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Implementation of a Scripted Education on Comfort Goals to Improve Patient Perception of Pain Control

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IMPLEMENTATION OF A SCRIPTED EDUCATION ON COMFORT GOALS TO IMPROVE PATIENT PERCEPTION OF PAIN CONTROL

A Scholarly Project

Submitted to the

Faculty of Liberty University

In partial fulfillment of

The requirements for the degree

Of Doctor of Nursing Practice

By

Victoria F. McLean

Liberty University

Lynchburg, VA

March, 2018
IMPLEMENTATION OF A SCRIPTED EDUCATION

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Title Page

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ABSTRACT

Pain management is the culmination of physician, nurse, and patient expectations. Successful pain management is impacted by the patient’s perception and expectation of the provided interventions, as well as the perception of the care provider of the patient’s pain. Pain assessment tools have been utilized for decades and still pain control is rated as inadequate. Providing scripted education to the patient on the purpose and utilization of these tools impacts the patient’s perception of pain management. This project implemented the evidence-based practice intervention of education to improve the relationship of comfort goals to pain management. Nurses’ knowledge of pain management may impact the quality of patient education. This variable was addressed by providing education to the nursing staff prior to the start of the project. A pretest and posttest was administered to measure change in knowledge. The staff showed a statistically significant change in the understanding of a comfort goal, 44.66% prior to education and 96% (p = of 0.00) after education. Change of practice was indicated in the pre and post documentation of comfort goals. Prior to the education, only 31.48% documented a comfort goal greater than zero, after, 68.51% (p = 0.02). The patient’s response was measured by a discharge survey on pain management satisfaction. The survey revealed that 68.18% (p = 0.61) of the patients felt their pain was always well managed. This was clinically significant, however, did not show statistical significance. This project supports intentional education of staff and scripted education on comfort goals to alter the patient’s perception of pain management.

Keywords: comfort goals, pain management, function goal, and pain scores
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by

Victoria F. McLean
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Special Thanks for the support and care of my project committee

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To my children; Stephen, Kathryn and Jonathan my at home support group, I could not have done it without you.
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List of Abbreviations

Centers for Medicare & Medicaid Services (CMS)
Certified Nurse Aide (CNA)
Clinical Nurse Specialist (CNS)
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
Licensed Practical Nurse (LPN)
Promoting Action on Research Implementation in Health Services (PARiHS)
Registered Nurse (RN)
The Joint Commission (TJC)
SECTION ONE: INTRODUCTION

Pain control has historically presented challenges for health care professionals and their patients. The perception of pain is different for each individual and needs to be addressed by the health care provider to meet that perception. Patients also verbalize the expectation that pain medication should be able to alleviate all their pain (Mathias, Parry-Jones, & Huws, 2013). Pain management is associated with the delivery of medication but Pasero and McCaffery (2004) emphasize the addition of non-pharmaceuticals to improve pain. Pain management is the blend of pharmaceuticals and non-pharmaceuticals to obtain a satisfactory level of comfort as defined by the patient (Pasero & McCaffery, 2004). Controlling pain to the patient’s expectation related to illness or procedures has been a strategic plan in the reimbursement to hospitals for their care (Ketelsen, Cook, & Kennedy, 2014). Pain scales, as an administration of pain control measures (Bhatnagar & Gupta, 2015) and increasing the patient’s own involvement in the control of their pain has led to the evidence-based use of comfort goals. A comfort goal is the level of discomfort or pain at which the patient feels they can still perform activities related to their recovery. A pointed, scripted education of the purpose of the comfort goal should provide the patient with a realistic perception of pain control (McLean, 2016).

Background

Patient satisfaction scores are used to measure the success of hospitals and provide a reference for reimbursement. Center for Medicare and Medicaid Services (CMS) quality based payment plans will account for 11% of reimbursements for hospitals (Ketelsen et al., 2014). Value-based purchasing accounts for 2% of that 11% (Ketelsen et al., 2014). That 11% is broken down into four sections: Hospital Consumer Assessment of Healthcare Providers and Systems
(HCAHPS) at 25%, outcomes at 40%, process of care measures at 10% and efficiency at 25% (Ketelsen et al., 2014). HCAHPS is a survey of the patient experience during hospitalization (Ketelsen et al., 2014).

The Joint Commission (TJC) revised and clarified the standard reflecting the management of pain beginning in January 2015 ("Joint Commission Perspectives," 2014). Standard PC.01.02.07 states that organizations will assess and manage pain. TJC allows for a wide scope of management methods ("Joint Commission Perspectives," 2014). The organization may use both pharmacologic and non-pharmacologic methods. The organization is also charged to make pain management patient centered ("Joint Commission Perspectives," 2014). Success of this standard is measured by patient response to the HCAHPS survey. Two questions are reflective of this measure. Question one is “During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?” Question two is “During this hospital stay, how often was your pain well controlled?” (CMS, 2014). The scores from this survey affect the hospitals’ reimbursement.

These two questions measure the patient’s perception of the staff’s attempt to control the patient’s pain and whether or not that pain was well controlled (Ketelsen et al., 2014). High patient satisfaction with pain control has been linked to better long-term outcomes (Ketelsen et al., 2014). Studies have also shown a link to the communication of pain expectations to patient satisfaction (Studneck Fernandez, Vandeventer, & Davis, 2012). Studneck et al. (2012) found that patients who understood the likelihood of pain could participate in the management of the pain and the activities of recovery better than those who expected to have no pain.

Documentation of comfort goals, pain scales, and reassessment of pain response after the administration of medication is a regulated process by the CMS (n.d.). Nurses will, however,
frequently apply their own perceptions of pain to the patient, such as with comfort goals (Overcash, Hines, Birkhimer, & Askew, 2013). Misunderstanding on the part of the nursing staff and a desire to provide good pain control often create the projection of comfort goals (Overcash, Hines, Birkhimer, & Askew, 2013).

The cardiac intermediate care unit of a local healthcare organization has faced challenges with these questions. They receive high scores on the question “Did the staff do everything they could to control your pain?” but low scores on “my pain was well controlled” (Centra People, n.d.). Scores for the unit reflected a 67% response of always to how often the pain was well controlled, contrasting to an 80% always response to how often did the staff do everything they could to help you with their pain (Centra People, n.d.). The HCAHPS handbook shows a correlation between the patient’s perception of pain control and communication with caregivers. Clear, repetitive education about pain control expectations is one of the key factors to that communication (Ketelsen et al., 2014). Scripting communication is a recommendation that has been successful in improving satisfaction scores (Tinkham, 2014).

A review of the nursing documentation, in the normal course of this Clinical Nurse Specialists (CNS) workflow, showed that on 30 out of 30 charts initial comfort goals were zero. These 30 charts were from a mixture of medical, procedural, and surgical patients. This CNS was also tasked to assist in improving the patient pain survey scores from HCAHPS for the interventional unit. The evidence-based correlation of patient education to improved patient pain control satisfaction prompted the desire to implement a new educational intervention. A comfort goal of zero is not a true expectation after a procedure or surgery. These goals reflect poor communication by nursing staff or poor understanding by the patients (Pasero & McCaffery, 2004).
Problem Statement

Patient satisfaction surveys report low scores on pain control for the interventional unit. Documentation of zero for a comfort goal on procedural and surgical patients reflects unrealistic expectations. The primary impacting factors for unrealistic pain control according to Pasero and McCaffery (2004), are educational. The educational deficits of both the nursing staff and their education of the patient on the purpose and intent of a comfort goal create the poor expectations.

Purpose and of the Project

The purpose of the project was to improve nursing knowledge of pain management and patient satisfaction with pain control in the cardiac intermediate care unit. This was achieved through improved communication and understanding. First, by the education of staff on comfort goals and pain scores. Second, by the use of nurse delivered scripted education to the patient on comfort goals and their intent.

Clinical Question

The clinical question was, Can scripted education to the patient improve understanding of the use of comfort goals in pain management thus improving patient satisfaction with pain control?

SECTION TWO: LITERATURE REVIEW

The key words utilized in the literature review were: pain management, patient perceptions, patient satisfaction, nursing perception of pain, pain scores, comfort goals and Press Ganey pain scores. A time span of January 2010 to May 2017 was entered into the database search. The project leader used databases focused on nursing and medicine. These included: CINAHL Plus, Health Source: Nursing/Academic edition, JAMA, Journals@ OVID, MEDLINE
with full-text, Nursing and Allied Health and the Nursing Reference Center. Levels of evidence for the articles ranged from seven to two based on Melnyk’s Pyramid (2010) and are individually cataloged (see Appendix B).

A great deal has been written on the management and assessment of pain. Studies have focused on the patient as the definer and communicator of pain. The caregivers’ perception of the pain experience and interpretation of pain management guidelines has also been given due diligence. Still, hospitals struggle to obtain high patient satisfaction scores for pain control. The satisfaction of patients with their pain control has been linked to better recovery outcomes as far as a year after discharge (Ketelsen et al., 2014). Recommendations for improving patient pain control have focused on early education, as to interventions and expectations (Glowacki, 2015). Education of pain interventions showed improved satisfaction with pain control in those patients receiving medical care without interventions, as well as those receiving surgery.

Two separate studies showed that education in pain expectation improved mobility in post procedural and surgical populations (Glowacki, 2015; Wadensten, Frojd, Swenne, Gordh, & Gunningberg, 2011). The patient’s ability to self-report pain level and trigger medical responsiveness is recommended by the Society of Critical Care Medicine to improve the patient’s perception of pain control. Nurses, however, frequently impose their perception of pain control on the patient (Overcash et al., 2013). Hospital reimbursement is linked to the patient satisfaction with pain control (Ketelsen et al., 2014). CMS and TJC have established that hospitals utilize comfort goals and pain scales (Ketelsen et al., 2014). They also require reassessment after pain medication administration (CMS, n.d.). Patients who have an expectation of pain and understand that they will need to perform activities of daily living to attain recovery with some degree of pain, tolerate pain better than those patients who expect no pain (Oien,
Raheim, Iversen, & Steihaug, 2008). Education of nurses will improve their differentiation of comfort goals and pain scales. The improved knowledge will assist the nurse to educate the patient to appropriate expectations (Bozimowski, 2012). The utilization of nurse delivered scripted education on comfort goals and pain management can improve patient understanding of pain management. Scripted education can also provide consistent delivery and content of pain management information from the care providers (Martin, 2015).

Margo McCaffery and Chris Pasero are leaders in understanding pain management and identify that an important aspect of pain intervention is the assessment of the interventions effectiveness (Pasero & McCaffery, 2004). A patient chosen comfort goal provides an assessment for the effectiveness of the pain intervention. The nurse should have intentional conversations with the patient at regular intervals to determine if the comfort goals are being met by the intervention and whether the patient can perform the tasks needed for recovery (Pasero & McCaffery, 2004). An inability to attain the selected goal would trigger an adjustment in the prescribed pain control interventions. This would reflect both pharmaceutical and non-pharmaceutical treatments (Pasero & McCaffery, 2004). The education on comfort goals should reflect the inappropriateness of both high and low extremes (Pasero & McCaffery, 2004). High comfort goals would provide poor pain control limiting participation in daily recovery functions and a goal of zero would reflect a poor understanding of the capabilities of pain relief measures (Pasero & McCaffery, 2004). Previous studies have indicated that a comfort goal greater than three does not allow adequate pain control to support adequate function in the postoperative patient (Pasero & McCaffery, 2004). Glowacki (2015) established that the education of the nurses in pain management and reinforcement of that education at regular intervals improved delivery of pain management and assessment. Pasero and McCaffery (2014) further confirmed
the connection of nursing education to the use of comfort goals to establish adequate pain intervention. They also linked the level of the nurses’ education as key component in the establishment of proper comfort goal usage (Pasero & McCaffery, 2004). Nurse education also changes their delivery of patient education which influences the outcomes of patient satisfaction with pain control.

**Conceptual Framework**

The Iowa Model provided the framework for this evidence-based project (Titler et al., 2001). Permission to use the model was obtained (see Appendix A). The Iowa Model consists of six steps. The steps of the Iowa Model are to identify a trigger, assess the organizational priorities for fit, formation of a team, evaluation of the evidence, and implementation and evaluation of the outcomes (Titler et al., 2001).

**Trigger for project.** The problem focused trigger for this project was the hospital databases and the benchmarking of the HCAHPS scores in relationship to the comfort goal documentation by nursing staff (Titler et al., 2001). The project leader works as a CNS in the cardiac intermediate care unit. The unit is attempting to improve the HCAHPS scores for patient satisfaction, particularly in regards to pain control. One question on the survey scored well for pain control, while the other did not. Question one, scored high, “During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?” Question two, scored low, “during, this hospital stay, how often was your pain well controlled?” (CMS, 2014). This CNS observed that the daily patient reports documented a comfort goal of zero on most the charts. Closer examination showed that out of thirty charts all had comfort goals of zero for an interventional, surgical and medical mixed patient population (Centra People, n.d.). Evidence shows that when patients do not receive pain management education on comfort goal selection,
their satisfaction with pain control is poor (Pasero & McCaffery, 2004). The knowledge focused trigger (Titler et al., 2001) was the education of nursing staff on pain management improves patient education. Patient education provides realistic expectations and improved perceptions related to pain control.

**Nursing strategic plan and organizational priorities.** The Iowa Model of evidence-based practice assesses if the trigger is significant to the organization’s strategic plan (Titler et al., 2001). The organization chose to focus on one primary reported metric of patient satisfaction. That metric was “Would you recommend our hospital to your friends and family?” (Ketelsen, Cook, & Kennedy, 2014). The perception of pain control is closely linked to the patient’s satisfaction with care and recommendation of the hospital to others (Ketelsen et al., 2014). Patients who are not satisfied with pain control do not recommend the hospital according to HCAHPS data (Ketelsen et al., 2014). This project was significant to the organizational priority.

**Formation of a team.** The team, based on the Iowa Model for evidence-based practice, consisted of the project leader and the Scholarly Project Committee. The committee provided guidance and evaluation of all aspects of the project. The committee consisted of subject matter experts from the organization of intervention and the academic institution.

**Evidence.** The project leader gathered evidence of the trigger, conducted a literature review, and provided a synthesis of the information. The committee, as content experts, reviewed the proposal and the evidence for validity. The team evaluation determined that the project be implemented into evidence-based practice.

**Implement practice change.** Piloting the evidence-based practice change was the next step in the Iowa Model (Titler et al., 2001). The outcomes were selected by the team. The project leader and team participated in baseline data collection, design of the evidence-based practice
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guidelines, and the evaluation of the outcomes. The project leader produced the scholarly project proposal and sought committee input for the formal evidence-based practice change.

**Outcome evaluation.** The project leader gathered and analyzed the data for presentation to the committee. The committee evaluated the outcomes and made recommendations for implementation into practice.

SECTION THREE: METHODOLOGY

**Design**

This was an evidence-based project utilizing a quasi-experimental approach to collect and analyze data. The project leader provided pain management education to the staff of the cardiac intermediate care unit. One educator maintained the consistency of the education. Scripted huddle education was provided to reinforce the information of the education sessions ("7 strategies," 2015). A pre and posttest was administered to assess changes in the nurses’ understanding and interpretation of comfort goals (see Appendix E).

The intervention was the nurses’ education of the patients with a scripted format on the purpose and usage of comfort goals. Included in the script was the difference between comfort goals and pain scales and how they interact. The foundation for success was the staff education and participation. There were two outcome measurements.

The first outcome measurement was the assessment of comfort goals. A baseline was obtained by reviewing a minimum of thirty charts for the comfort goal score documentation prior to the education of the staff. The assessed documentation was within the first 12 hours of admission to the cardiac intermediate care unit. One month after the staff initiated the scripted education, charts were reviewed for documented comfort goals within the first 12 hours of admission to the cardiac intermediate care unit to identify the distribution of comfort goal
scoring. The charts reviewed for comfort goal scores were selected as the patient population of the unit in a given day. The scores were gleaned from the charts by two staff members and the project leader to provide control over interpretation and data reliability (Burns & Grove, 2001). The data was entered into an Excel database for tabulation. No patient identifiers were placed on the data.

The patients were also given a pain management survey upon discharge to assess their perception of pain control during the hospitalization (see Appendix C). The surveys were given on the morning of discharge. There were no patient identifiers, and they were returned in a provided envelope to the main desk. Once collected, the data was tabulated utilizing the Excel database. The investigator could not locate any previous tools that focused on the concept of comfort goals. Therefore, the patient discharge survey was validated by review of the project committee members with expertise in pain management assessment. Protection of the population is a key focus of evidence-based practice. The project leader and team members have had protection of human rights training (see Appendix G). Patients were instructed that they did not have to participate in the survey. They were also told that no identifiers would be placed on the survey form. Nursing staff were informed that the test scores for the education on pain management would not be linked to them as individuals and, therefore, would not be a part of their job performance evaluations.

**Sample**

The primary population for this project was the patient population of the cardiac intermediate care unit. The secondary population for this project was the nursing staff of the cardiac intermediate care unit. Baseline data was collected on all inpatients of the cardiac intermediate care unit. This data consisted of the documented comfort goals for each patient at
0800 on two specific days that were determined at random. The average census on the unit is 33 so it was anticipated that there would be at least 60 entries for baseline data. Patients that were discharged from the unit were given the discharge pain survey. The information was collected over eight weeks. The staff of the interventional unit received the education on pain management. The staffing pattern is six to seven patients cared for by a triad of a registered nurse (RN), a licensed practical nurse (LPN), and a certified nursing aide (CNA). The education of all members of the patient care team provided consistency in dialogue with the patient. RNs and LPNs participated in the pretest and posttest. Scope of practice for LPNs does not allow for the assessment of patients, but they do administer pain medication and provide education on the medication that they administer, so it was essential that they understand pain management and the goals of the intervention. CNAs were also educated so that they could interact with the patients in utilizing the comfort goals prior to mobility.

**Setting**

The location of the project was a 36, bed mixed medical, procedural, and surgical patient population. Patient assignments are divided by location with surgical and higher acuity patients blended in the same assignments as medical and low acuity patients. The diversity of the patient population limits the control of entry points into the unit. For example, patients came as direct admits from the office, emergency room admissions, admissions from urgent interventions in the cardiac catheterization lab, transfers from the post-surgical critical care units and the medical critical care units. This diversity impacted the pain education the patient received prior to arrival. The patient population is also multigenerational with varying experiences with inpatient health care.
Support

Support for the project was given verbally and in writing from the service line Director (see Appendix F) and Unit Managers (see Appendix F). This project supported the organizational strategic plans. The primary imperative of the organization is to have patients be so satisfied with their care that they recommend the hospital to others. Satisfaction with pain control is a key factor in the satisfaction of the patient with the hospital as a whole (Ketelsen et al., 2014).

Intervention

Staff perceptions of pain management directly impact the success of the patient satisfaction (Glowacki, 2015). The first step in implementing an intervention is involving motivated key leaders within the unit. The project leader shared the vision of the project and involved the unit leaders in the process. A pretest and posttest was written to assess the staff nurses’ understanding and use of the comfort goal and pain scale. They were administered pre and post education test that consisted of no more than five questions. The education was provided to all the triad caregivers. However, only the RN and LPN surveys were tabulated as they were the only ones to document comfort goals and pain scales. Information was supplied in multiple presentations: formal gatherings on the unit during working hours, brief daily huddle reminders, electronic screen education that occurred in the breakroom and rounding inquiries.

The educational events were presented by the project leader. Handouts, slides and prompts were all designed by the project leader and based on the staff education outline (see Appendix D). Formal education was provided in 15- to 20-minute time frames. The education occurred in the staff lounge and work stations. During the staff education, they were provided with script cards for patient education. Daily huddles occurred on the unit on both day and night shifts and were attended by all staff members. The project leader was present at these huddles for
one week. These sessions were approximately 15 minutes in duration. A summation of the formal education was given to the staff focusing on the education script and process for administering the survey. The staff were given the educational information from the formal session in writing. PowerPoint slides were placed on the electronic education board in the lounge as a reinforcement and prompt to utilize the scripted education. Patient education was conducted by the RN and LPN. The patient education was also provided to the patient in a written format that was posted in the room. This educational document was written at a fourth to fifth grade reading level to capture the understanding of a broader range of clients (Ketelsen et al., 2014). The education and documentation of the patient comfort score occurred within the first four hours of admission or transfer of the patient. Reinforcement occurred with the regular assessment of pain. A brief survey of the patient’s experience was done with the discharge education. The survey was confidential and adhered to the guidelines established by HCAPHS. The organization cannot use the sentence structure of the HCAHPS in an individual survey (CMS, 2014). The survey questions were reviewed by the project committee. Once collected, the data was tabulated utilizing an Excel database.

**Measurable Outcomes**

Outcomes were measured in three areas:

1. Improvement in nurses’ knowledge of pain management and comfort goals as evidenced by an increase in test scores after pain management education. The education will be completed in a 4-week time period and will be instrumental in decreasing educational variables.
2. Increase documentation of comfort goal scores of greater than zero after nursing education and implementation of scripted education to the patient. Measured by an audit of patient charts on the project unit.

3. Improve patient discharge survey scores in the interventional unit after the implementation of scripted education as compared to patient surveys prior to the education.

**Tools**

Patient survey tools measuring comfort goal score were not found during the literature review. Therefore, the survey questions were reviewed and approved by the project committee’s pain expert member. Demographic information was included on the patient survey. This information includes age and reason for admission. Age is collected to assess for trends in pain tolerance; previous studies have indicated a difference in pain tolerance in specific age groups.

The test questions for nursing staff knowledge were based on the materials covered in the educational presentations. These tools, as well as the outline of the educational presentation, are included in the appendices (see Appendix C).

**Feasibility Analysis**

The project leader determined that the necessary equipment was present and available for data collection and education without additional expense. Surveys and testing material were budgeted though the project leader’s personal education planning. Key stakeholders gave their support of the project. Cost-benefit was assessed by the organization. Ethical issues were addressed to meet project guidelines.

**Personnel**

- Project Committee
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- Nursing support
- Statistical Support

Resources

- Office Supplies
- Pretest/posttest for nursing staff
- Patient Discharge Survey
- Data Collection Template

Technology

- EXCEL data base
- McKesson HER
- Excel
- Computer

Cost-Benefit Analysis

Organizational financial impact will be influenced through value-based purchasing. CMS quality based payment plans will account for 11% of reimbursements for hospitals (Ketelsen et al., 2014). Value-based purchasing accounts for 2% of that 11% (Ketelsen et al., 2014). That 11% is broken down into four sections: HCAHPS at 25%, Outcomes at 40%, process of Care measures at 10% and efficiency at 25% (Ketelsen et al., 2014). HCAHPS is the patient experience. Patient experience and employee engagement have a direct impact on patient outcomes (Clark, Wolosin, & Gavran, 2006). Therefore, it can be theorized that by improving HCAHPS, not only is that 25% reimbursement improved but the outcomes measure is directly impacted at 40% (McLean, 2016). The project intervention has a direct influence on the patient
satisfaction scores and outcomes. The implementation cost is primarily in personnel to provide education and indirect hours.

SECTION FOUR: RESULTS

Objective One: Improve Nursing Knowledge of Pain Management

Method and design. A quasi-experimental, pretest/posttest design was utilized to evaluate the impact of pain management education on nursing staff knowledge. Staff education was provided over an 8-week period; 49% of staff participated in the pre and posttest surveys. Education was provided in unit morning and evening huddles, in order to narrow the gap in performance of patient education. No staff were tested once the huddle education was started to prevent skewed responses in the pretest.

Sampling. RNs and LPNs on the cardiac intermediate care unit participated in the education and took the pre and posttests.

Instrumentation and data collection. The pretest and posttest consisted of the same questions. Questions were designed to reflect the material covered in the educational sessions. The pretest was given directly prior to the educational session. The posttest was given and collected at the end of the educational event. The unit manager or shift manager performed daily rounds. The questions they asked were recorded in an electronic database. The manager included a question on comfort goals, “Have the nurses talked to you about your comfort goal?” This data was to be collected and analyzed for compliance to the staff’s performance of the patient education. This was not completed because of the cessation of the program and the inability of the manager to retrieve the limited information.

Statistical analysis. Descriptive and inferential statistics were utilized to analyze the data. The demographics of the participant included job title, years of experience, and highest
level of education. Numerical values were assigned the answers to the test to allow for evaluation of correct responses and most frequent incorrect response.

Objective Two: Increase Documentation of Comfort Goals

Method and design. A quasi-experimental comparison pre and post education documentation of comfort goal scores design was utilized to assess the impact of staff and patient pain management education.

Sampling. The comfort goal scores were collected prior to staff education. All the charts that were on the unit on the specific days were reviewed for the first unit assessment comfort goal score. Two weeks after the education was complete, the comfort goal scores were collected on all the charts on the unit on specific days. The comfort goal score was collected on the first unit assessment.

Data collection and instrumentation. Data was entered by the same participant for each collection. The data was entered into an Excel spreadsheet. No identifiers were utilized. Information collected included: comfort goal score, age of patient and whether the patient was a medical, interventional or surgical admission. It was also noted if the comfort goal changed during the hospitalization.

Statistical analysis. Statistical analysis occurred both at baseline collection and post intervention. Descriptive and inferential statistical analysis was utilized to analyze the data.

Objective Three: Improved Patient Discharge Surveys

Method and design. This was quasi-experimental in design. The scores were utilized to assess the impact of nurse education on patient satisfaction with pain management. The survey was developed in collaboration with the project committee. Comfort goal assessment surveys were not discovered in the literature review. The staff nurses were instructed to administer the
survey at discharge. The patient was to be given the option to decline and assured that the survey would be anonymous. They were given an envelope and instructed to seal the completed survey and return it to the main desk.

**Data collection and instrumentation.** The patient was given the survey the morning of discharge using the prescribed instruction sheet. Patients had the opportunity to decline participation and the survey was confidential. The participant was given the survey tool, a writing utensil and an envelope in which to place the survey. The completed survey was placed in a box at the desk for the project leader to pick up.

**Statistical analysis.** Descriptive and inferential statistical analysis were done to evaluate the impact of staff and patient education on the perception of pain management.

**Statistical Analysis**

All data was analyzed utilizing Excel descriptive statistics. A *p value* of < 0.05 was accepted for statistical significance in the computation of all the forms of data collected throughout the project. Two independent, two tail, T-tests were utilized in the analysis of the data. Analysis was done to identify correlations among various data aspects, such as level of education and understanding of comfort goals in the staff tests. Total participants in both the patient survey and staff survey provided an N of less than 30 for each set.

**Evaluation of Staff Education**

The 29 staff members that participated included: Diploma RNs (2), associate degree RNs (4), bachelor degree RNs (12), Masters in Nursing (2), and Licensed Practical Nurses (4). The test consisted of four questions; demographics included title, educational level and years of experience.
The first question sought definition of what a comfort goal was, a “measurement of pain that allows patient activity.” Prior to the educational event, 46.66% responded with the correct answer. Correct responses after the educational event were 96% ($p = 0.00$). Significant to the management of the patient’s pain was the percentage of response to the second selection, “measurement of pain tolerance. If pain score is less than the comfort goal do not medicate.” 46.66% pre-education compared to zero ($p = 0.00$) after education. This concept was also investigated in the fourth question of the survey.

The second question measured perception of the pain scale. The correct response blended the other two selections to state that it was both a concrete measurement for labeling pain and the measurement of the patient’s perception of pain. Prior to education, 73.33% chose the best answer, and post education, the response was 92% ($p = 0.11$).

The third question of the test asked the staff to describe how they would educate the patient on comfort goals. Fifteen of the twenty-nine that took the pretest used wording that it was the level of pain they could tolerate without receiving any pain medication. The remaining fourteen incorporated the verbiage that it was the level of pain they could do activities to heal. They did not specify with or without pain medication. In post education, only one respondent stated that it was the level the patient could function without pain medication.

The fourth question assessed whether or not the respondent would medicate the patient if they were at the selected comfort goal. Prior to education, 63.33% selected that they would not. Post education, 100% ($p = 0.00$) selected that they would medicate if the pain scale provided for the score. See Figure 1 for scores.
Figure 1. Pre and post education test scores.

**Evaluation of Staff Documentation**

The trigger for this project was identifying a potential cause for the wide variance in patient response to “my pain was well controlled” and “the nurse did everything she could to control my pain.” An indication to the discrepancy was the documented comfort goals, as discovered in the routine course of the project leader’s role. The goal of zero was documented on 30 out of 30 patients on a 33-bed unit that was comprised of procedural, surgical and medical patients. One of the measures of success for the intervention was a decrease in comfort goal of zero documentation.

Pre-education documentation of comfort goals showed 13.55% were greater than zero. Of the documented comfort goals, 86.4% were zero. Post-education documentation of comfort goals of zero was 31.48%. Documentation of comfort goals greater than zero was 68.51% ($p = 0.02$). This was an increase of 54.96% in documentation greater than zero (see Figure 2). A
documented goal of zero is not always undesirable as many of the patient population may not have any pain when admitted for medical reasons rather than procedural or surgical.

![Comfort Goal Documentation](image)

**Figure 2.** Comfort goal documentation.

**Evaluation of Patient Discharge Surveys**

The patient discharge survey consisted of five questions. Prior to the education, staff were asked to collect patient surveys as a baseline over the course of 1 week. Two surveys were collected during that time period. Neither survey responded that they had received education on comfort goals. The respondents on both surveys selected that their pain was controlled most of the time. Surveys were collected over an 8-week period after staff education was completed. Twenty-five surveys were collected. The first question asked the patient what they understood was the definition of a comfort goal; 22 of the patients answered this question. Seven of the responses (33.81%) indicated that it was when they would receive pain medication. Nine,
(40.90%; p = 0.81) responded it was the level of pain they could do activity, and four (18.8%) responded that they had not heard the term comfort goal.

The second question of the survey asked the patient what score they used for a comfort goal. Twenty-two respondents replied with a numerical value, even those who answered the first question that they had not heard of a comfort goal. Five (22.72%) of the respondents selected a score of zero. Seventeen of the respondents (77.27%; p = 0.01) selected a score greater than zero and less than five.

Patients were asked to select the frequency of the nurse offering pain medication if their pain level was less than their comfort goal. Twenty-five patients replied to this question. Selections for the third question were: all of the time, most of the time, and never. Patients had a response of 44% (p = 0.06) to “all of the time.” Patients chose “most of the time” at 20%. The response of “never” occurred 16% of the time. Five (20%) patients wrote in that they never had pain and did not select a response.

The fourth question of the survey asked the patient to rank the frequency their comfort goal was reached or pain score was lower. Some patients left this question blank for a total of 16% of the responses. One patient (4%) selected that it was never reached. Nine (36%) of the patients selected that it was achieved most of the time. Eleven (44%) of the patients (p = 0.59), selected that their comfort goal or lower was achieved all of the time.

The final question, “my pain was well managed,” had a response on 22 of the surveys. The other three surveys had written that they never had pain. Fifteen (68.18%; p = 0.61) of the respondents selected that their pain was well managed all of the time. Seven (31.81%) selected that their pain was well managed most of the time.
Press Ganey Survey results were provided by the participating organization, using discharge dates to assess patient satisfaction with pain management. The month prior to the initiation of education, a total of 27 surveys were returned. Sixteen (59.3%) of those surveys responded that their pain was well managed all the time. Thirty patients discharged during the first month post education returned surveys. Twenty-two (73.3%; \( p = 0.14 \)) of those selected that their pain was well controlled always. Eight (26.7%) of the patients selected it was usually controlled. The second month post education, 26 surveys were returned and 17 (65.4%) selected that their pain was always well controlled.

![Patient Survey](image)

*Figure 3. Patient survey.*
SECTION FIVE: DISCUSSION

Significance and Implementations for Practice

Statistically there was significance in the staff education and documentation data collected. The patient survey data and organizational discharge data did not show statistical significance. However, based on the percentage of change that occurred, there was clinical significance. All the data groups showed an increase in positive performance after the educational events.

The staff education showed an improvement of 49.34% in the understanding of the definition of comfort goals and 36.67% changed their practice of withholding pain medication based on comfort goals. Post education, the staff surveyed answered 100% that they would medicate based on the available order even if the patient had met their comfort goal. The number of participants did not allow for correlation between educational level and title. One of the collected data points was the number of years the individual had practiced as a nurse. The responses ranged from 6 months to 40 years. Demographics on the number of years since receiving a degree would be recommended for future study to separate experience and training impact on practice.

Patient surveys indicated a definite improvement in the satisfaction with pain management. The increased number of comfort goals greater than zero documented in the patient charting mirrored the documentation of comfort goals by the patients on survey. This documentation reflected a patient expectation of some level of discomfort to be expected. The organization’s monthly reports on patient satisfaction with pain control also supported significant improvement. Returned surveys showed a movement from 59.3% satisfaction with pain controlled always the month prior to the project to a 73.3% score for pain always controlled.
This project reinforced that the tool of scripted education did impact the patient’s perception of pain control and led to higher patient satisfaction scores. Challenges to the process were the ability to educate and measure the impact of the education on all the staff on the unit. It was also difficult to obtain patient surveys prior to the implementation of education in a significant ratio to the number of patients discharged from the unit during the study period. Future projects would be recommended to utilize the unit secretaries, who prepare the discharge paperwork rather than the nursing staff, to distribute and collect the surveys. The similarity of the data collection within the organization surveys also did not yield statistical significance. Individually, staff were able to utilize the comfort goal tool to improve assessment of pain management interventions. This strategy improved patient response and expectation that they would have pain but that the pain could be managed to allow for activities of healing. The improvement of performance measures supports the implementation of the scripted education throughout the hospital system. Current focus on opioid usage needs to be addressed at the foundation of understanding and patient expectations correlate with the ability to manage pain.

**Dissemination**

The model for dissemination that was used for this project is PARiHS. PARiHS is Promoting Action on Research Implementation in Health Services. PARiHS is frequently used in the evaluation of evidence-based practice. It is focused on the clinical experience and utilizes the expertise of the clinicians. The sub-elements of PARiHS are evidence, leadership and facilitation (Gaglio & Glasgow, 2012). All of these elements are within this project which was based on documented evidence that scripting provides strong communication (Tinkham, 2014).

Dissemination will primarily be within the organization itself. The Nursing Governance Board at the interventional hospital and the pain steering committee have adapted the education
organizationally to improve patient pain education. The Clinical Educators would have high stake in the education of the script and the education on appropriate comfort goal assessments. Previously, there was no education within the institution on comfort goals and their utilization with the pain scale. Additionally, a forum is the Virginia Henderson Research Symposium. This is a sponsored event that highlights local research to the region (Centra People, n.d.). National dissemination will be pursued through this project leader’s involvement in the American Association of Critical Care Nurses through poster and/or podium presentations.

**Recommendations for Future Related Projects**

The institution in which the study was conducted implemented the education plan. The scripted patient education has been taught in educational updates for Joint Commission Survey preparation. A position to document function goal has been added to the patient communication boards. The organization also changed the terminology from comfort goal to functional goal and improve the electronic documentation fields to allow for a score of zero to five instead of zero to ten. The deficit of understanding for the nursing staff is being addressed by implementation of education on function goals during orientation. Pain Management classes are being schedule for the summer to reinforce many aspects of pain management including the utilization of function goals for pain management success. Function goals are also being reviewed in the yearly pain management mandatories.

The new terminology more accurately portrays the meaning of the score. It would be interesting to see if the new terminology changed the patient’s expectation of pain management. Since this is an institutional wide change, the organizational data collection on pain management would provide a significant participation pool. There are plans to continue to assess the patient’s perception of pain through these surveys as the education is increased. During the project, a
challenge was obtaining sufficient pre-education patient surveys. Utilizing the organizational database over the months prior and post organizational wide education will give a stronger before and after comparison.
References


McLean, V. F. (2016). *Nurse 716 assignment 5*. (Unpublished manuscript). Department of Nursing, Liberty University, Lynchburg, VA.


www.jointcommission.org
Appendix A: Iowa Model Permissions

From: 
Sent: 
To: 
Subject: Permission to Use and/or Reproduce The Iowa Model (2015)

You have permission, as requested today, to review/use The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care (Iowa Model). Click the link below to open.

Copyright will be retained by The University of Iowa Hospitals and Clinics.

Permission is not granted for placing the Iowa Model on the internet.

The Iowa Model - 2015

Citation: Iowa Model Collaborative. (in press). Iowa Model of Evidence-Based Practice: Revisions and validation. Worldviews on Evidence-Based Nursing.

In written material, please add the following statement:

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If you have questions, please contact: 


## Appendix B: Literature Review Grid

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Level 7</td>
<td></td>
<td></td>
<td>Level 6</td>
</tr>
<tr>
<td>Press Ganey</td>
<td>No info</td>
<td>Understanding pay for performance-patient satisfaction impact *utilize for case building, make it profitable</td>
<td>Good discussion on quality metrics</td>
</tr>
<tr>
<td>Pain Control</td>
<td>No info</td>
<td>Minor info</td>
<td>Useful discussion on pain control and the value of the clinical nurse specialist to decrease cost and develop interdisciplinary teams</td>
</tr>
<tr>
<td>Staff/patient education</td>
<td>Good points for engaging staff in learning and teaching new methods for successful comfort goals</td>
<td>Good for developing staff education</td>
<td>Weak information for staff development. Good patient information</td>
</tr>
<tr>
<td>Organization of change</td>
<td>Excellent, brief outline of change implementation to use for success in the project. Use as discussion points with team for implementation *ability to deal with uncertainty *focus shift from singular to collaborative - this will be important to take focus from “school project” to unit change *collaborative learning – I am a learner as well as educator *deepen partnership by communication style *manage resistance *reassess frequently</td>
<td>Provides understanding of financial motivation</td>
<td>Good discussion on financial impact of CNS lead program</td>
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<tbody>
<tr>
<td>Press Ganey</td>
<td>No info</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Pain Control</td>
<td>Very specific to techniques and assessment of pain by staff not patient perception</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Staff/patient education</td>
<td>poor</td>
<td>Good guide in reference to role</td>
<td>N/A</td>
</tr>
<tr>
<td>Organizational Change</td>
<td>No info</td>
<td>Good for guidance on writing project</td>
<td>Assist with appropriate set up of research process</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
<td>Level 2</td>
<td>Level 4</td>
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<td>---------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Pain Control</td>
<td>Effective January 1, 2015, for Ambulatory Care, Critical Access Hospital, Home Care, Hospital, Nursing Care Centers, and Office-Based Surgery Practice Programs Standard PC.01.02.07: The [organization] assesses and manages the [patient’s] pain. Revised Rationale for PC.01.02.07 (New for Ambulatory Care and Office-Based Surgery Practice) The identification and management of pain is an important component of [patient]-centered care. [Patients] can expect that their health care providers will involve them in their assessment and management of pain. Both pharmacologic and nonpharmacological strategies have a role in the management of pain.</td>
<td>N/A</td>
<td>Not specific but apply quality to pain issue</td>
</tr>
<tr>
<td>Staff/ Patient education</td>
<td>N/A</td>
<td></td>
<td>Strong for patient responsibility for managing own health, staff articulation to Patient so they can participate more knowledgably in care</td>
</tr>
<tr>
<td>Organization Change</td>
<td>Reflects goals of organization</td>
<td>Good to blend organizational goals as a triple responsibility</td>
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</tr>
<tr>
<td>Press Ganey</td>
<td>N/A</td>
<td>Organization Rules for reimbursement and limits set for hospital acquired and poor satisfaction scores</td>
<td></td>
</tr>
<tr>
<td>Pain Control</td>
<td>Ineffective pain management can lead to a marked decrease in desirable clinical and psychological outcomes and patients’ overall quality of life. Effective management of acute pain results in improved patient outcomes and increased patient satisfaction.</td>
<td></td>
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</tr>
<tr>
<td>Staff/ Patient education</td>
<td>What a patient believes and understands about pain is critical in influencing the patient’s reaction to the pain therapy provided.</td>
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<tr>
<td>Press Ganey</td>
<td>Excellent definition of patient satisfaction requirements Quality survey questions</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Pain Control</td>
<td>N/A</td>
<td>N/A</td>
<td>Acceptance of pain has been found to play an important role in functionality of daily living</td>
</tr>
<tr>
<td>Staff/ Patient Education</td>
<td>Information for building educational process for staff</td>
<td>Implementation guidance, writing assistance for paper</td>
<td>Good for discussion of need for patient to have an acceptance of a certain level of pain</td>
</tr>
<tr>
<td>Organizational change</td>
<td>Impact of HCAPS on reimbursement Strategies for improvement</td>
<td>Good information for cases building for change</td>
<td>n/a</td>
</tr>
<tr>
<td>Press Ganey</td>
<td>N/A</td>
<td>N/A</td>
<td>See below for specific points of information</td>
</tr>
<tr>
<td>Pain Control</td>
<td>The process of perception seemed to be integrated in all the changing patterns, and to be a basis for reducing pain, and changing movement, breath and expression. Perception appeared as a process of varying acts and self-knowledge.</td>
<td>Evaluates level of pain intensity and the interventions and perceptions of patients and staff</td>
<td></td>
</tr>
<tr>
<td>Staff/ Patient Education</td>
<td>Enforce that the patient’s perception/expectation actually alters their pain level</td>
<td>N/A</td>
<td>Valuable points for staff education</td>
</tr>
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<tr>
<td>Press Ganey</td>
<td>N/a</td>
<td></td>
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</tr>
<tr>
<td>Pain Control</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff/patient Education</td>
<td>Not specific</td>
<td>Vary specific to perceptions, education and satisfaction</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Refer to for education</td>
<td>Good information for improvement of scores on specific questions</td>
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</tr>
<tr>
<td><strong>Press Ganey</strong></td>
<td>Direct questions from survey and explanation</td>
<td><strong>Pain Control</strong></td>
<td>Good discussion on goal for pain questions in press gamey</td>
</tr>
<tr>
<td><strong>Pain Control</strong></td>
<td>Good discussion on goal for pain questions in press gamey</td>
<td><strong>Staf/f Patient Education</strong></td>
<td>Strong for educational planning</td>
</tr>
<tr>
<td><strong>Staff/ Patient Education</strong></td>
<td>Strong for educational planning</td>
<td><strong>Organizational Change</strong></td>
<td>Financial impacts defined</td>
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### IMPLEMENTATION OF A SCRIPTED EDUCATION

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<thead>
<tr>
<th>Level 7</th>
<th>Level 6</th>
<th>Press Ganey</th>
<th>Pain Control</th>
<th>Education</th>
<th>Organizationa l Change</th>
<th>Author</th>
</tr>
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<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Use in discussion of implementation, reevaluate frequently and adjust as necessary</td>
<td>Rejeh, N., &amp; Vaismoradi, M. (2009). Perspectives and experiences of elective surgery patients regarding pain management. <em>Nursing and Health Sciences, 12</em>, 67-73.</td>
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<tr>
<td>N/A</td>
<td>N/A</td>
<td>Perception and management of pain in addition to sedation</td>
<td>N/A</td>
<td>N/A</td>
<td>Project development and writing for clarity and success</td>
<td>Glowacki, D. (2015, June). Effective pain management and improvements in patient’s outcomes and satisfaction. <em>Critical Care Nurse, 35</em>(3), 42. <a href="http://dx.doi.org">http://dx.doi.org</a> doi:<a href="http://dx.doi.org/10.4037/ccn2015440">http://dx.doi.org/10.4037/ccn2015440</a></td>
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<tbody>
<tr>
<td>Press Ganey</td>
<td>Level 6</td>
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</tr>
<tr>
<td>Pain Control</td>
<td>Patient perception linked to satisfaction and a feeling of lack of control of their own pain management. Accepted pain management as “all there was” and remained unsatisfied</td>
<td>Strong reference for nursing perception and good reference for adequate history taking for patient experiences. Strong for education to help with pain perception</td>
</tr>
<tr>
<td>Education</td>
<td>Strong for nurses education in pain management</td>
<td></td>
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<tr>
<td>Organization and Change</td>
<td>Level 6</td>
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<tr>
<td>Press Ganey</td>
<td>Level 6</td>
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<tr>
<td>Pain Control</td>
<td>Strong support for patient expectation management</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>Good educational outline for nurses</td>
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<td>Organizational Change</td>
<td>Level 6</td>
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<tr>
<td>Press Ganey</td>
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<td>Level 6</td>
</tr>
<tr>
<td>Pain Control</td>
<td>Good on patient participation thru education and expectation</td>
<td>Excellent support for scholarly hypothesis</td>
</tr>
<tr>
<td>Education</td>
<td>Interesting survey tools</td>
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<td>Organizational Change</td>
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<tbody>
<tr>
<td>Press Ganey</td>
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<td>Level 4</td>
</tr>
<tr>
<td>Pain Control</td>
<td>Good foundation for general pain perception in patients, does not concentrate on the post-op</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>patient but on pain in the medical patient as well. Also good for nurse’s perceptions</td>
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<tr>
<td>Organizational Change</td>
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</table>
Appendix C: Patient Survey for Care

Thank you for choosing us for your hospital care.

Please take a moment to answer the following questions. This survey is not required.

1. I understand that a comfort goal is:
   a. The pain score for which I would receive medication.
   b. The Pain score number that I could still do activities of recovery.
      (walking in hallway, sitting up in chair, coughing)
   c. I have never heard of a comfort goal.

2. My comfort goal was ________. (number 1-10) or
   I was not asked to choose one during my hospital stay.

3. The Nurse offered me pain medication if my pain level was less than my comfort goal. (For example: Your comfort goal was 7 and your pain score was 5.)
   a. All the time   b. Most of the time   c. Never

4. My comfort goal or a score lower was achieved:
   a. All of the time   b. Most of the time   c. Never

5. My pain was well managed.
   a. All of the time   b. Most of the time   c. Never

Age________  Reason for admission: Medical  Procedural  Surgical  (circle)
Instructions for Administering Survey:

1. Ask the patient if they would mind filling out the survey.
2. Instruct the patient that they can decline to fill out the survey.
3. Give the survey and a writing utensil to the patient with the envelope.
4. Instruct the patient to fill out the survey and place it in the sealed envelope. Instruct the patient to not include their name.
5. Staff to place the envelope in the box on the unit.
Appendix D: Staff Education Outline

Staff Education Outline

I. Pain Scales
   A. Current Centra Scale
   B. Pain scale in relationship to medication orders

II. Comfort Goal (Pasero, C., & McCaffery, M. (2004).)
   A. Definition
   B. How to use in the care of patients
      1. Gaging when to do activity
      2. Gaging duration and effectiveness of pain medication and interventions
   C. Comfort Goal’s interaction with the Pain Scale

III. Presentation of Scripted Comfort Goal Dialogue
   A. Case Studies (use interactive role play)

IV. Presentation of Patient Education Flyer

V. Disclosure of drive to improve patient experience and elevate current pain management scores.

VI. How to present survey to the patient
   A. Right to refuse
   B. Do not guide response
   C. Only the patient fills out the survey
Appendix E: Staff Education Pre and Post Test

Employee Survey Pre-class / Post-class

1. How do you best define “Comfort Goal”?
   - b. Measurement of pain tolerance, if the pain score is less than the comfort goal do not medicate.

2. How do you best define a pain scale?
   - b. A concrete measurement for labeling pain as low, moderate or severe.
   - c. All of the above

3. Describe how you would currently explain “comfort goal” to your patient.

4. If your patient’s comfort goal is 5 and they report a pain score of 4 would you medicate the patient for pain?
   - a. Yes  
   - b. No

   Please explain why you chose the answer.

Job Title__________

Age______________

Highest level of education________

Years as a nurse _________
Appendix F: Letters of Support

From: [Redacted]
Sent: Friday, June 30, 2017 6:52 AM
To: [Redacted]
Subject: Fwd: letter of support

Sent from my iPhone

Begin forwarded message:

From: [Redacted]
Date: June 29, 2017 at 9:17:02 AM EDT
To: [Redacted]
Subject: RE: letter of support

Hello, [Redacted]. This is a worthy project and you have my full support to conduct this research. Thank you for your efforts that will impact our patient experience going forward.

From: [Redacted]
Sent: Thursday, June 29, 2017 8:46 AM
To: [Redacted]
Subject: letter of support

Dear [Redacted],

As a graduate student in the Nursing department at Liberty University, I am conducting research as part of the requirements for a Doctorate of Nursing Practice. The title of my research project is, "Does providing scripted education to the patient concerning expectations of pain control when assessing comfort goal score provide better perception of pain control?" The purpose of my research is to improve patient satisfaction with pain control.
Dear [Name],

As a graduate student in the Nursing department at [Institution], I am conducting research as part of the requirements for a Doctorate of Nursing Practice. The title of my evidence-based project is, "Does providing scripted education to the patient concerning expectations of pain control when assessing comfort goal score provide better perception of pain control?" The purpose of my research is to improve patient satisfaction with pain control.

I am writing to request your permission to conduct the project on the cardiac intermediate care unit at [Institution]. Staff participants will be asked to attend an educational presentation on comfort goals and pain management. They will be given a pre and posttest to assess the change in knowledge. Patients will be given a questionnaire at discharge to assess their perception of the pain management provided during their stay.

Thank you for considering my request. If you choose to grant permission, please provide a signed statement on approved letterhead indicating your approval or respond by email to [Email].

Sincerely,

[Name]
Permission

Today, 10:37 AM

It is in the thread below

RE: permission
Today, 10:31 AM

... can you respond to the original email I sent saying it is okay? I need to have it in my IRB file along with the ones from the managers and director. Thank you,

RE: permission
Yesterday, 3:07 PM

Great – I think that is all you need.

Re: permission
Yesterday, 1:59 PM

Yes, ... and ... have all given their approval. Sent from my iPhone

Scholarly Project Defense for July 6th (003)Vicky.docx4 MB

RE: permission
Yesterday, 1:30 PM

... is this something that you discussed with the unit manager...
Dear Mrs. Evans:

As a graduate student in the Department of Nursing at [Redacted], I am conducting an Evidence-Based Project as part of the requirements for a Doctorate degree. The title of my evidence-based project is, “Does providing scripted education to the patient concerning expectations of pain control when assessing comfort goal score provide better perception of pain control?”

The purpose of my project is to improve patient satisfaction with pain management.

I am writing to request your permission to have the nursing staff on the CIMU participate in this evidence-based study.

Participants will be asked to attend an educational event on comfort goals and pain management. They will be given a pre and posttest. The unit manager has agreed to host the project in the hopes to improve patient pain management. Thank you for considering my request. If you choose to grant permission, please provide a statement indicating your approval by email to [Redacted]

Sincerely

[Redacted]
Appendix G: CITI Training

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM) COURSEWORK REQUIREMENTS REPORT

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Victoria McLean (ID: 5142868)
- **Email:** vmclean@liberty.edu
- **Institution Affiliation:** Liberty University (ID: 2446)
- **Phone:** 434-384-4625

- **Curriculum Group:** Human Subject - Basic
- **Course Learner Group:** Nursing
- **Stage:** Stage 1: Basic Course
- **Description:** This course is appropriate for students doing class projects that qualify as “No More Than Minimal Risk” human subjects research.

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### REQUIRED AND ELECTIVE MODULES ONLY

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Appendix H: Patient Education Script

Script for Patient Comfort goal Education

We want to help you do what you need to do to get better. It is hard to do those activities when you are in pain. We will ask you to choose a “comfort goal”. A comfort goal is a number on the pain scale of 0 to 5 that you feel you will be able to do the activities that help you get better. Your pain medication is given based on a pain scale. Your comfort goal will not keep you from getting pain medicine, you will be given your medicine based on the pain scale score from 0 to 10. Our goal is to keep you at or below your comfort goal.

This script was tested for readability and scored fourth to fifth grade for understanding. The SMOG readability formula was utilized on the Readability Formulas webpage. (http://www.readabilityformulas.com/smog-readability-formula.php).