

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

identification of essential characteristics of PD; and (3) to increase visibility of the concept within the discipline of nursing.

METHODS

Walker and Avant's (2011) method of concept analysis provided the guiding framework. The authors completed a cross-disciplinary literature search in PubMed, CINAHL, PsychINFO, and Scopus to identify relevant literature.

RESULTS

The authors identified 39 articles for use in this analysis. The defining attributes of PD included: (1) The physical and/or psychological response to a painful trigger leading to a functional loss; and (2) The degree of ability to fulfill social and occupational role expectations. Biological, psychological, and social conditioning factors were found to influence the context of an individual's PD experience. The antecedent of PD was recognized as a painful trigger. The consequences of PD included physical and psychological suffering, experiencing secondary loss, and embracing new pain behaviors. Empirical referents directly measure the painful trigger, the physical/psychological consequences, and the functional limitations exhibited.

CONCLUSION

Through concept analysis, PD can be defined as the inability to maintain role expectations as the result of a painful trigger and subsequent physical and/or psychological dysfunction. Coping ability and strategies were identified as moderating factors in the PD cycle, both in response to the painful trigger as well as a product of pain behaviors. This process is further influenced by the personal and contextual conditioning factors that reflect person-environment interaction. This proposed model provides a framework for nurses to identify patients vulnerable to or currently experiencing PD as well as provides the groundwork for further investigation and comprehension of the relationship between pain and disability.

ILLUSTRATION

A proposed model of pain disability will be included.

C5 SCENTSible Aromatherapy

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The purpose of this project was to introduce aromatherapy within our organization as a nurse led symptom management intervention. Given the current issues surrounding opioid use, our pain group decided to explore other options that trained nursing staff (e.g., RN, MA, NA) could implement to improve the patient experience. Aromatherapy was chosen since it wasn't already something that we were using. External benchmarking was done with other organizations, experts and via the literature to assist in forming our organizational policy and procedure. A pilot was completed on our labor and delivery unit to determine feasibility and a process for implementation. Once feasibility, safety for patients and staff as well as patient satisfaction was established, a policy and procedure, documentation in the electronic medical record, and formal staff and patient education were taken through the appropriate organizational approval process. Surveys from staff and patients were obtained to garner data to support the project and other opportunities for improvement. Implementation began slowly via a step-wise process throughout the organization (e.g., one area at a time). To date, a majority of our inpatient areas and some outpatient areas have successfully implemented aromatherapy. In addition, there have been no adverse outcomes and only positive patient and staff feedback.

C6 What a Pain! Meeting The Joint Commission Standards for As-Needed Medication Indications

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The purpose of this project was to eliminate therapeutic duplication of PRN orders in the electronic medical record (EMR) and improve inter-professional collaboration, education and safety surrounding PRN

medications. Our organization lacked a standard approach to prevent therapeutic duplication. This was important for us to address since it is an important patient safety issue and violates The Joint Commission and Centers for Medicare and Medicaid Services compliance standards. The lack of clarity around medication orders resulted in inconsistent practices between nursing shifts and could cause misinterpretation of the providers' intent of therapy. Our organization created new as-needed reasons for key therapeutic classes with the assistance of all key stakeholders input. These new indications were then incorporated into new PRN order indications within the EMR system. Alerts were created for providers during order entry and for pharmacists during order verification of potential therapeutic duplication. Policy and collaborative practice enhancements as well as interprofessional educational materials and organizational campaign communications were created. Chart audits were performed pre- and post-implementation for the presence of therapeutic duplication. Post-implementation, an electronic survey of providers, nurses and pharmacists was done to ascertain if the changes made were positively impactful or not. Our results indicated that our organizational efforts were successful in improving patient safety and reducing therapeutic duplication without adversely impacting inter-professional workflow and processes.

C7 Improving Pain Management through the Creation and Commitment of a Pain Resource Nurse Program

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Pain management that is effective continues to be a challenge in acute care. One strategy implemented to increase patient satisfaction, and professionally develop nurses in the area of pain management, was to create a Pain Resource Nurse (PRN) Program. This evidence-based program, started in 2012, was designed to promote a cost-effective and unified approach to implement quality pain management. The PRN program at our organization, nurses representing each of fourteen clinical areas throughout the hospital, meet monthly for eight hours. PRN meetings focus on professional development, educating colleagues, patient rounding, researching best practices, and policy development. An annual two-day education program is facilitated to educate all clinicians in pain management. The PRNs interface with staff at the unit level as a peer resource and role model assisting to solve pain management problems, disseminate new information, and inspire positive change. Members assume an active role in promoting practice changes that will improve the quality of pain management for all patients. Since its creation, the PRN Program has shown positive outcomes. Patient satisfaction results via HCAHP scores indicate a consistent increase in all pain management domains over 5 years. The data reflects a 10 point improvement in "Always" patient responses, improving the hospitals standing from the 4th to 67th percentile among hospitals within the state, and 19th to 85th percentile among similar sized facilities. The PRN program functions as an interactive, multifaceted approach to pain management that improves both patient satisfaction and professionally develops staff. Staff enhanced their skills in terms of communication, evidence-based practice, and clinical knowledge. Members identify practice gaps and respond by a variety of process improvement tactics. It is possible to have a sustained improvement of patient satisfaction when a group of nurses is dedicated to focusing on initiatives related to pain management and improving patient outcomes.

C8 Sustaining Nurse-delivered Massage in Hospital Settings: A Global Perspective from Rome

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AIM OF INVESTIGATION

Research supports massage as a non-pharmacologic intervention to manage symptoms of pain, anxiety, and stress. This session examines how hospitals in Italy successfully integrated nurse-delivered massage using a Community of Practice theoretical model, and discusses how similar integration could occur in the U.S.