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Abstract

Data on patient satisfaction with care received in the hospital demonstrates that patients' pain management expectations are not being met. Of 35.1 million patient discharges annually, 71% report adequate pain control. A current hot topic within the health care community, barriers to effective pain management are multifactorial. Despite advances in the utilization of the electronic health record, charting of pain assessment datum is often ineffective. Pain assessment provides valuable information but it is only useful when accessible in the patient chart. Without access to pain assessment documentation, providers are unable to access critical information needed to promptly identify and treat patients during a pain crisis. Research strongly supports increasing visibility and rates of pain documentation to improve the quality of inpatient pain management. The purpose of this quality improvement project was to implement a standardized pain assessment flowsheet in the electronic health record. Corporate computer informatics technicians created a standardized pain assessment flowsheet for use in documenting pain assessment concurrent to as needed pain medication administration. While pain documentation rates increased from approximately 50% to greater than 90% after implementation of the standardized pain assessment flowsheet, results revealed that nursing satisfaction decreased. Potential implications of poor nursing satisfaction include reduced pain assessment documentation, as well as

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