Implementation of the CAPA© (Clinically Aligned Pain Assessment) Tool: Pain is More than Just a Number©

Debra J. Drew, MS, ACNS-BC, RN-BC
Debra Topham, PhD, JD, RN

Conflict of Interest Disclosure

• Authors Conflict of Interest
  – Debra Drew, No Conflicts of Interest
  – Debra Topham, No Conflicts of Interest

Lack of Confidence of One’s Impact

• “Nobody makes a greater mistake than he who did nothing because he could do only a little.”

  Edmund Burke
The Power of Many Drops

Objectives

Learners will be able to:
1. Discuss the concept of pain assessment as a social transaction between patient and clinician.
2. Summarize the outcomes of University of Minnesota Health’s implementation of CAPA©.
3. Describe the lessons learned from implementing a complex and culture-changing project.

Objective 1

1. Discuss the concept of pain assessment as a social transaction between patient and clinician.
Pain Assessment as a Social Transaction

Beyond the “Gold Standard”

- Self-report= gold standard
- Major disconnect between what is advocated and what clinicians actually do
- Pain assessment best described as a dynamic process, a transaction
  - Verbal and nonverbal interaction between patient and clinician is modified by the physiologic and social context


Problem with self-report using a uni-dimensional scale
- Pain is a multi-dimensional complex experience
- Numeric scale difficult for some to use
- Requires linguistic and social skills: problematic with some of most vulnerable populations
- Patients modulate pain behaviors and self-report based on their perception of what’s in their best interest

Patients Modulate Pain
Pain Assessment as a Social Transaction

Examples of Contributing Factors in Pain Assessment

<table>
<thead>
<tr>
<th>Biologic</th>
<th>Sociocultural</th>
<th>Developmental-Psychological</th>
<th>Contextual/Situational</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>Disease, clinical condition, drug influences</td>
<td>Ethnicity, sex, access to healthcare, cultural origin</td>
<td>Age, stress, drug addiction, interpersonal skills, fear</td>
</tr>
<tr>
<td>Clinician</td>
<td>Biologic disposition, stress, reactivity</td>
<td>Pt. preferences or biases, age, sex, education, ethnic background</td>
<td>Views on pain, trust/suspicion, interpersonal skills, critical evaluation of pain report</td>
</tr>
</tbody>
</table>

Summary of the Social Transaction of Pain Assessment

- “Pain is what the patient says it is” acknowledges subjectivity of pain, but ignores complex patient/clinician relationship
- “Pain as 5th Vital Sign” highlights significance of pain, but can be mechanistic
- Pain assessment = intersubjective exchange of meaning between patient and clinician
- Process dependent on internal/external factors to both parties and environment
University of Utah – 2012 Pilot Project

- CAPA© developed to replace conventional numeric rating scale (NRS; 0-10 scale)
- Press Ganey© scores increased from 18th to 95th percentile
- 55% patients preferred CAPA ©
- Nurses preferred CAPA © 3:1 over NRS

From, Donaldson & Chapman, 2013.

Clinically Aligned Pain Assessment (CAPA)
“Pain is More Than Just a Number” ©

- Evaluates
  - intensity of pain
  - effect of pain on functionality
  - effect of pain on sleep
  - efficacy of therapy
  - progress toward comfort
- Engages patient and clinician in a brief conversation about pain resulting in coded evaluation

From, Donaldson & Chapman, 2013.

CAPA© Tool (modified; original in blue)
The conversation leads to documentation - not the other way around.

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comfort</td>
<td>Intolerable</td>
</tr>
<tr>
<td></td>
<td>Tolerable with discomfort</td>
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<tr>
<td></td>
<td>Comfortably manageable</td>
</tr>
<tr>
<td></td>
<td>Negligible pain</td>
</tr>
<tr>
<td>Change in Pain</td>
<td>Getting worse</td>
</tr>
<tr>
<td></td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Getting better</td>
</tr>
<tr>
<td>Pain Control</td>
<td>Inadequate pain control</td>
</tr>
<tr>
<td></td>
<td>Partially effective</td>
</tr>
<tr>
<td></td>
<td>Fully effective</td>
</tr>
<tr>
<td>Functioning</td>
<td>Can’t do anything because of pain</td>
</tr>
<tr>
<td></td>
<td>What keeps me from doing most of what I need to do</td>
</tr>
<tr>
<td></td>
<td>Can do most things, but pain gets in the way of some</td>
</tr>
<tr>
<td></td>
<td>Can do everything I need to</td>
</tr>
<tr>
<td>Sleep</td>
<td>Unable with pain most of night</td>
</tr>
<tr>
<td></td>
<td>Unable with occasional pain</td>
</tr>
<tr>
<td></td>
<td>Normal Sleep</td>
</tr>
</tbody>
</table>

From, Donaldson & Chapman, 2013.
Change or Transformation?

Change is the “fixing” of past to future:
- Better, cheaper, faster, leaner, etc.

Transformation is the job of leaders:
- Building a vision
- Start with the future and work back
- Help people fall in love with the future

Transformation

The butterfly is NOT a better, faster caterpillar. It is a NEW system.

Steps of Implementation

1. Define the scope and team
2. Identify and manage the risks
3. Breakdown the work
4. Schedule the work
5. Communicate
6. Measure progress

From, Verzuh (2008).
1. Defining the scope and team – Phase 1

**Scope (Adult Inpatient)**
- Medical Units
- Surgical Units
- Behavioral Units
- Obstetrics Units
- Acute Rehabilitation
- Transitional Care
- Emergency Departments
- Perioperative Services

**Team**
- **Champion:** Chief Nursing Executive
- Quality and Performance Improvement Consultants
- Data Analysts
- Electronic Health Record Consultant
- Nurse Managers
- Staff Nurse Leaders
- Nurse Educators
- Communications Department

1. Defining the scope and team – Phase 2

- **Scope (Adult Outpatient)**
  - Infusion Centers
  - Clinics
  - Procedural Areas
1. Defining the scope and team – Phase 3

- Scope (Pediatrics)
  ➢ Process begins with validation of tool in pediatric population

2. Identify and manage the risks

Potential failures/risks
- Failure to gain cooperation of nurses and physicians
- Concerns of researchers using the numeric scale
- Failure to increase patient satisfaction or improve pain management

Managing Risks
- Buy-in from key leaders
- Contacted IRB to notify researchers of change
- Weekly monitoring of process with monthly monitoring of outcomes

3 & 4. Breakdown and schedule the work

<table>
<thead>
<tr>
<th>Month</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>April</th>
<th>May</th>
<th>June</th>
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</tbody>
</table>

- Take to leadership groups
- Empower content of measurement
- Measure data on numeric scale
- Take care and evaluate
- Enhance data score and feedback loop
- Engage leadership
- Obtain consent data at bedside
- Communicate/educate all levels
- Implement/champion
- Measure success, track, sustain
- Implementation completed
5. Communicate

- **Who**
  - Special interest groups: Nurse Managers/Directors, nursing staff, physician groups, APRNs, nursing practice committees, social workers, therapists, champions
- **When**
  - Before, frequently throughout
- **What**
  - Purpose, expected behaviors, expected outcomes, patient/family feedback, process and outcome measures
- **How**
  - Via meetings, newsletters, intranet, patient stories, staff stories, e-mail

6. Measure progress

- **Process measures:**
  - Weekly compliance report per unit
  - Identification of individuals still using numeric scale: can be coached and counseled
- **Outcome measures:**
  - Monthly CAPA© outcomes
  - Press Ganey© pain satisfaction scores
Objective 2

• Summarize the outcomes of University of Minnesota Health’s implementation of CAPA©.

Electronic Data Abstraction

<table>
<thead>
<tr>
<th>Patient Context</th>
<th>0830</th>
<th>1130</th>
<th>1200</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain Location</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>! Pain Intensity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain Orientation</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Pain Interventions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Response to Interventions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Pain Site Documentation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinically Aligned Pain Assessment (CAPA)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMIC Adults Only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comfort</td>
<td>comfort</td>
<td>getting</td>
<td></td>
</tr>
<tr>
<td>Pain Control</td>
<td>fully</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functioning</td>
<td>can</td>
<td></td>
<td>do</td>
</tr>
<tr>
<td>Sleep</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Process Measures – CAPA Compliance

- Both CAPA and Numeric
- CAPA Only
- Numeric Only
### Outcome Measures - CAPA©

**Effectiveness of Pain Control (by Month)**

- January: 27.81%
- February: 22.87%
- March: 23.47%
- April: 23.83%
- May: 23.00%
- June: 22.67%
- July: 22.67%

### Outcome Measures - CAPA©

**Degree of Comfort by Month**

- January: 44.00%
- February: 46.00%
- March: 48.00%
- April: 50.00%
- May: 52.00%
- June: 54.00%
- July: 56.00%

### Outcome Measures – Press Ganey©

- Overall Pain Management
  - Staff Did Everything They Could to Help With Pain
  - Pain Well Controlled
Anecdotes

Patient perspective: “Makes me feel like the nurses care more about my pain.”

Nurses perspective:
• “It makes sense.”
• Many frustrated by numeric scale. “I hated that 0-10 scale.”

Nurse Survey
1 med-surg unit (N=21, 67% return)
80% satisfied or very satisfied with implementation
80% felt communication with patients improved with CAPA©
71% satisfied with rationale for change
66% preferred CAPA© over NRS
47% believe patients have somewhat better pain management with CAPA©

Thanks to: Emily Drobinski, Carrie Hallstrom, Kelly Pavlicek, Mary Sylvestre, Heather White, Clare Zielinski: Unit 8A, UMMC

Objective 3
• Describe the lessons learned from implementing a complex and culture-changing project.
Learnings
• Numeric scale embedded in many different places in EHR.
• Pain assessment by many different people
  – Students, faculty, therapists, technicians, etc.
• Some staff are not skilled at “talking with” patients; this presented a challenge.
• Some people resist change!
• Staff can be the biggest champions!

Unexpected Occurrences

Additional Learnings
• Staff need to recognize this as culture change versus a “project”
• Glitches happen in spite of best planning
• Ripple effects of change
• Barriers along the way: people, processes, tools
• Facilitators: people, processes, and tools
Recommendations

• “Make it hard to do the wrong thing, and easy to do the right thing.” Joanne Disch, PhD, RN

• Educate via presentations, electronic learning, written materials, interpersonal meetings. Repeat, repeat again....

Recommendations

• Speak to fears and concerns:
  – Fear of making an “assessment”: some more comfortable with patient’s statement of a number
  – MDs fear that they won’t know how to respond when nurse calls with CAPA information

• Engage executive leadership as necessary

A Tale of Two Emergency Departments
Summary

• Pain assessment is **not merely the subjective statement** of the patient, **no more than it is the sole objective decision of the clinician.**
• Rather, pain assessment is the **intersubjective exchange of meaning** between the patient and clinician.
• It is a **process**, which is ongoing and dependent on both the internal and external factors inherent to both the parties and their environment.

Summary

• CAPA© is an expanded way to assess pain using a transactional conversation between patient and clinician.
• Findings: Changing from the numeric scale to the CAPA© tool is a cultural change for staff and patients.
• Next steps at our institution include:
  – Expansion to most care settings within hospital system.
  – Validation of tool in adolescents
Questions?

References

Donaldson, G., & Chapman, C.R. (2013). Pain management is more than just a number. University of Utah Health/Department of Anesthesiology. Salt Lake City, Utah: Department of Anesthesiology.

