**OBSERVATIONAL STUDY**

**Documentation for assessing pain in post-operative pain management pre- and post**- **intervention.**

**Abstract**

**Purpose:** Although Norwegian law requires the documentation of patients’ care processes, including pain assessment, research has shown that the quality of post-operativedocumentation for assessing pain does not meet an acceptable standard and requires improvement. Clinical nurses are required to undergo regular teaching about assessing, relieving, and documenting pain. The purpose of this study was to investigate whether an educational intervention can increase nurses’ documentation of post-operative pain assessments, alter patients’ opioid consumption, and ensure that patients have at least one documented Numeric Rating Scale (NRS) < 3 at rest before being discharged. A secondary aim was to investigate whether the nurses’ education and experience influenced their pain assessments.

**Design:** An observational study with a pre-post intervention.

**Method**: The study following a pre-post design involved documenting pain assessments of 304 patients undergoing cancer surgeries in a post -operative unit at the Norwegian Radium Hospital, Oslo University Hospital from November 2020 to February 2021. In an educational intervention, two 45-minutes teaching sessions within two weeks, addressed validated pain assessment tools and the documentation of pain assessment. Data were collected from MetaVision TM (an electronical patient chart system, iMDsoft, Israel) and analysed with SPSS Jamovi following statistical process control (SPC). Descriptive frequency analysis and partial correlation with Pearson’s r - value were used, with p<0.05 indicating significance.

**Findings**: Post-intervention, pain assessments in general increased significantly from a mean of two times per patient to three times. Overall, the use of assessment tool CPOT increased from 6.1% to 25.8%, opioid consumption increased in mean from 3.34 to 4.79 in milligram and the documentation at discharge increased from 81.4% to 91.4%. The documentation of nurses with more than 10 years’ experience in the unit especially improved from 17.5% to 31.7%.

**Conclusions:** Educational intervention and reminders about 29 basic systematic pain assessment and the evaluation of pain measures improved nurses’ documentation of post-operative pain management and documentation at discharge. The findings underscore the importance of regularly ensuring the quality of patients’ treatment by systematically documenting nurses’ clinical tasks and the outcome of patients’ care.

**Keywords:** Nursing documentation; post-operative pain assessment; opioid consumption; intervention study; cancer surgery.