Taking The Pain Out Of Quality Improvement: Improving Pain In Patients Seen By An Inpatient Palliative Care Service

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BACKGROUND

• The prevalence of pain in hospitalized adults is high and has been associated with reduced quality of life, lower patient satisfaction, and longer length of stay.1
• Refractory pain is a common reason for hospitalization and for palliative care consultation.
• Effective pain control is a core competency for hospital medicine and palliative care teams.

PURPOSE

• We sought to improve pain management in patients seen by the Palliative Care Service (PCS).
• We selected a goal that met was Specific, Measureable, Achievable, Relevant and Time-Bound (SMART).2
• Specifically, we aimed to increase the proportion of patients who experienced an improvement in their pain within 1 day of PCS consultation by 25% during at least 3 of 4 quarters of the academic year.

BASELINE DATA

• We recorded patients’ self-reported pain level on a 4-point scale (none, mild, moderate, severe) each day.
• During a baseline period from January to June 2013, an average of 46% of patients with pain on the day of initial PCS consultation had at least a 1-point improvement in their pain by the next day.
• We were behind some of our peers in the Palliative Care Quality Network, based on available data.

• A goal of 25% increase in the proportion of patients who had an improvement in their pain meant that we aimed to improve pain in at least 57% of patients.

PLANNING

• During the first three months of the year, while providing usual care, we observed the steps required for pain assessment and management. We created a process map of the steps involved in treating pain.
• We analyzed specific patient cases in which pain had not improved to identify steps in the process that had failed.
• We sought to identify steps that were quality gaps which the PCS could directly impact.
• We sought advice from providers who had been on the consult service during exceptionally successful months to determine how their processes differed from others.
• We shared our data and process map with palliative care teams at other hospitals within the Palliative Care Quality Network to solicit suggestions for process improvement.

INTERVENTION

• We formulated a three-part intervention to address steps in the process that were both quality gaps and directly actionable.
• First, we made educational cards for patients that emphasized key concepts of pain control including the appropriate use of “as needed” medications and the importance of treating pain before it becomes severe.
• Second, when we saw a patient with uncontrolled pain, we immediately discussed our concern with the patient’s nurse and solicited the nurse’s help with assessment and treatment of pain.
• Third, we communicated recommendations for pain management with primary teams immediately after seeing a patient with pain, prior to seeing other patients.

INTERVENTION

As your palliative care team, we want to improve your pain and other symptoms.

You have been prescribed an “as needed” pain medication, ______________________, which you can ask for every ________ hours. If you have pain, push your call button to ask for this medicine. If that medicine does not work within ________ hours, please tell your nurse.

It is generally easier to stay out of pain than to get out of pain once it is severe. Please let your nurse know early when your pain is worsening.

If you want to talk with our team directly, ask your nurse to page the palliative care team. We are committed to working with your primary team to help you feel better.

• Though we saw a decrement in the percentage of patients who had an improvement in their pain during our planning period, since enacting our intervention our rate of pain control has improved steadily and is now above our goal.
• We found that patients who had severe pain on the day of initial PCS consultation were more likely to have an improvement in their pain (86%) than were patients with mild pain on the day of initial consultation (0%).

RESULTS

• We selected a quality improvement goal that was relevant to patients and the healthcare system and met SMART criteria.
• Through process mapping, we identified modifiable gaps in quality at the patient, nurse, and physician level and implement a targeted, three-part plan for improvement.
• We observed a substantial 47% increase in the percentage of patients who experience pain relief within 1 day of PCS consultation.
• We continue to monitor progress and seek additional opportunities to improve practice.

NEXT STEPS

• We are investigating reasons for the initial decrement in pain improvement that we observed between July and September, including whether the “July Effect” exists for pain control in the hospital.
• We are considering involving nurses and other disciplines in the hospital to assist in distributing the patient education cards, as this need not be a physician level task.
• We are partnering with existing committees focused on pain improvement in the hospital, to share our work and expand the population of patients who might benefit from our intervention.
• We are working with next year’s fellows to continue this project, so that they may work towards even greater gains in pain improvement.

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