shift necessary to transform the traditional model of pain management into a practice that reflects present-day neurobiopsychosocial knowledge.

C2 Peripheral Nerve Catheters for Post-operative Pain Control in Patients Undergoing Orthopedic Surgeries

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Pain control is critical to help ensure the clinical success of surgery for total knee arthroplasty (TKA). A comprehensive plan of pain care aims to optimize patient comfort in order to support recovery while

minimizing pain management related side effects, particularly those stemming from opioid-based medications. In 2014, The Swedish Orthopedic Institute (SOI) began using the continuous adductor canal nerve block (ACC) for patients undergoing total knee replacement. Subsequently, our group conducted a retrospective data analysis of 796 patients that revealed statistically significant decreases in mean and peak pain scores, decreased total opioid consumption, and better range of motion at discharge for the ACC group (n=406) compared to those without ACC (n=390). Presently, nearly all patients undergoing TKA at SOI receive ACC in addition to treatment with a multi-modal pain protocol. Further, we now use a similar approach to support shoulder (brachial plexus block), hip (femoral nerve block), and ankle (sciatic nerve block) surgeries. A local anesthetic is dispensed as a continuous infusion by an elastomeric pump that delivers a regulated flow of medication through the peripheral nerve catheter (PNC). Patients go home with the PNC, and then remove it themselves once the infusion pump is empty. These PNCs are managed by nurse practitioners and anesthesiologists on the acute pain service, but RNs provide important patient assessment, monitoring, and reinforcement of patient education. The purpose of this clinical presentation is to review PNC placement, function, removal, and patient education, along with key points for relevant patient assessment.

C3 Non-pharmacological Acute Pain Control Utilizing Nurse-led Aromatherapy in Coronary Bypass Graft Patients: A Pilot Study

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AIM OF INVESTIGATION

Coronary Artery Bypass Graft patients require adequate pain control post-operatively in order to effectively participate in cardiac rehabilitation. Complimentary non-pharmacological pain control is essential to limit known side-effects of narcotic agents. Methods of this project included a pre and post pain score evaluation using the pain Assessment Intervention Reassessment (AIR) cycle, a nursing sensitive indicator. A rating system of 1-10 was used before and after intervention. Intervention included distillation of essential oils through aerosol, massage, or application of diffuse cotton gauze to bed linens.

RESULTS

Pre-intervention pain score mean was 6.68 with a median of 6. Post-intervention pain score mean was 5.08 with a median of 5. There were 25 participants with the years of age ranging from 31-82 who had a Coronary Artery Bypass Graft with post-operative acute pain. The average decrease in pain from pre- to post- was 1.6 and the paired t-test for the score reduction from pre- to post was significant ($t = 5.5$ and $p < .0001$). There was a significant decline in pain following Aromatherapy, compared with no treatment.

CONCLUSIONS

Aromatherapy can be used among bedside nurses with a process guided by protocol. Usage of essential oils in the Cardiovascular Intensive Care Unit among CABG patients was shown to be a viable complementary therapy for patients requiring non-narcotic pain control.

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C4 Improving the Understanding of Pain Disability through Concept Analysis

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AIMS

The aims of this concept analysis were threefold: (1) To clarify the concept of pain disability (PD); (2) to provide a global framework for the