

IMPROVING PAIN REASSESSMENT DOCUMENTATION PRACTICES AMONG
NURSES IN A CENTRAL MONTANA PROGRESSIVE CARE UNIT

by

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TABLE OF CONTENTS

1. REVIEW OF THE LITERATURE	1
Introduction	1
Background and Significance	1
Methods.....	2
Review of Literature	3
Interventional Subsets	4
Audit Feedback	4
Education	4
Visual Reminders	5
EHR Modifications	5
Other methods	6
Discussion and Conclusion	6
2. QUALITY IMPROVEMENT PROPOSAL	9
Introduction & Problem	9
Microsystem Assessment	11
Quality Improvement Model.....	13
Methods.....	14
Implementation Summary	14
Implementation and Evaluation	14
Safety and Confidentiality	16
Conclusion	17
3. QUALITY IMPROVEMENT MANUSCRIPT	18
Contribution of Authors and Co-Authors	18
Manuscript Information	19
Clinical Problem	20
Review of the Literature	21
Conceptual Framework	22
Rationale and Aim.....	23
Methods.....	24
Context.....	24
Intervention	25
Measures for Analysis	27
Results.....	28
Discussion.....	30
Limitations	32
Sustainability.....	33

Conclusion	34
4. ADVANCED NURSING ESSENTIALS REFLECTION	35
Domain 1: Knowledge of Nursing Practice	35
Domain 2: Person Centered Care.....	36
Domain 6: Interprofessional Partnerships.....	37
Domain 9: Professionalism	37
REFERENCES CITED.....	39
SMARTIE GOALS TO DRIVE PROJECT DIRECTION	44

LIST OF FIGURES

Figure	Page
1. Figure 1: Post PRN pain reassessment documentation adherence rates over time	29
2. Figure 2: results of SMARTIE goals following project completion	31
3. Figure 2: SMARTIE Goal One	45
4. Figure 3: SMARTIE Goal Two	45
5. Figure 4: SMARTIE Goal Three	46
6. Figure 5: SMARTIE Goal Four	46
7. Figure 6: SMARTI Goal Five	47
8. Figure 7: SMARTIE Goal Six	47

ABSTRACT

Background:

Timely pain reassessment following analgesic administration is essential for patient safety, quality care, and regulatory compliance. Despite this, documentation adherence remains inconsistent in many acute care settings.

Purpose:

This quality improvement project aimed to increase adherence to timely pain reassessment documentation among nursing staff on a progressive care unit.

Methods:

A multifaceted intervention was implemented to improve awareness, knowledge, and accountability. Strategies included live education sessions on institutional pain policy, visual reminder aids at workstation computers, and ongoing audit and feedback of monthly documentation rates. Education attendance was tracked, with supplemental written materials provided to non-attendees. Documentation adherence data were obtained through retrospective review of monthly electronic health record (EHR) reports and compared across pre- and post-intervention periods.

Results:

Baseline adherence was approximately 32% (n=57). Following initial EHR-related changes, adherence increased to 41% (n=56) in November and 53% (n= in December. After full implementation of interventions, adherence improved to 54% (n=v58) in January and 60% (n=61) in February. Education sessions reached 64% of staff, with 100% receiving educational content. Post-implementation feedback indicated 100% of respondents reported increased comfort with documentation, and audit and feedback were identified as the most effective intervention.

Conclusions:

A multifaceted approach incorporating education, visual reminders, and audit and feedback improved pain reassessment documentation adherence. Ongoing monitoring and reinforcement may support sustained improvement and enhance safe, consistent pain management practices.

CHAPTER ONE

REVIEW OF THE LITERATURE

Introduction

Pain, while widely subjective, remains one of the most frequent and significant clinical complaints among patients across healthcare settings. Chronic pain affects approximately 23.4% of U.S. adults each year (Lucas & Sohi, 2024), exceeding the incidence of high blood pressure, diabetes, and depression, with an estimated 52.4 new cases per 1,000 persons per year (National Institutes of Health [NIH], 2023). Among hospitalized patients, 46.5% report experiencing acute pain during their admission (Li-Ying et al., 2021), which can delay recovery, prolong hospital length of stay, and increase healthcare costs (Becerra-Bolanos et al., 2023).

Effective pain management is therefore essential to improving patient outcomes. Systematic pain assessment, timely reassessment, and accurate documentation are integral components of this process, ensuring both clinical accountability and continuity of care.

Background and Significance

Both the Centers for Medicaid and Medicare Services (CMS) and the Joint Commission (TJC) require nurses to complete an initial pain assessment followed by a post-interventional reassessment (Centers for Medicaid and Medicare Services, 2019; The Joint Commission, 2023). Each hospital is responsible for establishing institutional policies that define the parameters of timely reassessment; however, most follow TJC recommendations that pain be reassessed within 15-30 minutes following intravenous (IV) administration and within 60 minutes following oral administration, allowing sufficient time for therapeutic effect (Gordon et al., 2008).

Pain is expensive. Direct patient care in addition to lost wages and missed working days can amount to 560- 625 billion dollars annually ((Smith & Hillner, 2019) In postoperative patients, experiencing pain can increase hospital length of stay by two to four weeks (Sharma et al., 2020) and increase ambulatory follow up costs by 2,000 U.S. dollars per patient (Gan, 2017). Consistent pain reassessment improves patient outcomes by increasing satisfaction, strengthening trust in the healthcare team, reducing polypharmacy, shortening hospital length of stay, and lowering healthcare costs (Becerra-Bolanos et al., 2023; Hadjistavropoulos et al., 2016). Additionally, inadequate reassessment, particularly following opioid administration, can have adverse effects on the central nervous system, putting patients at greater risk for respiratory depression, sedation, and even death. Despite supportive research and established hospital policy requirements, pain reassessment documentation among nurses remains inconsistent and in some cases, absent (Sturesson et al., 2016). This scoping review aims to synthesize the existing literature regarding nursing non-adherence to pain reassessment documentation in the acute care setting and to analyze evidence-based interventions designed to address and improve this persistent gap in clinical practice.

Methods

This scoping review used the PRISMA framework guidelines for article inclusion which guided evidence identification and synthesis and helped identify the research question, relevant data, and appropriate studies. The search was conducted in September of 2025. Searched databases included PubMed, Web of Science, CINAHL, Psych Info, EBSCO, and Google Scholar. Articles not written in the English language and those published before the year 2015 were excluded. Search terms included: adherence or nonadherence, compliance or

noncompliance, nurse, documentation, pain assessment or reassessment. After sorting for eligibility, the search results yielded 120 articles which were exported for review. Five were successfully retrieved and five duplicates were removed. Of the remaining 115 articles, 88 were excluded based on title or abstract irrelevance. The final screening included 27 articles, six lacked relevance to pain reassessments, four only focused on pain scores vs. time to reassessment, and four did not have adequate information. The final literature for synthesis included 13 articles: two systematic meta-analyses, one randomized controlled trial (RCT), one cluster RCT, five quasi-experimental studies, two descriptive qualitative studies, and two quality improvement projects.

Review of Literature

The literature identifies three overarching domains of barriers that impede nurses' documentation of pain reassessments. *Knowledge-related barriers*, including limited understanding of policies, poor adherence to policy requirements, and general knowledge deficits; *organizational barriers*, such as inadequate staffing, heavy workload, and insufficient reassessment reminders; and *system-level barriers* characterized by a lack of clarity regarding electronic health record (EHR) documentation standards and challenges associated with EHR utilization (Bjerkan Jorunn et al., 2021; Espinoza, 2024; Kizza & Joshua K. Muliira, 2015; Smitha et al., 2023). Together, these domains contribute to the inconsistent compliance with pain reassessment documentation and highlight the complex, multifactorial nature of this issue.

Interventional Subsets

Audit Feedback

Audit feedback emerged as one of the most common interventions for improving pain reassessment documentation across the literature. “The underlying assumption for audit and feedback is that highly motivated health professionals who receive information showing that their clinical practice is inconsistent with desired practice, as described in evidence-based guidelines, and/or in comparison to peers, will shift their attention to focus on areas where improvements are needed” (Jamtvedt et al., 2019). In most cases, the audits were sent out in weekly newsletters; however, they were not nurse-specific, only showing the unit’s performance compared against other departments (Bunting & Klurk, 2022; Ho & Burger, 2020; Hogan et al., 2016; Wissman et al., 2020). In other instances, nurse-specific audit feedback was deidentified and disseminated to the staff (Cline, 2016), or nurses were educated on how to perform their own self-audit (Espinoza, 2024; Smitha et al., 2023). Based on the meta-analysis by Bunting & Klurk (2022), audit feedback is more effective when information is personalized to each staff member rather than generalized for the entire unit.

Education

Education was the second most common intervention method, identified in six of the studies included in this review. The educational strategies varied widely across studies. Some provided education through small focus groups or general in-services sessions (Espinoza, 2024; Wissman et al., 2020), while others implemented more extensive programs ranging from 12 to 40 hours in duration (Gunnarsdottir et al., 2017; Hogan et al., 2016; Innab Adnan et al., 2022).

Only two studies described in detail the type of education provided and the facilitators involved, which ranged from the use of a single educational poster board to training by a certified pain nurse champion (Espinoza, 2024; Gunnarsdottir et al., 2017). Notably only two studies utilized education as the sole intervention (Gunnarsdottir et al., 2017; Innab Adnan et al., 2022). These studies reported mixed findings, one demonstrated nonsignificant p value ($p > 0.5$), while the other observed an increase in compliance from 13% to 25% without analysis of p value or confidence interval. . The remaining studies combined education with additional with additional interventional components.

Visual Reminders

Four studies incorporated visual reminders into their interventions. Two quality improvement projects utilized visual dashboards to prompt pain reassessment documentation (Espinoza, 2024; Savitri, 2024). However, neither study clarified the placement or number of reminders used. Another study implemented individualized text and email reminders sent weekly to each nurse on the unit reinforcing adherence to the pain policy and noting instances of noncompliance (Smitha et al., 2023). In a study by Hogan et al. (2016), discipline-specific pocket cards were distributed; however, the authors did not describe the card content or the frequency of use. Such information would have been valuable, as the pocket card intervention was one component of a broader multimodal strategy that also encompassed audit feedback and educational initiatives.

EHR Modifications

The literature did not consistently specify which systems were used at each facility; however, several studies generalized modifications. Harilali (2024) implemented hard stops for

initial pain assessments along with timed interval pop-ups for reassessment. Although the study reported an increase in post-medication reassessment post-intervention, it also incorporated educational visual reminders, making it difficult to discern the specific impact of the EHR modification.

In a meta-analysis by Bunting & Klurk (2022), ten studies between 2011 and 2020 examined similar EHR interventions, including the creation of hard stops, reduction of clicks required for documentation, development of documentation shortcuts, and incorporation of timed reassessment triggers. Collectively, these strategies increased pain reassessment documentation compliance rates to greater than 70%.

Other methods

A single RCT evaluated the use of auditory alarms as an intervention (NG Von et al., 2018). The study was conducted in a simulated environment with a small sample of nurses ($n=7$) who were unfamiliar with the equipment until the day of testing. The simulation incorporated a predetermined number of initial and post-analgesia pain reassessments, measuring both the time to initial reassessment and the number of subsequent omissions. While the use of audible timers did not significantly affect the time to first reassessment compared with the control group, it did reduce the frequency of missed pain reassessment follow-ups ($p= 0.05$).

Discussion and Conclusion

When implemented together, personalized audit feedback and education demonstrated the greatest consistency in improving pain reassessment rates. The addition of complementary interventions, such as EHR documentation modifications and visual reminders, further enhanced

adherence outcomes (Bunting & Klurk, 2022). For example, allocating a PRN nurse for staff education in Iceland led to a 12% increase in reassessment rates (Gunnarsdottir et al., 2017). However, the educational component of this program was extensive, requiring 40 hours of didactic instruction per nurse (Ferrell et al., 1993), which may limit its practicality and cost-effectiveness, particularly in settings with high staff turnover.

Future research should focus on identifying the most effective and sustainable educational strategies, emphasizing reproducibility and feasibility in real-world practice. Additionally, given that only one study investigated the use of audible timers, further exploration of this intervention, particularly in non-simulated clinical environments, is warranted.

Overall, the level of evidence on this topic remains limited. Most existing studies were conducted within specific or high-acuity populations (Gunnarsdottir et al., 2017; Hogan et al., 2016; Smitha et al., 2023; Stureson et al., 2016), underscoring the need for broader, multicenter investigations. Many of the studies also had small sample sizes (Gunnarsdottir et al., 2017; Wissman et al., 2020), or lacked control groups. (Cline, 2016; Ho & Burger, 2020; Smitha et al., 2023; Wissman et al., 2020).

The only eligible RCT identified for this review was conducted in a simulated environment with a small sample size (NG Von et al., 2018), further limiting generalizability. Additionally, methodological inconsistencies across studies contribute to the overall imprecision of the evidence base (Bunting & Klurk, 2022).

Barring the simulated RCT study by NG Von et al. (2018), which showed no change in pain reassessment time post-intervention, ten of the eleven studies reviewed demonstrated increases in reassessment documentation rates ranging between 10% to 30%. However, seven of

these studies relied solely on descriptive statistics without reporting *p*-values or confidence intervals.

Only one study reported a statistically significant *p* value (Hogan et al., 2016), and another provided a 95% confidence interval (Wissman et al., 2020). The remaining studies either found nonsignificant *p*-values (Innab Adnan et al., 2022) or did not conduct statistical analysis regarding reassessment documentation outcomes (Cline, 2016; Espinoza, 2024; Gunnarsdottir et al., 2017; Ho & Burger, 2020; Savitri, 2024; Smitha et al., 2023). Additionally, few studies investigated long-term sustainability of these interventions, with only one reporting continued improvement over a 17-month period (Smitha et al., 2023).

The current limitations within this body of research include small and narrowly defined sample sizes, limited reproducibility, a scarcity of RCT's, and lack of statistically significant results. Additionally, the quality of studies published within the past five years was limited, necessitating the inclusion of older literature to achieve a sufficient review base. Continued research using more recent data is essential to strengthen the evidence and ensure relevance to current clinical practice.

Notably only three of the eleven interventional studies utilized a single intervention (Gunnarsdottir et al., 2017; Innab Adnan et al., 2022; NG Von et al., 2018), while the remaining studies employed combinations of two or more intervention types. The use of multimodal strategies, although common, introduces potential confounding effects that make it difficult to determine the independent impact of each intervention.

CHAPTER TWO

QUALITY IMPROVEMENT PROPOSAL

Introduction & Problem

Pain is a widespread clinical concern, occurring at rates that exceed hypertension, diabetes, and depression (National Institutes of Health, 2023). It affects 23.4% of adults annually (Jaqueline & Sohi, 2024) and up to 46.5% of those who are acutely hospitalized (Li-Ying et al., 2021). Both the Joint Commission and the Centers for Medicare & Medicaid Services require nurses to perform an initial and post-intervention reassessment of pain in a timely manner. This time frame is generally accepted as 60 minutes from oral administration or 15-30 minutes from IV administration, to allow ample time for therapeutic effects (Gordon et al., 2008). Performing pain reassessments have been shown to improve patient outcomes, decrease polypharmacy, decrease hospital length of stay, and reduce overall healthcare costs (Becerra-Bolanos et al., 2023; Hadjistavropoulos et al., 2016). In addition, particularly with opioid administration, timely reassessment can help prevent respiratory depression, oversedation, and even death. Despite TJC's timely assessment requirements and evidence of improved patient outcomes, the rates of pain reassessments among nurses remain low, and in some cases, are nonexistent (Sturesson et al., 2016).

Although national standards require timely pain reassessment, from July to September, pain reassessment rates in a central Montana hospital averaged 38%; The Progressive Care Unit (PCU), or the project-specific unit of interest, averaged 32% during the same period. At present,

this organization lacks a benchmark goal for pain reassessment rates and simply states that “pain should be reassessed frequently”. Furthermore, there is no documented consequence within the hospital policy if nurses do not chart their pain reassessments. This project aims to increase pain reassessment documentation adherence among nurses on the PCU from 32% TO 80% by April first, 2026. Based on the literature synthesis in chapter one, the most effective means for increasing documentation adherence include a mixture of individualized audit feedback, visual reminders, education to address knowledge deficits, and changes to EHR workflows (Bunting & Klurk, 2022; Cline, 2016; Espinoza, 2024; Ho & Burger, 2020; Hogan et al., 2016; Savitri, 2024; Wissman et al., 2020), audit feedback being the most well-studied. This project will utilize all four of these interventions in a two-fold manner.

SMART framework was used to guide appropriate project direction (Appendix A) and ensure goals are specific, measurable, achievable, relevant, and time bound. The project coordinator will perform a retrospective analysis of pre- and post-pain reassessment documentation rates following informational technology changes to the EHR workflow being implemented in November of 2025, with a goal of increasing adherence from 32% to 50% by January first of 2026. In January, four live educational in-services sessions will be held on the PCU, reaching at least 70% of staff. These educational sessions will include a review of the pain policy, why reassessments are important for patient outcomes, how to effectively document reassessments in the EHR, and instructions for accessing individualized reassessment adherence. The 30% who cannot attend live sessions will receive a hard copy of educational materials in their work email. Simultaneously, in January, laminated visual aid reminders for pain reassessment will be placed at each 13 nurse workstation computers, with all 13 of them

remaining in place by the end of March 2026. Following the implementation of educational materials and visual aids, by March 1, 2026, the project coordinator will conduct biweekly audits of pain reassessment documentation and provide individualized, deidentified feedback to all nursing staff after each audit cycle. After completion of this implementation period, unit reassessment adherence rates will increase to 80% by March 1st of 2026. By March 13th, 2026, post survey assessments will be distributed to all staff to evaluate which method best helped increase their reassessment documentation, with a target response rate of 90%.

Microsystem Assessment

The PCU is in a Central Montana 220-bed hospital that serves a 14-county region. This 33-bed unit serves adult patients aged 19 years and older in a ratio of four to six patients per nurse. Conditions seen on this unit include post-surgical interventions, post-cardiac percutaneous interventions, cardiac rhythm abnormalities, gastrointestinal bleeds, alcohol withdrawal, respiratory failure, and stroke. The unit does not manage ventilated patients but runs complex cardiac drips, transcutaneous pacing, and biPAP. At the time of this microsystem assessment, the unit consists of 57 registered nurses and five nurse interns (defined at this organization as nursing students who are covered by organization's liability insurance, and work under the supervision of a registered nurse on the floor). Of registered nurses, 24 were full-time employees (38.71%), 25 were registry employees (40.32%), and seven were part-time employees (11.29%). New grads with less than one year of experience accounted for 26% of the total number of nurses, 14% had 1-2 years of experience, 15.7% had 2-5 years, 21% had 5-10 years, 10.5% had 10-15 years, and 15.78% had more than 16 years of experience. The majority (40%) of this unit's experienced nurses (those with greater than 2 years of experience) are currently registry staff,

meaning that they are only required to work 200 hours per year and one holiday. This can make properly orienting new staff difficult and relies heavily on the 25% new grad population to set the standard for pain reassessment rates. Additionally, the PCU has the most beds per unit in the hospital which can make staffing based on acuity difficult, particularly when nurses are ill and unable to work their shift. Oftentimes, nurses will have more than one patient on a complex cardiac drip, requiring total care, or who is immediate post-op/post-procedure making up their four or six-patient load. This demanding workload and other barriers preventing follow-through on pain reassessments are discussed in more detail below.

When staff were interviewed, four major themes emerged impeding pain reassessment documentation: process, environment, people, and equipment. Nearly all nurses expressed some frustration with the EHR process/workflow, which displays a pain reassessment reminder on the “brain” (the main hub of patient lists); However, often even when the pain reassessment is documented, that reminder does not disappear, leaving many nurses frustrated and forgoing documentation entirely. There is also frustration in the inability to document a reassessment from one screen quickly. Currently, reassessments require a click from the brain of the EHR, continuous scrolling to the bottom of the flowsheet within the patient chart, clicking into the pain score box, selecting “0-10”, entering a numerical value, and clicking to file the data. If a nurse attempts to backdate a previous reassessment, three additional clicks are required to properly place the assessment, so it is “timely”. Many nurses report this workflow as tedious and contributing to lack of documentation. Presently, a “skip” button is also present on the brain for pain reassessment reminders, which makes reminder removal simple and easy. Finally, no

consistent process currently exists for sharing unit adherence rates; thus, staff are unaware that the reassessments require improvement.

As touched on above, many nurses noted inadequate staffing and heavy workloads (high acuity patients, or higher than normal patient ratios) which contributed to either being unable to physically reassess the pain and/or the inability to document it. Some nurses mentioned a perceived lack of importance on the matter within the unit, noting that it is not stressed as something of high priority among colleagues and managerial staff. Several nurses reported being unaware of why reassessment documentation was important/necessary or admitted to forgetting pain reassessments altogether.

The equipment used for documentation is one of three things: a desktop computer at the nurse's station, a "tap and go" computer at the bedside, or a rover (a portable phone with EHR documentation capabilities). PCU nurses make mention that the rovers are not intuitive and cumbersome to use, and the bedside computers are slow, making "real time" documentation difficult. They also mention that the nursing station is not where they spend most of their time, so sitting down to document at the desktop computer often doesn't happen within the reassessment window.

Quality Improvement Model

This project will use the Plan-Do-Study-Act (PDSA cycle). This form of quality improvement is iterative and often easier to manipulate than other forms of quality improvement models, as it is typically used on a smaller scale (unit-specific rather than hospital wide) (Barr & Brannan, 2024). This model allows for rapid-fire testing of workflow change and quick feedback to nurses, which aligns well with documentation improvements within the EHR. This method

provides ample opportunity for nurse feedback and allows the managerial stakeholder to adjust as needed. The estimated cost of implementing the PDSA cycle is zero dollars and can be continued by managerial and nursing stakeholders following the completion of this project. Additionally, since a quarter of the nurses on this unit are new grads, this will help lay a foundation of best practices while they are orienting and practicing on their own, paving the way for smoother cycles of PDSA in the future.

Methods

Implementation Summary

This project will be implemented in a Central Montana PCU among registered nurses and nurse interns. The interventions will include three components: (1) an educational in-service, (2) placement of visual aid reminders at workstation computers, and (3) individualized audit feedback of personalized pain reassessment documentation rates. Compliance data will be drawn from the EHR, deidentified, and compared to unit averages. The project coordinator will deliver the in-service education, place visual reminders, and compile individualized audit feedback using secondary EHR data. The PCU manager will assist in generating weekly unit-level adherence reports and sharing compliance updates in a weekly huddle email. These combined strategies are intended to increase staff awareness, reinforce expectations for reassessment documentation, and support consistent behavior change across the unit.

Implementation and Evaluation

The project coordinator will conduct a retrospective review of pain reassessment documentation rates on the PCU from November 1st, 2025, through December 31st, 2025. This

timeframe follows scheduled EHR workflow changes that reduced the number of clicks required to document a reassessment and added clearer pop-up reminders for timely documentation. Providing retrospective analysis will help determine how EHR changes alone affect pain-reassessment rates in comparison to the planned interventions starting in January of 2026.

Unit level documentation rates are compiled monthly through the EHR and shared with the PCU manager, who distributes weekly compliance updates to staff through email. The November and December 2025 rates will be compared to baseline unit performance from July through October 2025 to evaluate whether the EHR changes led to improvement in reassessment documentation.

Beginning in January 2026, the project coordinator will conduct four live in-person educational sessions. The in-service content will include a review of the pain policy, the importance of reassessments for patient outcomes, instructions for documenting reassessments in the EHR, and guidance on accessing individualized audit feedback. All materials will be reviewed and approved by the PCU manager before implementation.

To reach the broadest range of staff, two sessions will be offered during day shift huddles and two during night shift huddles on different days of the week. Staff attendance will be recorded, and those who are unable to attend will receive hard-copy materials via email. A potential barrier to this intervention may include the fact that 25% of the unit's workforce consists of registry nurses who do not work consistent schedules; This approach ensures equitable access to the educational content.

At the same time, laminated visual reminder cards will be placed at each of the thirteen workstation computers. These cards will include visual documentation prompts and reminder timelines PO and IV pain medication reassessments.

Following the educational in-service and placement of visual aid reminders, biweekly audit feedback will be provided to each nurse and nurse intern between January 15th and March 15th, 2026. All adherence data will be deidentified by the project coordinator and accessed by the PCU manger using secondary data from the EHR. The project coordinator and PCU manager will then disseminate the deidentified, nurse-specific information so staff may compare their individual rate to the overall unit rate. By April 1, 2026, unit pain reassessment documentation rates from January through March will be analyzed and compared to the rates from November and December of 2025.

Following project implementation and evaluation, a post-survey assessment will be distributed to all nurses and nurse interns through their work email and the unit Facebook group. This survey will determine which intervention strategies staff found most helpful for improving pain reassessment documentation, how comfortable they feel documenting pain reassessments in the EHR, and their confidence in understanding the importance of timely reassessments. Survey results will be compiled and provided to the PCU manager to guide future PDSA cycles, if needed.

Safety and Confidentiality

Safety and confidentiality were maintained throughout this process. No additional risks were introduced to participating nurses beyond their usual work activities All personal identified information (PII) was deidentified by the project coordinator and was only accessible to the

coordinator, the PCU manager, and the individual nurse to whom the data belonged. No identifiable information was shared with other staff at any time. Deidentified data were used solely to provide individualized feedback and were not used for any punitive or disciplinary action. Unit-level pain reassessment rates shared in staff huddles were presented in aggregate form and did not identify any individual nurse.

Conclusion

In conclusion, this quality improvement project aims to strengthen pain reassessment documentation on the PCU through a combination of targeted education, visual reminders, and individualized audit feedback. These interventions are designed to increase awareness, streamline workflow, and support consistent practice among registered nurses and nurse interns. Pain reassessment data will be analyzed using secondary EHR reports, comparing baseline performance from late 2025 with documentation rates following project implementation in early 2026.

The PCU manager, project coordinator, and nursing staff all play an essential role in supporting and sustaining these efforts. With a current reassessment rate of 32%, project seeks to improve to 80% by March 31st, 2026. The interventions can be implemented at no cost to the unit and are grounded in established best practices; they offer a sustainable approach to enhancing patient care. Post-project survey feedback will guide future PDSA cycles and support ongoing quality improvement in the unit.

CHAPTER THREE

QUALITY IMPROVEMENT MANUSCRIPT

Contribution of Authors and Co-Authors

Manuscript in Chapter 3

Author: Kristen Howick BSN, RN, DNP-FNP Candidate

Contributions: Developed the project proposal, conducted the literature review, engaged stakeholders, facilitated data collection and nursing education, analyzed and interpreted data, and drafted and revised the manuscript for publication.

Co-Author: Dr. Annie Brown, PhD, MSN, RN

Contributions: Served as project chair and advisor, provided first review and editing, assisted with the development of implementation methods, and provided final manuscript approval.

Co-Author: Dr. Stacy Stellflug, PhD, APRN, FNP-BC

Contributions: Served as project committee member, provided second review and editing, reviewed content for consistency and clarity, and contributed expertise regarding IRB approval.

Manuscript Information

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Status of Manuscript:

- ☒ Prepared for submission to a peer-reviewed journal
- ☐ Officially submitted to a peer-reviewed journal
- ☐ Accepted by a peer-reviewed journal
- ☐ Published in a peer-reviewed journal

Clinical Problem

Pain is one of the most prevalent and clinically significant concerns encountered across healthcare settings, yet it remains inherently subjective and challenging to manage effectively. Chronic pain affects nearly one-quarter of adults in the United States annually, surpassing the prevalence of several major chronic conditions, including hypertension, diabetes, and depression (Jaqueline & Sohi, 2024; National Institutes of Health, 2023). Acute pain is also commonly reported by nearly half of all hospitalized patients (Li-Ying et al., 2021).

Systematic pain assessment, timely reassessment, and accurate documentation are essential to ensuring safe and effective pain management. Regulatory bodies such as the Centers for Medicare and Medicaid Services and The Joint Commission mandate initial pain assessments and post-intervention reassessments (Centers for Medicaid and Medicare Services, 2019; The Joint Commission, 2023), with institutional policies commonly aligning with recommended timeframes allowing sufficient time for analgesics to take therapeutic effect (15-30 minutes for intravenous medication and 30-60 minutes for oral medications) (Gordon et al., 2008). Despite well established guidelines and evidence demonstrating that consistent pain reassessment improves patient satisfaction, reduces adverse events, shortens hospitalization, and lowers healthcare costs (Becerra-Bolanos et al., 2023; Hadjistavropoulos et al., 2016; Stureson et al., 2016), adherence to pain reassessment documentation remains inconsistent in acute care settings (Stureson et al., 2016). Failure to reassess pain, particularly following opioid administration, places patients at increased risk for serious adverse outcomes, including respiratory depression and oversedation. This persistent gap between evidence-based standards and clinical practice

underscores the need for targeted interventions to improve nursing adherence with pain reassessment documentation and quality of care.

Review of the Literature

The literature consistently identifies pain reassessment documentation as a complex, multifactorial issue influenced by three primary domains of barriers: knowledge-related, organizational, and system-level functions. Knowledge barriers include limited understanding of institutional pain policies, poor adherence to documentation requirements, and general knowledge deficits among nursing staff (Bjerkan Jorunn et al., 2021; Espinoza, 2024; Kizza & Joshua K. Muliira, 2015; Smitha et al., 2023). Organizational barriers, such as inadequate staffing, increased workload, and competing clinical priorities, further impede timely assessment documentation, while system-level challenges (particularly unclear electronic health record (EHR) documentation standards and usability issues) contribute to omissions and inconsistencies (Bjerkan Jorunn et al., 2021; Espinoza, 2024; Kizza & Joshua K. Muliira, 2015). Together, these barriers highlight the complexity of pain reassessment documentation and the need for multifaceted interventions.

Multiple intervention strategies have been explored to address these barriers, with audit and feedback emerging as the most frequently implemented approach. Audit and feedback is grounded in the assumption that clinicians will modify practice when presented with data demonstrating discrepancies between actual and desired performance, particularly when benchmarked against evidence-based guidelines or peers (Jamtvedt et al., 2019). While many studies utilized unit-level audit feedback distributed through newsletters (Bunting & Klurk, 2022; Ho & Burger, 2020; Hogan et al., 2016; Wissman et al., 2020), evidence suggests that

nurse-specific, individualized feedback is more effective in improving compliance (Bunting & Klurk, 2022; Cline, 2016). Educational interventions alone demonstrated mixed results and modest improvements when used in isolation (Gunnarsdottir et al., 2017; Innab Adnan et al., 2022); However, education combined with visual reminders, audit and feedback, or EHR modifications produced more consistent improvements (Espinoza, 2024; Smitha et al., 2023). Notably, EHR-based interventions, including hard stops, timed reassessment prompts, and streamlined documentation workflows, were associated with the most substantial and sustained increases in pain reassessment documentation, with compliance rates exceeding 70% in several studies (Bunting & Klurk, 2022; Hadjistavropoulos et al., 2016; Savitri, 2024).

Conceptual Framework

The Plan-Do-Study-Act (PDSA) cycle was selected as the guiding framework for this quality improvement project due to its iterative, flexible, and unit-specific approach to practice change. PDSA is particularly well suited for addressing documentation-related gaps because it allows for rapid testing of workflow modifications and timely evaluation of outcomes within a clinical practice environment (Barr & Brannan, 2024). By applying the PDSA cycle, this project facilitates small-scale implementation of targeted interventions aimed at improving pain assessment documentation, enabling adjustments to be made based on real-time feedback and measurable outcomes. This approach supports ongoing refinement of processes without disrupting broader organizational workflows.

Additionally, the PDSA model emphasizes continuous stakeholder engagement and shared accountability, both of which are essential to sustaining improvements in nursing documentation practices. Providing timely feedback to nursing staff aligns with evidence

supporting audit and feedback as an effective strategy for behavior change, particularly when integrated into existing EHR workflows. The minimal financial burden associated with the PDSA cycle further supports its feasibility, allowing the intervention to be sustained by nursing and managerial staff beyond the duration of the project. The unit analyzed in this study has a high proportion of newly licensed nurses on the unit, therefore, implementing the PDSA cycle during orientation and early independent practice may help establish best practices, promote consistency, and support future quality improvement efforts aimed at enhancing patient safety and regulatory compliance.

Rationale and Aim

Despite established regulatory requirements and strong evidence supporting timely pain reassessment, documentation compliance among nursing staff in the acute care setting remains inconsistent. This same gap was identified on the selected acute care unit, where baseline data demonstrated low compliance with post-intervention pain reassessment documentation, placing patients at increased risk for adverse outcomes and organizations at risk for regulatory noncompliance. The rationale for this project is to address identified knowledge, workflow, and system-level barriers contributing to gaps in pain reassessment documentation through targeted, nurse-centered interventions. Guided by the PDSA framework, the aim of this quality improvement (QI) project is to increase nursing compliance with post-intervention pain reassessment documentation from a baseline of 32% to at least 80% by project completion. This aim will be addressed through the implementation and evaluation of audit and feedback, education, visual reminders, and EHR-supported workflow changes. By improving

documentation practices, this project seeks to enhance patient safety, support regulatory compliance, and promote sustainable evidence-based nursing workflows.

Methods

Context

The microsystem for this quality improvement project is a 33-bed progressive care unit (PCU) within a 220-bed hospital located in Central Montana that serves a 14-county rural region. The unit provides care to adult patients aged 19 years and older with a wide range of moderate to high acuity conditions, including post-surgical recovery, post-cardiac percutaneous interventions, cardiac rhythm abnormalities, gastrointestinal bleeding, alcohol withdrawal, respiratory failure requiring noninvasive ventilation, and acute stroke. Although the unit does not manage mechanically ventilated patients, it frequently administers complex cardiac infusion, transcutaneous pacing, and bi-level positive airway pressure (BiPAP). Nurse-to-patient ratios range from four to six patients per nurse, with acuity-driven variability that can significantly increase workload, particularly during periods of staffing shortage or high patient complexity.

At the time of this assessment, the PCU employed 57 registered nurses and five nurse interns, who functioned as student nurse under the direct supervision of a registered nurse. New graduate nurses with less than one year of experience comprised 26% of the nursing staff, while a substantial proportion of experienced nurses (40%) were registry staff with fewer required scheduled hours, creating challenges for consistent orientation, mentorship, and practice standardization. This unit also houses the largest number of beds in the hospital, further complicating staffing flexibility and acuity-based assignments, often requiring nurses to take

several high acuity patients at once. This places significant demands on time and attention and contributes to missed or delayed pain reassessments.

Interviews with nursing staff identified four primary themes contributing to inconsistent pain reassessment documentation: process, environment, people, and equipment. Nurses expressed frustration with EHR workflows, including persistent pain reassessment reminders that fail to clear after documentation, excessive navigation steps, and the presence of a “skip” function that enables dismissal of reminders without completion. Environmental and staffing challenges, including high patient acuity and workload, further limit opportunities for timely assessment and documentation. Knowledge gaps and inconsistent prioritization of pain reassessment within unit culture were also identified, compounded by the absence of routine feedback on unit-level compliance. Additionally, documentation equipment limitations, such as slow bedside computers, non-intuitive mobile devices, and limited access to stationary workstations, hinder real-time documentation. Together, these microsystem factors highlight a complex interplay of workflow, staffing, and technological barriers that directly inform the need for targeted, nurse-centered interventions on this unit.

Intervention

This quality improvement project employs a phased, multimodal intervention strategy designed to improve pain reassessment documentation on the progressive care unit. Before implementation of the additional multimodal interventions, the project examined documentation rates following recently implemented EHR workflow enhancements to establish a comparison period and assess the preliminary effect of those changes. The project coordinator conducted a retrospective analysis of pain reassessment documentation rates from November 1 through

December 31st, 2025. During this period, the previously implemented EHR changes reduced the number of required documentation clicks and introduced clearer, time-based reassessment reminders. Unit-level documentation rates from this period were compared with baseline data collected between July and October 2025 to evaluate the preliminary impact of EHR modifications prior to the introduction of additional interventions.

Beginning in January 2026, the project implemented targeted educational interventions to address identified knowledge and process gaps. Four in-person educational sessions were delivered during both day and night shift huddles to ensure broad staff participation. Educational content included a review of institutional pain policies, the clinical significance of timely pain reassessments, step-by-step guidance for documenting reassessments in the EHR, and instruction on accessing individualized audit feedback. Attendance was tracked, and staff unable to attend received materials electronically to promote equitable access, particularly given the high number of registry nurses with variable schedules.

To reinforce education and support real-time documentation, visual reminder cards were placed at all workstation computers on the unit. These laminated prompts outlined reassessment timelines for oral and intravenous pain medications and served as cognitive aids during clinical workflows. Following implementation of education and visual reminders, biweekly nurse-specific audit feedback was disseminated between January 15 and March 15, 2026. All audit data were deidentified and shared by the project coordinator and progressive care unit (PCU) manager, allowing nurses to compare their individual performance with unit-level trends and peer benchmarks while maintaining confidentiality.

Evaluation of the interventions occurred by April 1, 2026, through analysis of pain reassessment documentation rates from January through March 2026 and comparison to pre-intervention data. Additionally, a post-intervention survey was distributed to all nurses and nurse interns to assess perceived usefulness of the interventions, comfort with EHR documentation, and understanding of the importance of timely pain reassessment. Survey findings were shared with unit leadership to inform future PDSA cycles and support the sustainability of improvements in pain reassessment documentation.

Measures for Analysis

Measures for this quality improvement project were guided by six SMARTIE goals to evaluate implementation, process outcomes, and the overall effectiveness of interventions aimed at improving pain reassessment documentation on the PCU. Data were collected using EHR-generated reports, attendance records, direct observation, and post-intervention surveys, with analyses focused on descriptive statistics and percentage changes over time.

The first outcome measure assessed the impact of information technology (IT)-based EHR workflow changes implemented in November 2025. Monthly adherence rates for November and December 2025 were obtained from EHR-generated reports and compared with baseline data from July through October 2025. The benchmark for success was an increase in adherence to at least 50% by January 1, 2026.

Educations reach was evaluated by measuring staff participation in four live educational in-service sessions. Attendance records were compared with the number of eligible staff to determine whether the target of 70% attendance was achieved. Distribution of supplemental educational materials ensured access but was not included in the primary attendance metric.

Implementation of visual pain reassessment reminders was measured by the presence of laminated reminder cards at workstation computers. The number of reminders in place at project completion was compared with the number initially deployed (n=13), with 100% retention serving as the benchmark for sustainability.

The effectiveness of audit and feedback was measured through biweekly analysis of individual pain reassessment documentation adherence between January 1 and February 28, 2026. Using EHR-generated data, individual and unit-level adherence rates were analyzed over time to assess trends in the documentation performance, with improvement in adherence serving as the indicator of effectiveness.

The primary project outcome was unit-level reassessment documentation adherence. Monthly adherence rates for January and February 2026 were obtained from EHR reports and compared with adherence rates in October through December of 2025. Project success was defined as achieving at least 80% adherence by March 1, 2026.

Staff perceptions of intervention effectiveness were measured with a post-intervention survey distributed electronically in March of 2026. Survey responses assessed perceived usefulness of interventions, comfort with EHR documentation, and an understanding of timely pain reassessment. Results were analyzed descriptively, with a target response rate of 90%.

Results

A retrospective analysis of post-PRN pain reassessment documentation following implementation of the updated information technology (IT) algorithm showed improvement in documentation adherence over time. Rates increased from a baseline of 32% (n=57) to 41% (n=56) in November and further to 53% (n=60) in December. Following implementation of the

project interventions including visual aid reminders, live educational session, and individual as well as group audit feedback, documentation adherence continued to improve, reaching 54% (n=58) by the end of January and 60% (n=61) by the end of February. This did not meet the project aim, nor SMARTIE goal 4 of reaching 80% post PRN pain reassessment documentation adherence (Figure 1).

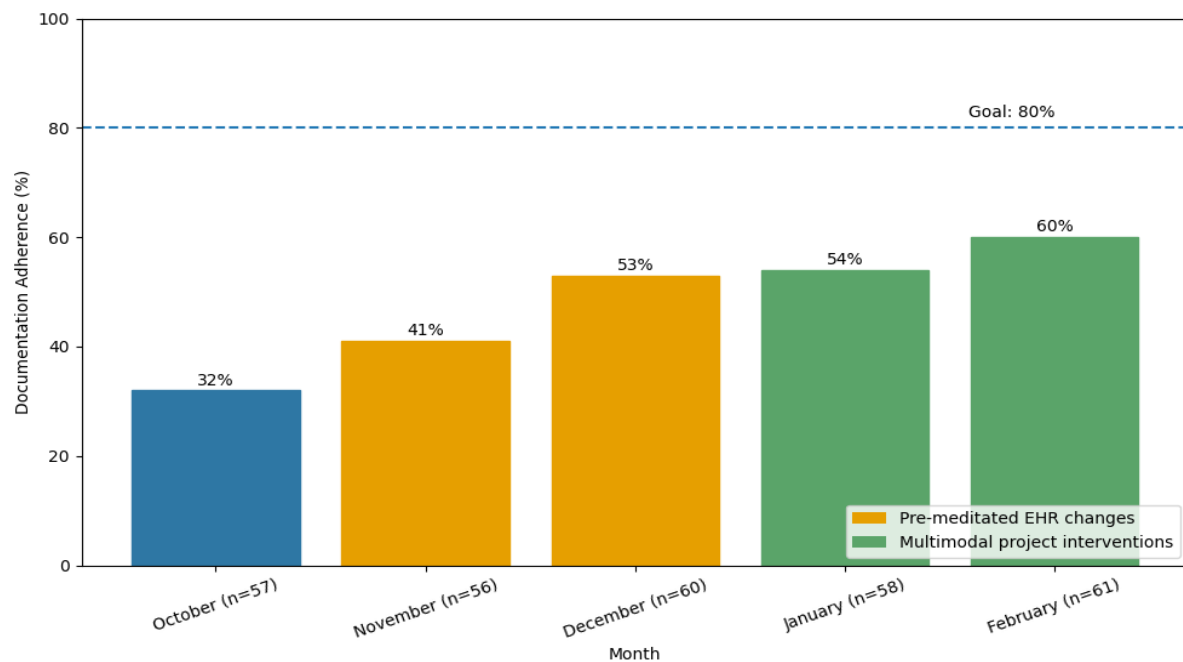


Figure 1: Post PRN pain reassessment documentation adherence rates over time

Attendance at live educational sessions reached 64% of staff, which was less than the 70% benchmark, however, 100% of non-attendees received supplemental educational materials in digital and printed formats. In addition, thirteen visual reminder aids were placed at workstation computers at the initiation, and all remained in place at project completion, reaching the 100% benchmark goal.

Post-project qualitative surveys were distributed electronically to all staff members, and the response rate was 90%, meeting the benchmark response goal. Among respondents, 100% reported increased comfort utilizing post-PRN pain reassessment documentation within the electronic health record (EHR), as well as an enhanced understanding of the importance of timely pain reassessment. When asked to identify the most helpful intervention implemented during the project, 85% of respondents identified audit and feedback as the most effective strategy, followed by live education sessions (10%) and visual reminder aids (5%).

Discussion

The findings from this quality improvement project suggest that targeted system-level and educational interventions can improve adherence to post-PRN pain reassessment documentation within the EHR. Following implementation of updated IT algorithms, staff education, audit and feedback mechanisms, and visual reminder aids, documentation adherence increased from a baseline of 32% (n=57) to 60% (n=61) by the end of the project period. These findings suggest that multifaceted interventions addressing both workflow and nursing awareness may support improved compliance with pain reassessment policies. Four of the five SMARTIE goals set for this project were met (Figure 2). While the primary aim of the project (meeting 80% documentation adherence) was not met at the completion of this project, the rate of pain reassessment documentation nearly doubled from October of 2025 and increased by 7% in only two months following the multimodal project intervention implementation. This project was also implemented over a short period of time and given the projection of results, may have continued to improve compliance over time.

Goals	Actual	Timeline	Achieved
70% live attendance to educational in-services	64%	End of 4 sessions	NO
50% post-PRN documentation adherence	50%	January 1, 2026	YES
80% post-PRN documentation adherence	60%	March 1, 2026	NO
90% post-project staff survey response	90%	March 15, 2026	YES
100% visual reminders remaining of workstation computers	100%	March 1, 2026	YES

Figure 2: results of SMARTIE goals following project completion

Among the implemented interventions, audit and feedback was identified by 85% of survey respondents as the most helpful component of the project. This finding is consistent with existing literature demonstrating that audit and feedback interventions can improve clinical documentation and adherence by increasing self-awareness of performance metrics and promoting accountability (Jamtvedt et al., 2019). Regular updates regarding adherence may also have reinforced expectations and supported ongoing behavior change.

Educational sessions also appeared to contribute to improved documentation practices by reinforcing the rationale for timely pain reassessment and clarifying the documentation process within the EHR. Although attendance at live educational sessions only reached 64%, staff members who were unable to attend received digital and/or printed educational materials, supporting broader dissemination of the content. Ninety percent of survey respondents also reported increased comfort using the EHR for post-PRN pain reassessments and improved

understanding of the clinical importance of reassessing pain following medication administration.

Visual aid reminders placed at workstation computers served as an additional reinforcement for desired workflow behaviors. Although fewer staff members identified this intervention as the most helpful, visual prompts are known to support adherence to clinical protocols by reducing reliance on memory and increasing awareness at the point of care (Gordon et al., 2008). The sustained presence of these reminders throughout the project period suggests they may help reinforce desired documentation behavior over time.

Limitations

Several limitations should be considered when interpreting the findings of this QI project. First, the project was conducted within a single patient care unit, which may limit the generalizability of the results to other clinical settings or healthcare organizations with differing workflows, staffing models, or EHR configurations. Second, documentation adherence was measured through retrospective EHR data, which reflects documentation behavior rather than direct clinical practice. Thus, it is possible that pain reassessments were performed but not documented, potentially resulting in an underestimation of actual reassessment practices.

Additionally, the project was implemented over a relatively short timeframe, which limits the ability to evaluate long-term sustainability of the observed improvements. Staff awareness that documentation was actively being monitored may also have influenced behavior during the project period, a phenomenon commonly referred to as the Hawthorne effect (McCambridge et al., 2014). Furthermore, while the project utilized multiple interventions including IT workflow, staff education, audit and feedback and visual reminders, it was not designed to isolate the

independent effect of each intervention. Although qualitative surveys suggested that audit and feedback was perceived as the most helpful strategy, the observed improvements likely reflected the combined effect of all interventions. Additionally, because the surveys were qualitative, they may have been subject to response bias and may not have captured the true perspectives of all staff members.

Sustainability

Sustaining improvements in documentation adherence will require continued integration of the interventions from this project into routine clinical practice. Maintaining the updated EHR workflow and IT algorithms will remain critical in supporting timely post-PRN pain reassessment documentation. These system-level changes help align documentation processes with clinical workflows and reduce barriers to completing reassessment documentation.

Ongoing audit and feedback mechanisms should also be maintained to reinforce accountability and provide staff with continued awareness of documentation performance. Incorporating periodic review of documentation rates into existing unit quality metrics or staff meetings may further support sustained adherence. Continued dissemination of documentation adherence data can help maintain engagement and promote a culture of quality improvement.

Education will also remain an important component of sustainability. Integrating pain reassessment documentation education into orientation for new staff members and providing refresher education for current staff may help ensure that expectations remain clear. Visual reminder aids at workstation computers can continue to serve as cognitive prompts, reinforcing documentation behaviors at the point of care.

Future efforts may also consider expanding these interventions to additional patient care units and integrating them into automatic EHR prompts or decision-support tools to further support pain reassessment documentation. Sustained monitoring, combined with leadership support and staff engagement, will be essential to maintaining improvement and promoting long-term adherence to pain reassessment documentation standards.

Conclusion

This QI project demonstrated that a multifaceted intervention, incorporating EHR workflow optimization, staff education, audit and feedback, and visual reminders, can meaningfully improve adherence to post-PRN pain reassessment documentation. Audit and feedback emerged as a particularly impactful strategy, reinforcing the importance of performance transparency and accountability in sustaining behavior change. Additionally, staff-reported increased confidence with EHR documentation suggest that targeted education can further support adherence. These results highlight the practical importance of implementing layered, complementary interventions to address documentation gaps in clinical practice. Sustained improvement will likely depend on continued monitoring, reinforcement of expectations, and integration of feedback mechanisms into routine workflows. Collectively, this approach offers a scalable and sustainable model for improving compliance with pain management documentation standards and enhancing overall quality of care.

CHAPTER FOUR

ADVANCED NURSING ESSENTIALS REFLECTION

The Essentials set out by the American Associates of Colleges of Nursing (AACN) provide a thorough framework by which advanced practice nurses can shape their practice. They provide a foundation for competent care across the lifespan and are pertinent for all levels of life: prevention, regeneration/restoration, chronic disease, and hospice/palliative supportive care (American Association of Colleges of Nursing, 2021). Throughout both the clinical and didactic components of my graduate education, the program essentials have been foundational in shaping my knowledge base and clarifying my professional role as a future Nurse Practitioner.

Domain 1: Knowledge of Nursing Practice

Domain one is the cornerstone of effective practice as a Nurse Practitioner (NP), as it serves to provide the science behind the art of nursing. Through this domain, I have been able to synthesize and integrate foundational knowledge as well as emerging evidence into my practice. Participating in courses such as Evidence-Based Practice I and II, Advanced Nursing Leadership, Vulnerability and Health Care in Diverse Communities, Advanced Pharmacology and Pathophysiology, as well as Statistical Applications, I have been able to strengthen my foundational knowledge of providing healthcare to generations across the lifespan.

In addition to the didactic portions of my graduate education, Advanced Clinic I – IV allowed me to translate foundational evidence from nursing as well as other sciences into practice, while keeping informed of new, emerging evidence within the field. Furthermore, not

only does providing healthcare in a clinical setting require vast integration of knowledge and evidence, but it also requires a sound understanding of ethics within the system (Haddad & Geiger, 2023). Ethics are essential to practicing medicine because, as a Nurse Practitioner, I must be able to recognize healthcare dilemmas and make sound judgments, all while keeping within the laws that govern our society. Through my clinical experience, as well as a didactic course dedicated solely to ethical considerations (Ethics, Law, and Policy), I have been able to sharpen my craft of providing ethical healthcare to underserved and minority populations making me a more well-rounded NP.

Domain 2: Person Centered Care

The defining strength of an advanced practice registered nurse lies in treating the person as an integrated whole, not merely the sum of individual parts. I have routinely demonstrated this ability during each of my clinical rotations during my graduate career. For example, during each wellness visit, I intentionally assess the patient's social context, sources of joy, mood perception, and overall satisfaction with their current state of well-being. Beyond simply asking whether a patient is sexually active, I explore whether they feel comfortable and fulfilled with that choice, whatever it may be.

In addition to my clinical practice, I have demonstrated person-centered care within my thesis project. While moving to increase pain treatment and post pain reassessment rates among nurses, I utilized McKinsey 7-S Framework for change, which includes not only tangible methods for change (daily processes and workflow), but four intangible elements regarding how people change their practices: their skill level/competency, their culture and common goals, their leadership style, and how each individual person has been trained and shaped during their

employment (McKinsey, 2008). The intangible aspects of a person are just as important as the tangible aspects when determining how to invoke change.

Domain 6: Interprofessional Partnerships

Throughout my graduate coursework and clinical experiences, I have developed a deeper appreciation for the role of professional partnerships in delivering effective, person-centered care. Working alongside nurses, physicians, case managers, and other members of the healthcare team has reinforced the importance of core professional values such as respect, ethical practice, clear communication, and shared accountability. Patients see many different doctors for many different reasons, and it is crucial, as a primary care practice provider, to retain a partnership among them all to ensure the best outcome for the patient. I had the pleasure of working with a preceptor who excelled at this. She had a patient in her primary care practice who was seeing seven other specialties throughout the year for various comorbid conditions. This preceptor and I made a point of reaching out to two specialists directly to confirm plan of care goals for the patient prior to implementing change and sending the person out the door after her visit. Because of clinical experiences such as this, I have become more confident in guiding care coordination, patient education and health promotion.

Domain 9: Professionalism

Throughout my graduate coursework, clinical practice and thesis development, the intentional development of professionalism has been central to my identity formation as a nurse practitioner. Engaging in both medically and socially complex clinical situations has required ethical reasoning, moral courage, assertive decision-making, and patient advocacy. For example,

I once spent the majority of an office visit with a patient trying to coordinate care for mental health and specialty services because the patient had tried for weeks with no correspondence from either facility. These experiences have enhanced my emotional intelligence, allowing me to better recognize my own biases and provide care that encompasses the autonomy and humanity of everyone individually. The mutual respect between patients and their providers is sacred and my clinical experiences throughout my graduate education have solidified my ability to think, act, and feel like a nurse practitioner. As I transition into advanced clinical practice, I intend to carry forward a professional identity grounded in humility, confidence, and advocacy, as well as a dedication to the ever-evolving role a nurse practitioner inhabits.

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APPENDIX

SMARTIE GOALS TO DRIVE PROJECT DIRECTION

SMARTIE Goal #1: Implementation of IT interventions to the EHR workflow will increase documentation adherence to 50% by 1/1/26		
Strategies to accomplish: Retrospective analysis of monthly pain reassessment documentation adherence, per EHR from November 1, 2025 – Jan 1, 2026		
Data to be collected	Collection Process	Planned data analysis
PCU pain reassessment documentation rates for November and December of 2025	-This information is sent to the PCU manager monthly. -reviewed by project coordinator -disseminated to staff via email	-Direct comparison to monthly rates from September and October of 2025. -calculate number of percentages increased (or decreased) each month.

Figure 3: SMARTIE Goal One

SMARTIE Goal #2: Four live educational in services sessions will be held to reach 70% of staff.		
Strategies to accomplish educational sessions will be held during two-day shift. huddles and two-night shift huddles and will include review of the pain policy, why reassessments are important for funding as well as patient outcomes, how to effectively document reassessments in the EHR, and instructions to access individualized reassessment adherence. Staff will sign off once completed. Those who cannot attend will be emailed hard copies to their work emails.		
Data to be collected	Collection Process	Planned data analysis
Signatures of staff who attend the in-service.	Collected by project coordinator during in service sessions.	Calculate the number of staff who attended and compare to the number of total staff who should have attended.

Figure 4: SMARTIE Goal Two

SMARTIE Goal #3: Visual pain reassessment reminders will be placed at all 13 workstation computers and will remain in place by the end of March 2026.		
Strategies to accomplish: Project coordinator will laminate educational/reminder cards and attach to each workstation computer.		
Data to be collected	Collection Process	Planned data analysis
The number of visual aid reminders	Project coordinate will count those placed and those remaining in place at the end of March 2026	Those remaining on the computers will be compared to the number originally placed.

Figure 5: SMARTIE Goal Three

SMARTIE Goal #4: Bi-weekly analysis of individual adherence will be deidentified and emailed to all staff between 1/13/26 and 2/28/26 in comparison to the unit adherence.		
Strategies to accomplish project coordinator will deidentify all nursing staff and provide ID to individual staff member. Personalized adherence rate will be individually emailed to each staff member in comparison to the unit rate.		
Data to be collected	Collection Process	Planned data analysis
Individual pain reassessment documentation rates for the past two weeks among each nursing staff and intern on PCU	Project coordinator and managerial stakeholder will access and disseminate data to staff emails.	Comparison of unit vs. individual staff adherence rates biweekly for 8 weeks.

Figure 6: SMARTIE Goal Four

SMARTIE Goal #5-unit pain reassessment documentation adherence rates will increase to 80% by March 1st, 2026.		
Strategies to accomplish culmination of visual reminders, individualized audit feedback and educational in services as described above.		
Data to be collected	Collection Process	Planned data analysis
Unit monthly pain reassessment documentation rate per EHR for March 2026	Information is sent directly to manager. -project coordinator will assess and disseminate to staff in established unit huddle.	Compare rate at the end of March to the rate at the beginning of January and calculate percentage increased.

Figure 7: SMARTI Goal Five

SMARTIE Goal #6 post survey assessments distributed to all staff with a 90% response rate.		
Strategies to accomplish disseminate survey to staff via link in email and unit Facebook group.		
Data to be collected	Collection Process	Planned data analysis
What strategy they felt was most helpful in increasing documentation. Perception of comfort with documenting a pain assessment in the EHR as well as knowledge level of pain reassessment importance.	Surveys will be distributed and analyzed by project coordinator at the end of the implementation period, in March of 2026.	Analyze responses and calculate percentages to which method was most effective

Figure 8: SMARTIE Goal Six