



# DEDER GENERAL HOSPITAL

## Standard Operating Procedure (SOP) for Sustaining improvement in Inpatient Pain Management

**BY: HSQU**

**April 2025**

**Deder, Eastern Ethiopia**

### SMT SOP APPROVAL

TITLE	<b>SOP for Sustaining improvement in Inpatient Pain Management</b> <b>Version: DGH-SOP-IPD-002</b>			
	NAME	POSITION	ROLE	SIGN
AUTHORS	Abdi Tofik (BSc, MPH)	Quality Director	Team leader	
	Abdella Aliyi (BSc MW)	Quality Officer	Member	
	Mahammad Aliyi (BSc N)	Reform head	Member	
	<b>Approved Date: April 2025</b>			
SMT APPROVAL	Name	Position	Role	Sign
	Nuredin Yigezu (BSc, MPH)	CEO	Chair person	
	Dr. Derese Gosa (GP)	Medical director	Member	
	Dr Isak Abdi (G/Surgeon)	Staff Representative	Member	
	Dr. Dawit Seifu (GP)	IPD Director	Member	
	Abdi Tofik (BSc, MPH)	Quality Director	Member	
	Hamza Jamal (BSc N)	Metron	Member	
	Abrahim Tahir (BSc N)	HR Head	Secretary	
	Obsa Usma'il (BA)	Finance and procurement head	Member	
	Bellisa Usma'il (BSc Pharm)	Pharmacy head	Member	
	Alamudin Usma'il (BSc Lab)	Laboratory head	Member	
	Dine Bakar (BA)	Internal Auditor	Member	
	Redwan Sharafuddin (BSc Pharm)	Planning Head	Member	
	Nure Jamal (BA)	General service head	Member	
REVIEW	Mahammad Shamshaddin (BSc)	Qondaala Naamusaa	Member	
	<b>Review date: April 2026</b>			

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## 1. Purpose

To provide a structured, sustainable, and measurable approach for inpatient pain management that ensures  $\geq 90\%$  compliance with pain assessment, intervention, and reassessment. This SOP integrates continuous monitoring, PDSA cycles, clinical forums, and feedback systems to strengthen sustainability and patient satisfaction.

## 2. Scope

### This SOP applies to:

- All clinical staff (nurses, physicians, midwives, pharmacists).
- Ward Heads and Pain Focal Persons.
- HSQU & QI Team.
- Hospital senior management responsible for resourcing and accountability.

## 3. Definitions

- **Pain Assessment:** Evaluation of intensity, location, and impact using standardized scales (0–10).
- **Pain Focal Person:** Ward-based staff designated to coordinate audits, tools, and feedback.
- **Sustained Pain Management:** Achieving and maintaining  $\geq 90\%$  documented compliance with pain control practices.
- **PDSA Cycle:** Plan–Do–Study–Act framework used to implement and scale improvement strategies.
- **Implementation Checklist:** Tool to confirm readiness, resourcing, and monitoring before interventions.

## 4. Responsibilities

Role	Key Responsibilities
<b>Hospital CEO &amp; SMT</b>	Allocate resources (staff, training, analgesics); review performance quarterly.
<b>Clinical Director</b>	Approve protocols, supervise SOP compliance.
<b>Ward Heads</b>	Ensure integration of pain assessment into daily rounds and handovers; follow up corrective actions.
<b>Pain Focal Person (per ward)</b>	Conduct biweekly chart audits, track compliance, maintain dashboard.
<b>Nurses &amp; Physicians</b>	Assess, document, intervene, and reassess pain per SOP; educate patients/families.
<b>Pharmacy Head</b>	Ensure essential analgesics availability; report shortages weekly.
<b>HSQU &amp; QI Team</b>	Run PDSA cycles, manage dashboard, analyze data, and facilitate forums.

## 5. Procedures

### 5.1 Planning & Standardization (PLAN)

- Review and align protocols with latest WHO/national guidelines.
- Standardize job descriptions, audit tools, and reporting formats.
- Confirm readiness using an implementation checklist.

## **5.2 Training & Awareness (DO)**

- Structured training for all staff; refreshers every 6 months.
- Include new staff induction.
- Keep training logs and allocate training budget.

## **5.3 Measurement & Data Collection (STUDY)**

- Define indicators: % patients assessed at admission, % patients reassessed within 60 minutes, % documentation compliance, patient satisfaction scores.
- Pain Focal Person ensures data entry; HSQU reviews monthly.
- Use Traffic Light Dashboard for ward-level trends.

## **5.4 Implementation & Feedback (ACT)**

- Pilot changes in one ward → scale hospital-wide.
- Provide feedback within 72 hours of each audit.
- Document corrective actions, responsible person, and timelines.

## **5.5 Clinical Forum Integration**

- Keep pain management as a standing agenda item in ward forums.
- Present run-charts and dashboard results.
- Encourage cross-learning between wards.

## **5.6 Sustainability & Resourcing**

- Monitor drug supply chain weekly.
- Maintain assessment tools (scales, posters, audit forms).
- Conduct quarterly self-audits for SOP adherence.

## **5.7 Documentation & Change Control**

- Update SOP annually or earlier if compliance drops below 85%.
- Keep paper and digital records of audits, feedback logs, training records.

- Track modifications using a Change Request Form.

## 6. Documentation

The following records must be maintained:

- PDSA Worksheets (pain cycles).
- Audit & Feedback Records.
- Integrated Pain & Vital Signs Sheets.
- Meeting minutes.
- Monthly/Quarterly reports.
- Change Request & Implementation Checklist.

## 7. Resources Required

- Pain scales, posters, documentation sheets.
- Essential analgesics.
- Computers/forms for dashboard entry.
- Training materials and budget.

## 8. Review & Update

This SOP shall be reviewed annually by HSQU & Clinical Director, or earlier if compliance falls below 85% or systemic changes occur. Revisions should be tested through PDSA cycles before full roll-out.

## APPENDICES

### Pain Assessment) – Implementation & Monitoring Tools

#### 1. PDSA Cycle Worksheet

Stage	Items to Complete	Response / Notes
PLAN	Objective	_____
		_____
	Prediction	_____
	Plan for data collection	_____
	Who is involved	_____
DO	When & Where	_____
	What was implemented	_____
	What actually happened	_____
STUDY	Problems encountered	_____
	Data collected	_____
	Results vs. prediction	_____
ACT	Lessons learned	_____
	<input type="checkbox"/> Standardize successful change	
	<input type="checkbox"/> Modify plan and test again	

#### 2. Audit & Feedback Record

Date	Auditor	Patient / Chart ID	Audit Finding (Type of Issue)	Corrective Action	Staff Feedback (Verbal/Written)	Follow-Up Date
2025-09-21	Nurse B	001	Inadequate reassessment	Reassess within 30-60 min	Written	Next Audit

#### 4. Meeting Minutes Template

Date: \_\_\_\_\_

Facilitator: \_\_\_\_\_

Department: \_\_\_\_\_

<b>Agenda Item</b>	<b>Discussion Summary</b>	<b>Decisions / Action Points</b>	<b>Responsible Person</b>	<b>Timeline</b>
Pain Audit Results				
Analgesic Stock Status				
Training Update				
Challenges & Recommendations				

## 5. Monthly & Quarterly Pain Management Report with KPIs

<b>S/N</b>	<b>Indicator</b>	<b>Target</b>	<b>Current Result</b>	<b>Status (Achieved/Not Achieved)</b>	<b>Remarks</b>
1	Pain Assessment Rate (%)	≥90%	___ %		
2	Pain Reassessment Rate (%)	≥90%	___ %		
3	Documentation Compliance (%)	≥90%	___ %		
4	Patient Satisfaction (%)	≥90%	___ %		
5	Audit Completion Rate (%)	100%	___ %		
6	Feedback Timeliness (%)	≥90%	___ %		

### Traffic Light Key:

- ✓ **Green:** ≥90% (target achieved)
- ✗ **Yellow:** 70–89% (needs improvement)
- ✗ **Red:** <70% (urgent corrective action)

### Corrective Actions

<b>Issue Identified</b>	<b>Corrective Action</b>	<b>Responsible Person</b>	<b>Timeline</b>	<b>Status</b>
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Way Forward:

## 6. Pre/Post Implementation Checklist – Pain Management

Key Implementation Area	Checklist Items	Responsible Person	Status (Yes/No/Partially)	Comments / Notes
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<b>Standardization</b>	Pain management guidelines reviewed & updated	Clinical Director / HSQU Lead		
	Job descriptions and roles aligned with SOP	Hospital HR + Ward Head		
<b>Documentation</b>	Updated audit tools available (Pain Audit Form, Dashboard)	HSQU		
	Feedback log format standardized	HSQU		
<b>Training</b>	Training procedure developed (induction + refresher)	QI Coordinator		
	Training resources allocated (budget, materials)	Hospital Management		
	Training schedule completed	HSQU		
	New staff induction process updated	Ward Head		
<b>Measurement</b>	Indicators defined (Pain Assessment, Reassessment, Documentation, Satisfaction)	HSQU Lead		
	Measurement responsibilities assigned	Pain Focal Person		
	Monthly review meetings scheduled	Clinical Director		

<b>Resourcing</b>	Essential analgesics supply chain monitored	Pharmacy Head		
	Pain scales/posters/forms available in all wards	Ward Heads		
<b>Sustainability</b>	Quarterly self-audit planned	HSQU		
	Corrective actions documented & closed	Ward Head		
	Lessons scaled to other wards	QI Team		