Relief of post surgical pain is a major medical challenge, and unrelieved pain is one of the strongest predictors of prolonged postoperative stay. In the perioperative setting, the administration of pre-procedure, preemptive pain medication can minimize related outcomes and increase patient satisfaction. Successful pain management is dependent upon teamwork and a multidisciplinary approach. The Press Ganey patient survey of our surgical patients indicated that our surgical patients were experiencing uncontrolled pain during their postoperative phase. In 2007, during the months of April, May, and June, 11% of our total volume of patients having Laparoscopic Cholecystectomy procedures were being admitted for 23-hour stays for pain during their postoperative phase. In 2008, after the implementation of new practices and improvement in our admission rate (5.1% and has continued to decrease overall admission rate in 2011. In addition, a review of post-operative data showed an overall decrease in pain scores from 97.8 in 2010 to 97.8 in 2011. It should be noted that the decrease in our admission rate is likely due to new pain management practices and increases in our overall performance with Press Ganey scores.

To assess appropriate pain parameters in the pre, intra, and post-operative phases of care, to ensure timely, appropriate pain control, to reassess effectiveness, and to take appropriate action, several methodologies were utilized, including Six Sigma (DMAIC) and Lean. In the first phase of analysis, several methodologies, including a Six Sigma (DMAIC) and Lean, were utilized to identify house-wide inconsistencies in the management of pain. In the second phase of the project, the team leveraged data from a random sampling of cases from 2007 through 2008, focus groups, and practice reviews from Anesthesiology and Nursing teams. As a result of the data and information, a new pain assessment and medication delivery protocol was developed. This new protocol, launched in 2008, was based on pain management best practices and modeled after our top performing Anesthesiologists. New ambulatory chairs were purchased in early 2008 and the Nursing teams from PACU and Day Surgery initiated an “Early Ambulation” program that promoted faster patient recovery and reduced the likelihood of an overnight patient stay as evident in Figure 2.

CONCLUSION

While there are many factors that contribute to patient outcomes, including patient, type and severity of surgery, the following programs for post-operative management of pain have been successful:

- Early ambulation along with ambulatory chairs
- Improved pre-procedure pain assessment
- A new protocol for pain assessment and medication delivery protocols
Nursing Anesthesia Assessment Tool

MEDICAL STAFF / EVIDENCE-BASED MEDICINE

Other:

Medications:

CONSIDER PATIENT PARAMETERS / MEDICAL CONDITION PRIOR TO THE
ADMINISTRATION OF ANY MEDICATION

☑️ DON'T ADMINISTER OPIATES OR SEDATIVES IF RESPIRATORY RATE IS LESS
THAN 10 PER MINUTE. SEDATION SCALE IS GREATER THAN 1, OR PATIENT
STATES PAIN LEVEL IS TOLERABLE - Sedation scale as per Post-anesthesia Nursing
☑️ Standards of Care - Nursing Unit-based Policy and Procedure Manual

NOTE: This patient has special analgesic needs (Refer to the Pain Management Policy)

- History of Chronic pain
- History of ETOH Abuse
- History of Substance Abuse

Analgesics - Opioids

○ Morphin Succfate 2 mg IV every 5 minutes PRN for mild pain (1-3/10)
  ○ Morphin Succfate 2 mg IV every 10 minutes PRN for mild pain (1-3/10)
  ○ Morphin Succfate 3 mg IV every 5 minutes PRN for moderate pain (4-6/10)
  ○ Morphin Succfate 3 mg IV every 10 minutes PRN for moderate pain (4-6/10)
  ○ Morphin Succfate 4 mg IV every 5 minutes PRN for severe pain (4-6/10)
  ○ Morphin Succfate 4 mg IV every 10 minutes PRN for severe pain (4-6/10)

Notify Anesthesiologist if cumulative Morphin Succfate dose reaches ______ mg

- Fentanyl 12.5 micrograms IV every 5 minutes PRN for mild pain (1-3/10)
  - Fentanyl 12.5 micrograms IV every 10 minutes PRN for mild pain (1-3/10)
  - Fentanyl 25 micrograms IV every 5 minutes PRN for moderate pain (4-6/10)
  - Fentanyl 25 micrograms IV every 10 minutes PRN for moderate pain (4-6/10)
  - Fentanyl 50 micrograms IV every 5 minutes PRN for severe pain (7-10/10)
  - Fentanyl 50 micrograms IV every 10 minutes PRN for severe pain (7-10/10)

Notify Anesthesiologist if cumulative Fentanyl dose reaches ______ micrograms

Hydromorphone 0.2 mg IV every 5 minutes PRN for mild pain (1-3/10)

Transfer from PHASE II to Phase III
☑️ Standards of Care – Nursing Unit-based Policy and Procedure Manual

Discharge from Phase II to Home
☑️ Standards of Care – Nursing Unit-based Policy and Procedure Manual

DISCONTINUE ORDERS
☑️ Standards of Care – Nursing Unit-based Policy and Procedure Manual

Anesthesiologist Signature:

Phase II RN Signature: