

**NURSES' EXPERIENCES WITH PAIN MANAGEMENT IN  
LONG TERM CARE SETTINGS:  
A GROUNDED THEORY STUDY**

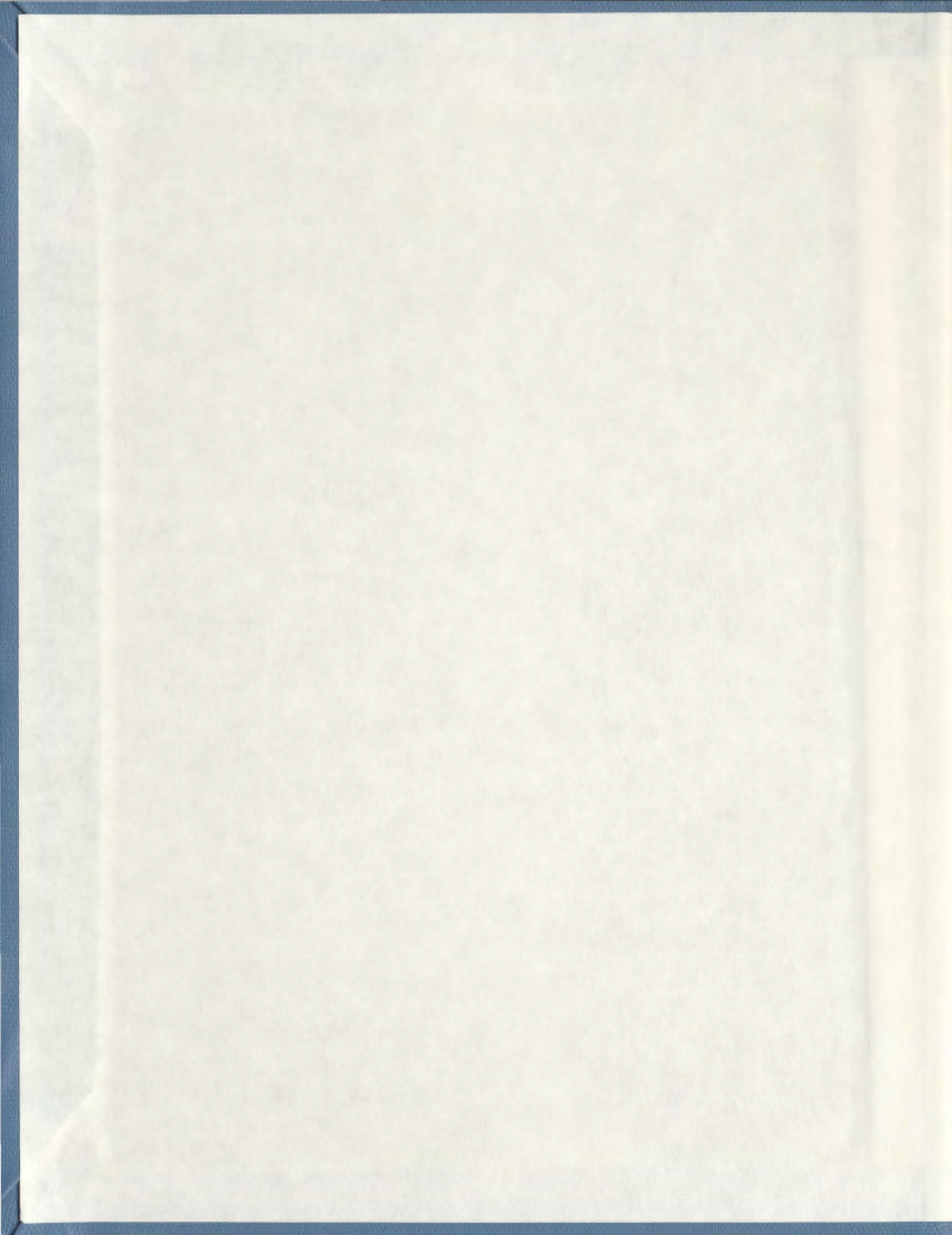
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**Nurses' Experiences with Pain Management  
in Long Term Care Settings: A Grounded Theory Study**

**by**

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**A thesis submitted to the  
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## **Abstract**

The purpose of this grounded theory study was to investigate nurses' experiences with pain management in long term care settings where the majority of the residents are elderly persons. A non-probability, purposive sample of sixteen registered nurses was obtained from three nursing homes in St. John's, Newfoundland. Semistructured interviews, averaging approximately one hour, were audiotaped and conducted in a private place. Open-ended questions explored nurses' perceptions of assessment protocols, intervention strategies, knowledge requirements, and barriers to and facilitators of effective pain management. Interviews were transcribed verbatim within 48-hours, checked for accuracy, and subjected to the constant comparative method of analysis. Credibility and accuracy of the themes and emerging conceptual categories were confirmed by an independent rater and follow up telephone calls to participants.

Three theoretical categories have emerged to define nurses' experiences with managing pain: knowing the resident; assuming the helping role; and striving to achieve positive outcomes. The emerging theory suggests that the constructs of knowing the resident, assuming the helping role and striving to achieve positive outcomes exert independent and interactive effects on nurses' abilities to manage residents' pain in long term care settings. Based on theoretical insights gleaned from the data it is postulated that "overcoming

barriers” is the common thread intersecting and joining the constructs.

Nurses are experiencing both success and frustrations in managing patients' pain. The current study's findings suggest that unless nurses have adequate understanding of the total person and insight into the barriers to and facilitators of pain management efforts, decisions about appropriate strategies and effective monitoring of intervention outcomes will be compromised in long term care settings.

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## **CHAPTER 1**

### **Introduction**

The International Association for the Study of Pain (IASP) defines pain as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage” (1986, p. 12). Pain is always subjective; each individual learns the application of the word through experiences related to injury early in life. Pain is that experience we associate with actual or potential tissue damage. It is a sensation in part or parts of the body. It is also always unpleasant and therefore also an emotional experience. This definition implies that pain is a subjective experience and should be taken for what it is, not what accompanies it or follows from it (Merskey, 1997). Pain is an abstract concept that represents a complex interaction between a stimulus, the person reacting to it, and the situational context. Pain is the result of a combination of sensory, affective and emotional factors (Melzack & Wall, 1965). Pain perception is influenced by culture, meaning of the situation, past experiences, current anxiety, available options, and sense of control (Watt-Watson, 1992). There is no evidence to suggest that the aging process affects the location, extent, or intensity of pain; all neurophysiological processes that subserve nociception remain intact throughout the life span (Gagliese & Melzack, 1997; Harkins, 1996; Harkins & Price, 1992).

Although there are no known age-specific diseases (Saxon, 1991), elderly people are more likely to have several diseases, to suffer from acute and chronic pain, and to take multiple medications (Closs, 1994; Mobily, Herr, Clarke, & Wallace, 1994). It is projected that by the year 2011 the senior population (>65 years) will increase from the current level of 12% to 14% of the Canadian population, and the percentage age 45 years or over will increase from 31% to 42% (Statistics Canada, 1993). It is also projected that the population aged 85 and over will almost double from the current 245,800 to 433,200 by the year 2011 (Statistics Canada, 1996).

Pain is a critical symptom that affects quality of life and health outcomes in both acute and chronic illness. Epidemiological surveys of the elderly population, although limited, suggest that from 25% to 86% of those living in the community have pain (Brochet, Michel, Barberger-Gateau, & Dartigues, 1998; Crook, Rideout, & Brown, 1984; Millar, 1996; Mobily et al, 1994). Estimates of the prevalence of pain in institutionalized elderly people range from 45% to 80% (Ferrell, Ferrell, & Osterweil, 1990; Roy & Thomas, 1986, 1987). Given the dramatic growth projections for the elderly and the prevalence of pain in this population, greater attention should be given to pain management with this group. In recent years, pain management strategies across all age groups have come under closer scrutiny. Some authors suggest that there is a tendency to

undertreat all types of pain regardless of the age group (McCaffery, Ferrell, O'Neill-Page, & Lester, 1990). It is estimated that as many as 50% of surgical patients and 80% of cancer patients experience inadequate pain management (Ferrell, Whedon, & Rollins, 1995). Pain management focuses on the alleviation or modification of constant or recurring physical or psychological symptoms. To be successful with pain management, nurses require knowledge of pain theory, experience in caring for people in pain, and insight into the interrelations among pain, suffering, and human behaviour (Barnason, Merboth, Pozehl, & Tietjen, 1998; Burke & Jerrett, 1989; McCaffery & Ferrell, 1997 a; Nash, Yates, Edwards, Fentiman, Dewar, McDowell, & Clark, 1999; VonPost & Eriksson, 1999).

The purpose of this study was to investigate factors that influence nurses' pain management practices with elderly people in long term care settings. A second purpose was to identify, describe, and provide a theoretical basis for nurses' experiences with pain management in this setting.

### **Background and Rationale**

The pain experiences of the geriatric population differs from younger age groups and has been coined "geriatric pain" (Melding, 1991). Older people are prone to many painful diseases such as musculoskeletal disorders (e.g., osteoarthritis, osteoporosis, osteomalacia, rheumatoid arthritis, Paget's disease,

cervical spondylosis, etc.), fractures, cerebrovascular accidents, vascular diseases (e.g., intermittent claudication, temporal arteritis, sympathetic dystrophies, vasculitis, etc.), neuropathies (e.g., diabetes mellitus, herpes zoster, etc.), and malignancies. Also, chronic pain is more prevalent in older than younger people (Closs, 1994, 1996; Mobily et al., 1994; Melding, 1991).

Pain experiences can be more problematic than the disease itself.

Although pain can arise from one or many pathophysiological sources, psychological factors can vicariously impact on function and quality of life (Minor & Sanford, 1993). The impact of pain on elderly people, besides that of physical and emotional distress, includes problems with mobility, walking, moving, performing household chores, sleep disturbance, and interference with social and leisure activities. Pain may result in depression and depressed people report more pain (Herr & Mobily, 1992).

Elderly patients may present special problems when clinicians try to obtain an accurate pain history. Failures in memory, depression, cultural influences and sensory impairments may hinder history taking. It has also been suggested that elderly people may underreport symptoms because they expect pain to be associated with aging and diseases, and may not want to burden others (Ferrell, 1991).

Clinicians, in particular nurses, play a significant role in the alleviation of

pain and suffering in their patients. The goal is to manage pain through accurate assessment and implementation of effective measures to achieve relief or modulation. However adequate assessment, treatment, and evaluation of pain in all age groups remain problematic for nurses and other health care professionals (Brunier, Carson, & Harrison, 1995). Many reasons have been suggested for this state of affairs including: inadequacies in education, lack of information about pain assessment and pain control, inaccurate knowledge of pharmacological and nonpharmacological strategies for pain management, and/or negative attitudes or beliefs (Brunier et al., 1995; Closs, 1996; Fagerberg & Ekman, 1997; Hamilton & Edgar, 1992; Lander, 1990; McCaffery et al., 1990; Watt-Watson, 1992).

Nurses often fail to understand the nature, theory, origin and transmission of pain, the effects of anxiety and depression on pain, and the differences between acute and chronic pain. Nurses overestimate psychological addiction in patients (Charap, 1978; Watt-Watson, 1992; Taylor, Skelton, & Butcher, 1984). Significant discrepancies have also been noted between nurses' and patients' perceptions of pain levels (Camp & O'Sullivan, 1987; Field, 1996; Lauri, Lepisto, & Kappeli, 1997; Middleton, Knezacek, Robinson, Hartley, & Kaasalainen, 1997; Teske, Daut, & Cleeland, 1983).

Despite the high prevalence of significant pain in the elderly population,

most research on pain control has been conducted with younger age groups and many of the interventions have not been tested with older people (Ferrell, 1991; Wallace, 1994). Pain programs for practitioners often lack information on effective management strategies for elderly patients in particular. In a review of 12 studies on the effects of pain management programs for nurses, Francke, Garssen, and Abu-Saad (1996) only identified one course for nurses working in geriatric settings. Medical and nursing schools' curricula also rarely address the anatomy, physiology, assessment and treatment of pain (Ferrell, 1991; Rosomoff, 1996).

### **Problem Statement**

In nursing theory, nursing is generally represented as a helping process with a primary focus on interpersonal interactions between a nurse and a patient (resident, client). This general stand implies that, for nursing, interpersonal interactions (i.e., the development and maintenance of the nurse-patient relationship) are of primary importance to the nature of nursing (Chinn & Kramer, 1991). Nurses' relationships with elderly patients must acknowledge the unique age related differences of this group in order to effectively assess and manage pain. The consequences of stereotyping most elderly people as experiencing less pain may result in needless suffering and decreased quality of life (Ferrell,

1991; Harkins, 1988).

Nurses have the responsibility for managing patients' pain but pain control remains a continuing problem. Greater research efforts are needed to identify the factors that impede or facilitate effective pain management. The current study explored the experiences of nurses with pain management in long term care settings with a majority of elderly patients. The objective was to enhance our understanding of the present nursing pain management process.

### **Research Questions**

This study was designed to address the following research questions:

- (1) What is the meaning of pain management for nurses?
- (2) What factors impede and/or facilitate the selection and implementation of pain management strategies in long term care settings?

## **CHAPTER 2**

### **Literature Review**

The literature on pain management practices of health care professionals, in particular nurses, reflects mostly quantitative research. Studies have suggested that nurses' assessment of pain is influenced by their value and belief systems, attitudes, and knowledge base. Nurses' management strategies often vary according to specific patient characteristics and preconceptions of what is appropriate for their patients.

Studies on pain in elderly people will precede a review of studies on nurses in order to familiarize the reader with the problems unique to this population. The review of studies on nurses will focus on knowledge of, attitudes toward pain issues, as well as the educational preparation of nurses in pain management. This literature review is divided into four major sections: (1) pain in elderly people, (2) knowledge of pain assessment and management, (3) attitudes toward pain assessment and management, and (4) pain management education programs.

### **Pain in Elderly People**

Persistent pain is an important problem in elderly people. There is an obvious need for more epidemiological investigations of the subjective and

behavioural manifestations of pain to document the natural history of pain, to identify those at greatest risk for developing chronic pain behaviour, and to facilitate evaluation of methods for preventing disability (Von Korff, Dworkin, LeResche, & Kruger, 1988). Even though elderly people are more likely to have chronic illnesses resulting in pain, little attention has been given to effective pain assessment and management strategies (Closs, 1994; Ferrell & Ferrell, 1991; Harkins, Price, Bush, & Small, 1994; Melding, 1991; Middleton, et al., 1997; Mobily, Herr, Clark, & Wallace, 1994; Saxon, 1991). The studies reviewed in this section highlight the prevalence and type of pain in elderly people residing in community and institutional settings, and the important influence of cognitive status on accurate pain assessments and effective pain management.

### **Community and Institutional Settings**

Despite the growing body of evidence suggesting that elderly people have major problems with pain, it is difficult to construct an accurate picture of its prevalence due to the limited research base (Mobily et al., 1994). Studies investigating pain problems are especially scarce for nursing home residents. The studies reviewed in this section suggest that 70% to 86% of elderly people experience pain on a regular basis, and those residing in nursing homes have similar pain prevalence patterns as their counterparts living in their own homes.

In a descriptive study, Roy and Thomas (1986) investigated pain problems in a sample of elderly nursing home residents and geriatric day hospital patients (N = 132). Both groups completed a comprehensive questionnaire on prevalence and type of pain and the Visual Analogue Scale - a 100 mm. line that represents the continuum of experiences like pain. The findings indicated that a significant proportion of the sample (83%) reported problems with pain. Fifty percent of those subjects reported low levels of pain, 32% moderate levels, and 18% intolerable levels. The majority of patients attributed their pain to connective tissue disorders. Eighty-eight percent of sample subjects with pain reported back, joint and muscle pain. About 12% of the sample identified headache as a major complaint. Of those reporting problems with pain, 16% were not receiving any treatment. The authors failed to report on group differences.

Using a descriptive survey design, Roy and Thomas (1987) investigated the prevalence of pain in a random sample of elderly persons over 60 years of age living in the community (N = 205). Telephone interviews were conducted with open-ended questions to elicit data on the type, severity (mild, moderate, severe), and prevalence of pain. The findings revealed that 70% of the sample reported experiencing current pain. There were no significant differences observed between those with or without pain in terms of age, gender, marital

status, education, income, living arrangements, or participation in social activities.

In a pilot epidemiology study of residents ( $N = 97$ ) in a long term care facility, Ferrell, Ferrell, and Osterweil (1990) explored problems with pain management. Five structured instruments with established reliability and validity were used to assess different aspects of pain: experiences and management strategies (Pain Experience Measure), pain intensity (McGill Present Pain Intensity Scale), functional status (Katz Activities of Daily Living Scale), and mental status (Folstein Mini Mental State Examination and Yesavage Geriatric Depression Scale). Additional data were collected on select demographic characteristics, medical conditions, and medications. The researchers found that 71% of the sample reported some degree of pain, with 34% describing their pain as continuous and 66% as intermittent. Of those with intermittent pain, 44% noted the presence of pain on a daily basis. Major sources of pain included low back pain (40%), arthritis of appendicular joints (24%), previous fracture sites (14%), and neuropathies (11%). The authors concluded that pain was a major problem with patients in this long term care facility.

In a retrospective study, Moss, Lawton, and Glicksman (1991) compared previous ( $n = 200$ ) and current caregivers' ( $n = 150$ ) perceptions of the quality of life of elderly family members in the last year of life versus an ordinary year of

life. Researcher-developed instruments measured perceptions of quality of life in nine domains (i.e., frequency and intensity of pain, physical health, cognitive function, use of time, social behaviour, personality traits, perceived quality of life, and mental health). Most respondents (70%) reported that elderly family members experienced some degree of pain. Caregivers' of deceased family members reported significant increases in the prevalence of pain over the final year of life (i.e., 37% reported intermittent or continuous pain at 12 months versus 66% at one month prior to death). Further, caregivers' of deceased significant others reported significantly greater pain prevalence at all time periods (i.e., 12, 3, and 1 months) than those currently caring for elderly family members. Despite the significant differences observed between perceived pain levels in the last year of life versus an ordinary year of life at all three time periods, the correlates of pain were similar for both groups. For example, greater pain was consistently associated with lower education and income, deterioration in physical health, decreased participation in activities and social behaviour, less satisfaction with life, and reduced psychological well-being.

As part of a longitudinal, epidemiological study exploring a broad range of physical, mental, and social characteristics, Mobily, Herr, Clark, and Wallace (1994) investigated the prevalence (as experienced in the past year) and type of pain in a sample of rural elderly people aged 65 years and over ( $N = 3,673$ ).

Trained interviewers used a closed ended questionnaire, at baseline and annual follow-up. The researchers found that 86.3% of the sample reported experiencing pain, with 59% reporting multiple pain complaints. Joint pain was the most prevalent type, followed by night leg pain, back pain, leg pain while walking, and chest pain. The type and prevalence of pain did not vary by gender or age group.

In a large cohort study of elderly people in France, Brochet, Michel, Barberger-Gateau, and Dartigues (1998) investigated the prevalence of pain in a random sample of elderly people ( $N = 741$ ) aged 65 years and over living in the community. Trained psychologists used a closed-ended questionnaire to conduct interviews with elderly subjects annually over three years. The questionnaire sought information on frequency of pain, location of pain, and the temporal pattern of each pain episode. Study findings indicated that approximately 71.5% of respondents reported experiencing some type of pain. The most common location of pain was limb joints and back pain, followed by neck pain and generalized limb pain.

With such a high prevalence of pain in elderly people living at home one might expect a greater tendency to use formal health services. In a cross-sectional survey study of elderly people ( $N = 112$ ), Cook and Thomas (1994) failed to find support for the assumption that pain would lead to increased

service use. The researchers found that a substantial number of participants coped positively with pain, and demonstrated as much self-reliance in dealing with pain as the use of formal health services. The most common form of pain management was a combination of analgesics and acceptance of mild pain as a normal part of daily living. Study limitations include the use of a non-probability, community-based sample that excluded elderly people in acute care or nursing home settings.

### **Cognitive Status**

Patients' pain complaints and/or request for analgesia is a key signal for nurses to implement appropriate strategies. What happens when patients are unable to adequately express their needs because of cognitive impairment? Many elderly people with cognitive deficits are admitted to nursing homes where assessment of pain status can be quite challenging for nurses. A number of studies were identified from the literature that explored the effects of cognitive status on pain assessment and management. Study findings suggest that it is possible to accurately assess pain with people who have cognitive deficits, however research also indicates that there is a tendency to use fewer pain management strategies with this group.

In a cross-sectional correlational study, Parmalee, Smith, and Katz (1993)

investigated pain complaints in a sample of patients with mild ( $n = 292$ ), marked ( $n = 89$ ), and no cognitive impairment ( $n = 372$ ) from a large nursing home. The Fuld Blessed Test was used to assess the degree of cognitive impairment. A number of measures were used to assess pain status (i.e., physician health status ratings, functional disability scales, and scales that measured pain intensity and localized pain complaints). Reliability and validity of all instruments were reported. Study findings revealed that 79.9% of patients reported at least one pain complaint. Importantly, an inverse relationship was observed between the number of reported pain problems and cognitive status (i.e., decreased reports, increased cognitive impairment). The researchers concluded that self-reports were valid even when cognitive impairments were present, and the findings were more supportive of the hypothesis that cognitive impairment interferes with pain reporting and not the reverse.

In a methodological study to validate a pain assessment instrument, Simons and Malabar (1995) studied patients ( $N = 105$ ) admitted to hospital with cognitive deficits and who could not communicate verbally. Pain status was assessed with an amalgam of pain behaviours (i.e., verbal response, facial expression, body language, physiological changes, other behavioural changes, others' input, and level of consciousness), and chart documentation of pain behaviour and response to intervention. The findings indicated that patients'

pain behaviours changed to non pain behaviours following appropriate intervention (i.e., analgesic administration). Further, nurses reported that this type of assessment facilitated recognition of pain and timely intervention strategies. The researchers concluded that the use of multiple measures is a more accurate approach to pain assessment in cognitively impaired patients.

In a methodological study, Ferrell, Ferrell, and Rivera (1995) investigated the usefulness of existing pain measurement instruments in a sample of elderly residents ( $N = 217$ ) of nursing homes with varying degrees of cognitive impairment. Data were collected on select demographic and illness-related variables (i.e., age, gender, and medical diagnoses) and pain management strategies (i.e., prescribed medications, and non-drug interventions) from a cross-section chart review. The Folstein Mini-Mental State Exam (MMSE) assessed cognitive status, and the Katz Activities of Daily Living Scale assessed functional status. During structured interviews with residents, pain status was assessed with multiple instruments (i.e., investigator-developed 33-item questionnaire; McGill Pain Questionnaire; a verbally administered 0 to 10 scale; a 100mm horizontal visual analogue scale; subscale of the Memorial Pain Card; and the Rand COOP Chart). Sixty-two percent of study participants reported pain complaints during the interviews. Of those reporting pain, 37% had no documentation of this problem in their medical records. For the most part,

documentation of pain complaints was unstructured and did not indicate routine monitoring of pain status. The treatment of choice was acetaminophen, with limited use of non-pharmacological strategies (i.e., 4% to 6%). Of the five scales used to assess pain status, 83% of participants could complete at least one but there was no single pain intensity scale that performed better than the others. These findings suggest the importance of modifying existing scales or using multiple instruments to assess pain with the cognitively impaired.

Using a correlational descriptive design, Kassalainen, Middleton, Knezacek, Hartley, Stewart, Ife, and Robinson (1998) examined nurses' ( $n = 25$ ) pain ratings of and medication use with elderly patients ( $n = 83$ ) in institutional settings. The researchers also investigated the similarities/differences in pain medication orders/practice for patients who were cognitively intact ( $n = 19$ ) or cognitively impaired ( $n = 64$ ). Cognitive status was assessed with the MMSE, pain with a visual analogue scale for pain (VAS-P), and pain management from nurses' documentation in medication records. Study findings indicated that nurses' ratings of pain were not significantly associated with the administration of pain medication. As well, cognitively impaired residents were prescribed significantly less pain medication than cognitively intact elderly residents. The authors conclude that with increased knowledge and the availability of appropriate pain assessment instruments, pain in elderly people, especially

those who are cognitively impaired, will be more thoroughly alleviated.

### **Summary**

Epidemiological studies have shown that a high percentage of elderly people experience pain (i.e., estimates range from 70% to 86%). Pain is described as ranging from mild to severe, with joint, back, and neck the most common sites. With such high reportings, there may be a tendency to underestimate the prevalence and intensity of pain. Further, these findings may be limited due to the questionable reliability and validity of study instruments, use of small, non-probability samples, and conduciveness of data collection procedures (e.g., telephone versus face-to-face interviews with subjects that may have sensory impairments; no descriptive data on the meaning and context of the pain; etc.).

Study findings also suggest that the prevalence and type of pain is similar for elderly people residing at home or in institutions. Further, comparative studies of people of variant cognitive status suggest that accurate pain assessment can be effectively completed on those with cognitive deficits; and patients with cognitive decline appear to have the fewest number of pain management strategies implemented. Elderly people who live in institutions and are cognitively impaired may be the most vulnerable population that experiences

unresolved pain. Nurses and other caregivers must be able to assess pain status through utilizing creative ways of observing pain behaviours.

### **Knowledge of Pain Assessment and Management**

Limited research studies have been conducted to confirm or refute a perception that nurses and other health care providers do not have adequate knowledge about pain assessment and effective pain management strategies. In the early 1970's educators were encouraged to improve practitioners' knowledge but research findings have failed to document significant improvements (Field, 1996; McCaffery & Ferrell, 1997a). Lander (1990) argued that educators have either not responded well to the challenge or have failed to alter the misconceptions of practitioners that the current status of pain management is satisfactory to people experiencing pain. Until recently there was no standard of care by which to judge the adequacy of pain management. However the development of clinical guidelines by the Agency for Health Care Policy and Research (AHCPR) now provide a standard of care to which health care professionals and organizations can be held accountable (Ferrell, Whedon, & Rollins, 1995). The existence of such guidelines may have improved nursing practice around pain management in various practice settings; however no studies were found that explored the effectiveness of clinical guidelines for pain

management in long term care settings.

Pain is not and should not be expected to be a normal part of aging; however many clinicians assume that the aging process itself, not the disease process, is the causative factor associated with an increase in suffering and pain complaint (Harkins & Price, 1992). Nurses may need specific skills in managing pain in older people due to factors that may complicate both the assessment and control of pain. Many authors reference the paucity of research conducted with this population. The following section reviews studies on nurses' knowledge of pain management strategies with the general population of patients and elderly clients.

### **Nurses' Knowledge Base**

Variable study results have been obtained on nurses' knowledge of pain assessment and management strategies. Several factors (e.g., years of nursing experience, education, age, clinical area, etc.) have been found to influence knowledge levels and practical application in different settings. Findings tend to be fairly, though not totally, consistent across studies. There is also limited research focusing on nurses working with elderly people.

**General population.** Using a descriptive design, Watt-Watson (1987) investigated nurses' (N = 208) knowledge of pain assessment and narcotic

administration. The sample consisted of a group of graduate and nursing students from a variety of clinical areas (i.e., medical, neurology, and neurosurgery) who attended pain management presentations. The researcher-developed instrument was administered prior to each presentation and consisted of 18 questions dealing with pain assessment and narcotic administration, as well as two open-ended questions inquiring about common problems with patients in pain and current assessment tools and/or approaches used by the nurses. No information was presented on instrument reliability or validity. The findings indicated that the majority of nurses and nursing students expected patients to experience minimal to moderate pain, as well as to tolerate pain. In addition, most of the sample did not differentiate between acute and chronic pain, believed (erroneously) that malingerers were not rare, did not use pain assessment tools, and found assessment difficult for patients with chronic pain. It was noteworthy that graduate nurses showed a lack of knowledge about addiction, duration of action, equianalgesic dosing, and side effects of narcotics. There were no significant variations in the findings for the graduate nurses in terms of the educational level or years of nursing work experience.

In a descriptive study, Dalton (1989) compared the pain assessment and management behaviours of oncology nurses ( $n = 19$ ) and acute care nurses with ( $n = 37$ ) and without ( $n = 22$ ) experience in caring for patients with cancer. A

researcher-developed instrument was used to collect data on the frequency of assessment of select factors (e.g., meaning of pain, coping strategies, desire to control pain, pain activity, physical and psychological factors, pain tolerance and intensity, etc.) and use of select pain management strategies (e.g., cutaneous stimulation, distraction, relaxation, imagery, awakening patients for pain medications, etc.). Study findings indicated that pain assessment and management strategies were similar, for the most part, across the three groups of nurses. Most respondents assessed pain characteristics, treatment effects, pain behaviours (e.g., moaning, facial expressions, etc.), select activity factors (i.e., time out of bed, and sleep pattern) and meaning of pain for the patient. Less attention was given to psychological assessments, differentiating between pain tolerance and intensity, the effects of pain on quality of life, suggesting or teaching alternate behavioural interventions to augment medications for pain relief, and the importance of maintaining a pain free state.

Using a descriptive design, McCaffery, Ferrell, O'Neill-Page, and Lester (1990) investigated knowledge of pharmacological pain management in a convenience sample of nurses ( $N = 2,459$ ) prior to their participation in a series of pain workshops. A researcher-developed questionnaire was designed to measure knowledge of analgesic drugs and analgesic addiction frequency. The authors' intent was to revise the questionnaire following study completion to

enhance its reliability and validity. The findings suggested that participants lacked adequate knowledge of analgesic drugs (i.e., narcotic vs. non-narcotic, and the incidence of addiction). Importantly, many nurses incorrectly classified milder analgesics as non- narcotic and cocaine as a narcotic rather than an anaesthetic agent, and were not aware that the frequency of drug addiction in patients is less than 1%.

Using a survey design, Lander (1990) investigated common misconceptions about pain management in a convenience sample of nurses (N = 63) working on medical/surgical units in an acute care hospital in Alberta. A researcher-developed questionnaire assessed perceptions about pain reporting and addiction, placebo responses, clinical skills in judging and managing pain, and efficacy in pain management. The questionnaire was revised based on content validation and pilot testing prior to its use in this study. Most participants believed that the risk of narcotic addiction was greater than actually is the case, gave incorrect ratings of placebo effects, and were confident about their ability to judge patients' pain.

In a cross-sectional study, Hamilton and Edgar (1992) investigated knowledge of pain assessment and management in a convenience sample of nurses (N = 318) from diverse clinical areas within a university, teaching hospital in Montreal. The self-administered Pain Control Survey, adapted from two

instruments developed by McCaffery et al. (1990), assessed knowledge of opioid classification and opioid effects, and pain assessment and management issues. The authors did not address the instrument's reliability and validity. The findings indicated that over 90% of respondents achieved an overall score of less than 80% (i.e., the majority demonstrated inaccurate responses on 20% of the items). Knowledge about principles of opioid analgesia (i.e., addiction, ceiling effect, equivalent dosing, and respiratory depression) was generally weak. Most nurses did not understand the behavioural and physiological adaptations that normally accompany pain experiences over time, and questioned whether sleep indicated lack of pain. Overall performance did not vary by educational preparation, years of experience, age, or clinical area.

Using a descriptive-comparative design, Fothergill-Bourbonnais and Wilson-Barnett (1992) examined knowledge levels and perceived adequacy and acquisition of knowledge in a sample of nurses (N = 100) working in intensive therapy units (ITU) and in hospices with patients who had cancer. A researcher-developed instrument was used to assess knowledge of pain and pain management strategies (i.e., pharmacological knowledge, clinical application, signs and symptoms of acute pain, and incidence of addiction), perceived adequacy of knowledge, and perception of the most effective modes for knowledge acquisition (e.g., practical experience, structured learning,

colleagues/supervisors, personal experiences, etc.). Information was also collected on select demographic characteristics (i.e., years of nursing experience, age, and gender). The sample was divided into beginners (i.e., 1 year or less of experience) versus experts (i.e., a minimum of 3 years). The authors used a pilot study to establish instrument validity and reliability. Study findings indicated that both groups demonstrated inadequate knowledge of pain management. Hospice nurses scored significantly higher than the ITU nurses but there were no significant differences observed between beginners and experts. The current work environment and years of nursing experience were found to exert the greatest influence on acquisition of nursing actions directed toward pain management. Importantly, study participants acknowledged that they required more knowledge of pain management strategies.

Using a naturalistic design, Jacavone and Dostal (1992) examined the practical knowledge and thought processes of expert ( $n = 4$ ) and beginning ( $n = 4$ ) nurses while assessing and treating patients with cardiac pain. Data were collected through observations and informal interviews during clinical encounters, and formal interviews which focused on clinical judgments related to paradigm cases and significant events. Study findings were collapsed into three major themes - practical knowledge of drug titration, qualitative distinctions in pain assessment, and holistic perception. With regard to the practical knowledge

theme, expert nurses recognized the need for and used a more aggressive approach to pain relief than beginning nurses. Expert nurses' confidence was grounded in knowing the actions of cardiac drugs (theoretical) and the importance of continuous assessment of individual patient's physiological response to drugs administered (practical). The qualitative distinction theme was defined in terms of the expert nurse's ability to make informed clinical judgments about patients' response to drug interventions, while aggressively pursuing a pain-free state. Expert nurses made qualitative distinctions by attending to the inward-focusing and energy-conservation behaviours of patients, as well as engaging in continuous assessment to detect and eliminate residual pain. The final theme reflected the expert nurse's ability to perceive the situation holistically while zeroing in on the particulars that indicated subtle but significant changes in a patient's clinical status. The author concluded that expert nurses working in cardiac care did manage pain effectively but did acknowledge the need for further research due to the small sample size.

Using a survey design, Vortherms, Ryan, and Ward (1992) examined knowledge of and perceived barriers to pharmacological management of cancer pain in a random sample of nurses ( $N = 1,173$ ) working in different settings (i.e., nursing homes, public or home health, clinics, offices, education, and oncology). A researcher-developed 82-item questionnaire was constructed from previous

surveys on pain management. The questionnaire was content-validated by five experts in pain management, reviewed by survey research experts for format and style, and pilot tested in a sample of nurses with oncology experience. The findings revealed that most nurses, regardless of clinical setting, had poor knowledge of opioid analgesia. Importantly, nurses with greater experience working with cancer patients, higher education, more hours of pain management education, and a greater willingness to attend pain management classes tended to have more knowledge about pain management. However, knowledge levels were not found to vary by age, years in nursing, personal experience with pain, or access to a pain team.

In a subsequent study, Ryan, Vortherms, and Ward (1994) investigated knowledge about pharmacological management of cancer pain in a convenience sample of oncology nurses ( $n = 72$ ) and a random sample of long term care (LTC) nurses ( $n = 128$ ). Data were collected with the 82-item questionnaire validated in previous studies. Study findings revealed that oncology nurses were significantly more knowledgeable about pharmacological management of cancer pain than LTC nurses.

Using a descriptive, correlational design, Brunier, Carson and Harrison (1995) investigated knowledge about pain in a sample of nurses ( $N = 514$ ) working in acute and long term care settings of a large Canadian teaching

hospital. Data were collected with the 46-item tool Nurses' Knowledge and Attitudes Survey (NKAS). Information was also collected on knowledge of pain management strategies and select demographic characteristics. The authors reported on the reliability and validity of the NKAS. Study findings revealed significant gaps in knowledge about pain. There were also noteworthy differences across groups. Clinical educators, specialists, and nurse managers had significantly higher knowledge scores than registered nurses and registered nursing assistants (RNAs). In addition, nurses with baccalaureate and higher degrees had significantly higher scores than diploma prepared nurses or RNAs; oncology nurses had significantly higher scores than nurses working in other clinical areas (i.e., medicine, surgery, and special care units); nurses with less experience caring for patients in pain scored significantly higher than those with more experience; and nurses who had inservice on pain scored significantly higher than those without such preparation. The researchers acknowledged the limitations with the scoring of the NKAS and the need for further research in this area, as well as more continuing education on pain management for nurses.

Clarke, French, Bilodeau, Capasso, Edwards, and Empoliti (1996) examined the knowledge, attitudes, and clinical practice of registered nurses (N = 120) working in various clinical settings in a large, university-affiliated teaching hospital. The NKAS assessed pain knowledge and management in three

domains (i.e., general pain management, pain assessment, and use of analgesics). Data were collected on demographic characteristics (i.e., area of clinical practice, age, years of nursing experience, basic nursing degree, and other educational degrees or certifications). A 5-point Likert scale measured depth of educational preparation in select areas of pain management (i.e., anatomy/ physiology of pain, acute and chronic pain, pain assessment, and pharmacological/non-pharmacological interventions). Frequency of use of patient self-assessment tools was measured, as well as the intensity of personal pain with a Pain Intensity Scale ranging from 1 to 10. The Pain Audit Tool (PAT) was also used to collect data on the documentation of pain management practices in patient charts ( $n = 82$ ). The researchers reported that the PAT and NKAS have documented reliability and validity. The mean NKAS scores suggested knowledge deficits and inconsistencies in many areas of pain management. Masters-prepared nurses had significantly higher mean scores than those with less educational preparation; and medical oncology nurses also demonstrated significantly higher scores than their counterparts working in other areas. Further, study participants reported receiving the least amount of pain information from formal education sources on nonpharmacological pain interventions, acute versus chronic pain, and the anatomy and physiology of pain. Finally, an audit of patient charts indicated that 76% lacked documentation

of the use of self-assessment tools to evaluate pain, 79% had descriptive recordings of pain in the nursing notes, and 90% had no documented evidence of nonpharmacological strategies.

**Elderly patients.** In a comparative-descriptive study, Brockopp, Warden, Colclough, and Brockopp (1993) investigated practicing nurses' ( $n = 70$ ) and senior nursing students' ( $n = 65$ ) knowledge about pain management of elderly patients. An investigator-designed instrument, the Acute Post Operative Pain Inventory: Elderly Patients, was used during data collection. Instrument items were developed from relevant literature and content validated by experts in pain management (i.e., nurse clinician, psychologist, and anesthesiologist). Internal consistency ranged from low to moderate ( $\alpha = .44$ ) on initial testing. The findings indicated that practicing nurses demonstrated significantly higher knowledge levels than senior students. However, the authors noted that both groups did not appear to understand some basic tenets of pain management (e.g., postoperative pain control, effectiveness of pain assessment with confused patients, usefulness of patient self-reports of pain, etc.).

Using a postal survey design, Closs (1996) examined nurses' knowledge of and experience with pain and its management in elderly patients. Nurses ( $N = 208$ ) from four clinical areas - cardiothoracic surgery, orthopedic surgery, general surgery, and geriatric wards - were asked to complete a 17-item questionnaire.

Item content focused on nurse perceptions of elderly people in terms of pain prevalence, the likelihood of requesting pain relief, effects of chronic unrelieved pain, pain perceptions and analgesic responses, and the presence of pain in patients in confused and demented states. Questions also asked about pain assessment methods with elderly people and the use of opioid drugs and complementary therapies for reducing pain. There was no mention of the reliability and validity of this instrument. Study findings indicated that most nurses did not have good knowledge of pain management in elderly people. Although experience and education were not found to influence knowledge levels, nurses working in surgical areas tended to have higher knowledge levels than their counterparts working in geriatric wards. Based on study results, it was recommended that all nurses working with elderly people should be educated about the special needs of this group, including the use of and risks associated with analgesic drugs and complementary therapies.

### **Nurse Versus Patient Perceptions**

Studies have contrasted patients' perceptions of pain with those of their attending nurses. The following review highlights study findings on nurses' versus patients' perceptions of their pain.

In a descriptive, correlational study, Teske, Daut, and Cleeland (1983)

compared patients' self-reports of pain with nurses' observations of patients' pain behaviours. A researcher-developed instrument, Pain Assessment Instrument (PAI), was designed to assess patients' pain. The first set of data were obtained from observer ratings of the intensity of 23 behaviours (e.g., restlessness, muscle tension, variety of body movements and sounds, etc.) on a 7-point scale ranging from none to extreme, and global judgment ratings of patient suffering on a 7-point scale ranging from none to extreme. Using a visual analogue or line scale, a second set of data compared observer and patient ratings of the degree of patients' pain. The interrater reliability and validity of the PAI was assessed with 34 inpatients and 37 outpatients. The findings indicated good inter-observer reliability for nurse ratings of patients' suffering ( $r = .78$ ) and degree of pain ( $r = .69$ ). In contrast, a lower but significant correlation was observed between patients' and nurses' judgments about the degree of pain ( $r = .38$ ). Given the low correlation between patients' and nurse observers' ratings, the researchers questioned the validity of the PAI. In a descriptive, correlational study, Camp and O'Sullivan (1987) compared medical, surgical and oncology patients' perceptions of pain with assessments and documentations made by their attending nurses (84 nurse-patient dyads). Patient pain ratings were assessed in eight content domains (i.e., location, quality, pattern, and intensity of pain; factors increasing pain; general comments on pain; nonverbal pain behaviours;

and pain symptoms) during structured interviews with the McGill Pain Questionnaire (Melzack, 1975). Nurse ratings of patients' pain were derived from recordings in nursing notes. The findings revealed that nurses' documentations of descriptions of pain were significantly less than the patients' descriptions. Pain experience was described by patients during interviews with the researchers. Camp and O'Sullivan concluded that nurses do not adequately document patients' pain and thus do not have the necessary information to assess the effectiveness of pain regimens.

Using a matched group of surgical patients ( $n = 39$ ) and attending nurses ( $n = 78$ ), Field (1996) examined the similarities among post-operative pain assessments and the effects of extraneous variables (i.e., type of operation, gender, time since surgery and nursing experience) on nurse ratings. Nurses' and patients' pain ratings were measured on a 5-point verbal pain scale administered on day 1 and day 4 of the post-operative period. Study findings indicated that nurses gave consistently lower pain ratings than patients. As predicted both patients' and nurses' pain ratings decreased in the post-operative period (i.e., day 1 to day 4). With regard to demographic variables, patients' and nurses' pain ratings were not found to significantly differ by type of surgery or gender. Finally, years of experience did not affect nurses' pain ratings.

Middleton, Knezacek, Robinson, Hartley, and Kaasalainen (1997)

examined differences in the pain ratings of elderly residents ( $n = 84$ ), registered nurses (RNs) ( $n = 25$ ), and resident attendants (RAs) ( $n = 44$ ). Residents' cognitive abilities were assessed with the Mini Mental State Exam (MMSE), communication level with two items from the Multidimensional Observational Scale of Elderly Subjects (MOSES), and perceived pain (i.e., present level and 12-month averages) with a numeric scale, ranging from 0 (no pain) to 100 (as bad as it can be). The RNs and RAs were asked to rate residents present pain and 12-month pain averages within an hour of the residents' ratings with the same numeric scale. As well, staff members were asked to rate the "present" and "past" pain of elderly women from photographs. The findings did not indicate that health care providers underestimate pain in elderly patients. Significantly, RAs tended to rate present pain ratings higher than RNs. The researchers acknowledge that the Hawthorne effect may have influenced staff responses (i.e., higher ratings could be a function of a desire to demonstrate clinical skills in pain assessment).

In a descriptive-comparative study, Lauri, Lepisto, and Kappeli (1997) examined differences in medical/surgical patients' ( $n = 92$ ) identified needs and nurses' ( $n = 69$ ) perceptions of patient needs. A researcher-developed instrument, based on Yura and Walsh's theory of basic human needs, assessed four major need domains (i.e., vital functions, functional health status, reactions

to functional status, and environment). The instrument was completed by both patients and nurses. Study findings suggested that nurses tend to underestimate patient needs related to chest pain but overestimate patient needs related to sudden, acute pain.

### **Summary**

Study findings support the premise that many nurses have inadequate knowledge about pain theory, assessment, and management strategies, especially pharmacological and non-pharmacological strategies. Importantly, study findings suggested that nurses do not objectively assess pain or individualize care plans for patients with pain complaints. In particular, nurses expect patients to tolerate pain, do not differentiate well between acute and chronic pain, consistently overestimate the incidence of narcotic addiction and malingering (i.e., false pain complaint), and tend to rate patients' pain and related needs lower than patients themselves.

Conflicting findings were noted with regard to the effect of demographic factors (e.g., age, years of experience, clinical setting or workplace, inservice, educational preparation, speciality area, etc.) on nurses' knowledge about pain assessment and management strategies. These differences may be attributed in part to theoretical and methodological variations in the research studies (i.e.,

nature and size of sample, diverse data collection instruments with limited reliability and validity testing, etc.). Despite these limitations the findings do suggest that nurses working in geriatric settings appear to be less knowledgeable about pain assessment and management than nurses working in other clinical areas.

### **Attitudes Toward Pain Assessment and Management**

Pain assessment is the first step in effective pain management and is an independent nursing function. It has been estimated that a significant number of problems with pain management relate to inadequate assessment (Clark et al., 1996; Dufault, Bielecki, Collins, & Willey, 1995; Nash, Yates, Edwards et al., 1999; Scott, 1992; Watt-Watson, 1987). Nurses initiate the assessment protocol following patients' communicated reports of pain. Each nurse brings theoretical and experiential knowledge, values and attitudes, as well as personal experiences with pain, to clinical situations which can enhance or impede interaction with patients who are having pain and consequently influence the nurse's clinical judgement (Parke, 1998). The research evidence suggests that nurses' attitudes and beliefs constitute significant barriers to effective pain management.

In a descriptive study, Taylor, Skelton, and Butcher (1984) investigated

the influence of patient characteristics on pain assessment and treatment choices in a sample of registered nurses ( $N = 232$ ) working in a variety of clinical areas in acute care settings. Vignettes containing hypothetical descriptions of patients experiencing pain were used to collect data on nurses' pain management practices. Respondents were asked to rate the patient's pain on an 11-point scale (i.e., no pain to worst pain imaginable), to identify appropriate pain relief actions (i.e., list of 10 provided) and rate them in order of importance (i.e., first to last), and to rate the patient on nine bipolar personality and behavioural traits (e.g., strong/weak, ambitious/lazy, pleasant/unpleasant, etc.) using a 7-point Likert scale. The authors reported on the reliability and validity of study instruments. The findings indicated that nurses attributed significantly less pain to patients without signs of physical pathology and longer illness duration or chronic conditions than those with evidence of pathology and acute conditions. With regard to appropriate nursing actions, most respondents gave the highest priority to information-seeking or assessment-type actions and the lowest priority to more active interventions (i.e., administering or requesting medication). Further, perceptions about patients' psychological and physical status had a significant effect on nurses' willingness to engage in active interventions (i.e., fewer interventions for depressed vs. non-depressed patients; and more interventions for patients with physical pathology). Finally, a greater number of

negative personality and behavioral traits were attributed to patients with no signs of pathology than those with signs of pathology. Notably, type of pathology also affected trait ratings (i.e., more positive trait ratings for patients with headaches and chronic joint pain than chronic low back pain).

In a descriptive study, Burke and Jerrett (1989) examined factors influencing nursing students' ( $N = 97$ ) perceptions of appropriate pain management strategies. The Nursing Interventions for Pain (NIP), a researcher-developed instrument, assessed pain management strategies in two principle content domains (i.e., pharmacological and non-pharmacological) for different age groupings. Limited information was provided on the reliability and validity of the NIP. The findings indicated that medication, physical comfort measures, and verbal reassurance were the most frequently selected pain interventions for all age groups. Notably, a greater percentage of nursing students selected medication for elderly persons than for other age groups. Another important finding was the tendency for most nursing students to select non-pharmacological techniques (i.e., relaxation, breathing, massage, physical comfort, and verbal reassurance) for use with elderly people.

Dalton (1989) also investigated the influence of attitudes on pain assessment and management practices in a sample of oncology ( $n = 19$ ) and acute care nurses with ( $n = 37$ ) and without ( $n = 22$ ) experience caring for

patients with cancer. A researcher-developed instrument collected information on attitudes toward pain, and how attitudes affected assessments of patient pain complaints, personal pain experiences, and frequency of educating patients on pain management strategies. Study findings indicated that pain assessments and management strategies were influenced by nurses' attitudes and personal feelings. Specifically, most respondents reported being more empathetic towards patients with difficult pain management problems; gave patient-oriented statements more frequently than self-oriented ones when asked about personal feelings about pain; managed own pain with medication more often than alternate behaviours; and acknowledged that personal beliefs about pain influenced assessments of patient pain complaints.

Vortherms, Ryan, and Ward (1992) examined attitudes toward pharmacological management of cancer pain in a random sample of nurses ( $N = 1,173$ ) in different settings (i.e., nursing home, public or home health, clinic, office, educational, and oncology). Attitudes were assessed with a subscale of the researcher-developed 82-item questionnaire. The findings indicated that nurses with more experience caring for cancer patients, higher education, more hours of pain management education, and a greater willingness to attend pain management classes tended to have more liberal attitudes toward pain management. Attitudes toward pain management did not vary by age, years in

nursing, personal experience with pain, or access to a pain team.

Using a descriptive, correlational design, Nash, Edwards, and Neubauer (1993) investigated factors influencing pain assessment in a systematic sample of nurses ( $N = 59$ ) working in diverse clinical settings in Australia. Pain assessment was measured with a 22-item researcher-developed instrument, the Attitude Intention Questionnaire, which operationalized the major constructs (i.e., attitudes, subjective norms, perceived control, and behavioural intention) of the theory of planned behaviour. Study findings indicated that nurses had positive attitudes toward pain assessment and believed that others (i.e., patients, friends, and other nurses) expected them to perform assessments. However, participants also reported that they had limited control over conducting pain assessments, and minimal intention to perform pain assessments. During regression analysis, attitudes, subjective norms, and perceived control combined to account for 21% of the explained variance in behavioural intentions. Significantly, the variable of perceived control made the greatest contribution to the regression equation (i.e., 19.4%).

Using a convenience sample of oncology nurses ( $n = 72$ ) and a random sample of long term care (LTC) nurses ( $n = 128$ ), Ryan, Vortherms, and Ward (1994) examined differences/similarities in attitudes toward pharmacological management of cancer pain. Attitudes were assessed with a subscale of the

previously validated researcher-developed 82-item questionnaire. For the most part, the two groups did not differ on their attitudes towards pain management. However, LTC nurses were more likely than oncology nurses to believe that patients over report pain, and to identify inadequate assessment, lack of equipment, and inadequate skills to use equipment as major impediments to pain management.

In a retrospective survey of 180 medical records, McDonald (1994) investigated variations in nurse administration of narcotic analgesics in terms of gender and ethnicity (i.e., white versus ethnic minorities). The findings indicated that male patients received significantly larger initial postoperative analgesics than female patients, and White (Caucasian) patients received significantly more total postoperative analgesia than ethnic minority patients. The researcher acknowledged study limitations (i.e., one diagnostic category and geographic area) and the need for further investigation of additional influencing factors.

In a descriptive, correlational study, Brunier, Carson and Harrison (1995) compared acute and long term care nurses' ( $N = 514$ ) attitudes toward pain management. Attitudes were assessed with a subscale of the 46-item Nurses' Knowledge and Attitudes Survey. The findings indicated that most nurses had negative attitudes toward pain management. Clinical educators, specialists, and nurse managers tended to depict significantly more positive attitudes than

registered nurses and registered nursing assistants (RNAs). Further, attitudes tended to be more positive for nurses with baccalaureate and higher degrees, working in oncology, less experience working with patients in pain, inservice education on pain than their counterparts with less education (i.e., diploma prepared or RNAs), working in other clinical areas (i.e., medicine, surgery, and special care units), more experience caring for patients with pain, and no inservice on pain.

In a descriptive survey, McCaffery and Ferrell (1997b) compared nurses' decision-making about pain assessments and analgesic use when assuming the role of a professional ( $n = 306$ ) versus a family member ( $n = 301$ ). Vignettes were used to collect data on pain management practices. While assuming the role of either a professional or family member, respondents were asked to rate the person's (i.e., sibling versus patient) pain level on a five-point scale (i.e., no pain/discomfort to worst pain/discomfort), to select an appropriate nursing action (i.e., variant doses of morphine medication) following assessment at three hours post-medication on the second post-op day, and to highlight those factors that would influence medication choice (e.g., respiratory depression, addiction, etc.). The vignette was reported to have content validity. The findings revealed that nurses who assumed the role of siblings were more likely to agree with the person's pain report and administer an appropriate medication dose than those

who assumed the professional role. In contrast, nurses who assumed the professional role were less concerned about respiratory distress and tolerance to analgesia than those who assumed the role of sibling. The authors concluded that nurses require education on ways to increase empathy.

### **Summary**

In summary, study findings suggest that negative attitudes and beliefs held by nurses constitute significant barriers to effective assessment and management of patients' pain. Nurses attributed less pain to patients with chronic pain or no signs of physical pathology, and intervened less often with depressed patients who have pain complaints. Some studies also found that nurses made inferences about pain based on patient characteristics (e.g., gender, ethnicity, socioeconomic status, illness type, etc.), and used different pain management strategies with elderly people due to such biases rather than age related considerations. As found in the previous section on knowledge of pain assessment and management, study limitations (i.e., samples and instrument reliability and validity) make it difficult to reach definite conclusions about the effects of attitudes and beliefs.

### **Pain Management Education Programs**

The limited number of educational programs and pain issues and the need for more efficient pain management education is a matter of some concern.

Some studies suggest that education, preparation and development and implementation of pain management programs are successful in certain nurse populations.

Using a quasi-experimental design, Hauck (1986) examined the effects of an educational program on nurses' attitudes toward pain management and knowledge of analgesia. The experimental intervention was a two-hour program that addressed pain problems experienced by cancer patients and appropriate pain management strategies. The nurses comprising the experimental group ( $n = 32$ ) did not differ significantly from those in the control group ( $n = 20$ ) on select demographic characteristics. The Attitude Inventory and Knowledge Questionnaire was administered 48-hours prior to and 3-days following delivery of the educational program. Reference was made to the content validity and reliability of the study instruments. There were no significant differences observed in either the attitudes or knowledge of the experimental and control groups during the pretest period. However, during the post-test period, the experimental group demonstrated significantly higher knowledge scores and more positive attitudes than the control group. The authors acknowledged study

limitations (i.e., selecting nurses in both groups from the same unit, use of a convenience sample, and instituting changes in staffing patterns) and the need for further research on the effects of education programs on attitudes and knowledge.

Ferrell, Grant, Ritchey, Ropchan, and Rivera (1993) evaluated the effects of an education program, the Pain Resource Nurse (PRN) Training Program, on a convenience sample of nurses ( $N = 26$ ) working with oncology patients. The program consisted of 40-hours of didactic instruction (e.g., group discussion and exercises, literature, clinical practice, etc.) that addressed major content areas related to pain theory, assessment, and management (e.g., anatomy and physiology, misconceptions about pain, pain behaviours, pharmacological and nonpharmacological, as well as surgical approaches to pain, etc.). Program instructors were available following the course program to reinforce information received on pain management and to assist with role implementation. The Nurses Knowledge and Attitudes Survey (NKAS) was administered on the first and final day of the course. A researcher-developed instrument also assessed role implementation issues and clinical application of pain management knowledge. There was a 35% increase in overall NKAS scores, indicating more positive attitudes toward patients in pain and improved knowledge levels. Nurses also reported spending an increased amount of time in teaching patients

and co-workers about pain, improvements in care planning by assessing psychosocial issues, improved communication with physicians about patients' pain, and continued interest in keeping current on relevant pain issues.

Francke, Garssen, and Abu-Saad (1996) examined the program characteristics, teaching strategies, and research methods of published studies ( $N = 12$ ) reporting on the effectiveness of pain programs for nurses. The authors found that most programs were of short duration (i.e., 8-hours or less) and focused on pain assessment, pain medication, with only two focusing on nonpharmacological aspects of pain management. Most programs also used a combination of teaching strategies (e.g., lectures, discussion, practical application, etc.). The most significant limitation noted was with the methods used to evaluate the effectiveness of programs (e.g., a before-after design without a control group was the most common evaluation approach; researcher-developed instruments without established reliability and validity; failure to control for confounding variables; timing of post-measurement assessments; select population of nurses; descriptive analyses, etc.). However, the authors noted improvements in a number of areas over time (i.e., pain documentation, assessment, attitudes towards pain control and pain management, frequency of analgesic use, greater pain relief and improved quality of life, increased patient teaching, and improved pain knowledge).

## **Summary**

The literature review identified few studies that investigated the effects of pain management education on nurses' knowledge and attitudes. Study findings suggest that programs specifically geared toward managing pain are successful in influencing nursing actions. With pain management programs as the dominant intervention, study findings demonstrated higher scores on knowledge about pain theory, assessment techniques, and strategies, as well as more positive attitudes toward pain control. A general limitation in many of these studies was the use of small, convenience samples and limited reports on instrument reliability and validity.

## **Discussion**

The literature on pain management focused on patients in pain and also on health caregivers who are responsible for managing patient pain. A review of the literature reveals nurses' attitudes, perceptions and knowledge affect how they assess and manage pain. Attitudes may also be affected by the nurse's age and/or time spent in practicing nursing. Knowledge of pharmacological and non-pharmacological pain management strategies has consistently been found to be inadequate and often inaccurate. There is an incongruence between

nurses' perceptions and the patients' perceptions of their pain. Only a few studies were found that specifically explored pain management in elderly patients in long term care. Closs (1996) states that very little information is available which either identifies nurses' experiences with and skills in managing pain in older people, or validates the use of specific methods of pain assessment and management for this elderly population.

The literature search revealed only a few qualitative studies that investigated nurse perspectives on the meaning of pain management. There is a paucity of qualitative research on this phenomenon despite the inconsistent and conflicting findings from quantitative studies. This fact may be contributing to the unsuccessful attempts to manage pain by health professionals. Pain assessment and management are integral to effective care giving activities by nurses. Individual nurses have unique perspectives and experiences that may shape pain management strategies regardless of their appropriateness for different groups of patients. An in-depth study of a small number of nurses working with elderly patients in long term care settings may provide some insight into pain management decision making and factors that influence the use of different approaches under variant circumstances.

## **CHAPTER 3**

### **Methodology**

This qualitative study used a grounded theory methodology to explore nurses' experiences with pain management. With grounded theory a social unit (group of people) of interest is selected, recognizing that in order to understand human behavior, interactions with others must be the contextual focus. The objective of grounded theory is to understand how various groups of people (nurses) define reality through their associations with one another (nurse/patient interactions) and to communicate this in the form of theory (Stern, 1980). In this study conceptual categories were created from properties (themes) that emerged from data acquired from respondents' interviews. The intent was to create substantive theory that captured the meaning of pain management for nurses working with mostly geriatric clients in long term care settings. Wilson and Hutchinson (1996) emphasize that grounded is "a highly useful approach to generate much needed knowledge of complex phenomena that are directly linked to the human world we seek to understand" (p. 24).

### **Research Method**

The grounded theory approach is attributed to Glaser and Strauss (1967) whose basic premise is that "generating grounded theory is a way of arriving at

theory suited to its supposed uses" (p. 3). The central idea behind this methodology is that theory is generated from and grounded in the data; it involves generation of theory, not verification of previously hypothesized theory (Sheldon, 1998). The theory of symbolic interactionism which focuses on the meaning of events for people in natural settings underpins grounded theory.

Grounded theory provides a way of studying, understanding and creating new perspectives on human behaviour (Chenitz and Swanson, 1986). This method explores the richness and diversity of human experience and facilitates understanding of behaviour based on how the participants see it, learn about their world, interpret the self in interactions, and share their definitions (Streubert and Carpenter, 1995). Furthermore, the grounded theory approach is well suited to providing nurses with an understanding of social behaviour so they can enhance patient care (Sheldon, 1998).

A fundamental feature of grounded theory is the simultaneous collection, categorization and analysis of data, a process known as the constant comparative method of analysis. Theory generation is inductive so that categories emerging from the data are constantly compared with those that have emerged from earlier data. As categories emerge they are also used to direct and advance further data collection, a process known as theoretical sampling. Data collection continues until data saturation occurs. Furthermore, the

deliberate sampling of subjects who have experienced the phenomenon being studied works to ensure the validity of the study (Glaser & Strauss, 1967; Polit & Hungler, 1995).

This qualitative study used a grounded theory method to generate a theoretical model that captured nurses' experiences in managing pain in residents who reside in long term care settings. Simultaneous data collection, analysis and theoretical sampling facilitated identification of conceptual categories, their properties and themes, and relevant incidents. This flexible methodological approach allowed rich data to emerge that provided meaningful insights into the process of assessing and strategizing to achieve success with pain management.

### **Population and Sample**

The target population is all nurses who work with geriatric clients in long term care settings. The accessible population was restricted to nurses who worked in three nursing homes in St. John's, Newfoundland.

A non-probability, purposive sample of 16 registered nurses was selected from the accessible population. Nurses who were interviewed had a wide range of characteristics. Participants ranged in age from mid-twenties to late fifties; the time spent in the setting ranged from 4 to 25 years; the years since graduation

from nursing school ranged from 7 to 30 years; all were diploma prepared graduates; two people worked on a part time basis with the remainder full time employees; and, one nurse was male, all others were female.

### **Procedure**

Study participants were identified through consultations with the administrators of the various nursing homes. Permission was requested to enter the facility to access the sample of nurses (see Appendix A) and received from three administrators. The nursing administrator who did not give permission was concerned about extra time the nurses would need to do the interviews.

Once permission had been granted by the administrators, nursing managers of selected units were contacted by the researcher and given an explanation of the study. Nurse managers initially approached potential participants to determine their willingness to be contacted by the researcher. The names of staff nurses who expressed interest in participating were forwarded to the researcher who in turn contacted the nurses and explained the study in greater detail. Those who indicated a willingness to participate were given a detailed description of the study and a copy of the informed consent (see Appendix B). The time and place for the interviews were scheduled at this time.

Written, informed consent was obtained prior to each interview. All interviews were audiotaped. The interviews took approximately 50 to 60 minutes

to complete, and were conducted during work hours. Follow-up telephone conversations or face-to-face meetings were held with participants to confirm interpretive summaries of their interviews.

### **Interview Schedule**

Interviews were conducted using a semi structured interview schedule (see Appendix C). The questions comprising the original interview schedule were based on key findings identified from the literature review. The researcher also conducted a pilot study to investigate the most appropriate qualitative approach to explore nurses' experiences with pain management, and the relevancy of identified interview questions/probes. The pilot study findings indicated that nurses tended to place greater emphasis on perceived barriers to effective intervention and the importance of having an extensive knowledge base for effective pain management. Additional questions were included to address these two areas of concern.

### **Data Analysis**

Taped interviews were transcribed and checked for accuracy within 48 hours by the researcher. The constant comparative method of analysis as defined by Glaser & Strauss (1967) was then applied to each data set. Initially,

each transcribed interview was analyzed line by line to identify key incidents and facts by raters/coders (the researcher and thesis supervisor) working independently. The researcher and thesis supervisor met frequently for debriefing sessions during data collection to discuss major themes and identify the conceptual categories and properties being generated by the initial joint coding and analysis. This process produced a number of substantive thematic codes which were examined for similarities and differences. Category exhaustiveness and exclusiveness was assured by continuous reassessment of how well slices of data fitted one category versus another.

### **Validity and Reliability**

Credibility measures how vivid and faithful the description of the phenomena are and provides the standard for judging the truth value. The deliberate sampling of subjects who are able to explain through experience the phenomenon being studied works to ensure the validity of the study (Glaser & Strauss, 1967; Polit & Hungler, 1995). Registered nurses working in long term care facilities are considered the experts and therefore the most credible sources of information about pain management in elderly residents.

A qualitative study is credible when the participants recognize the descriptions and interpretations of the experience as their own (Sandelowski,

1986; 1995). During the second interview, each participant reviewed an interpretative summary of their transcribed interview, and asked to validate the conclusions drawn. Credibility of the findings was also ensured by having a researcher with experience in grounded theory methodology cross validate the themes as they emerged from the data set.

### **Ethical Considerations**

Steps were taken to protect the participants' rights. First, the proposal was forwarded to the Human Investigation Committee (HIC), Memorial University of Newfoundland, for approval to implement the study (see Appendix D). After ethical approval was received, permission was sought from long term facilities where the nurses worked. Nurses who met the criteria were initially approached by their managers. Those who indicated a willingness to participate were then contacted by the researcher. The nurses at this time were given more detail about the study's objectives and a copy of the informed consent to read and reflect upon to eliminate the possibility for coercion or undue influence. Written, informed consent was obtained by the researcher immediately prior to commencing the formal interview.

Appropriate measures were taken to ensure that confidentiality of all data was maintained. All tapes and transcriptions were kept in a locked filing cabinet.

Names were not revealed and names were known only to the researcher.

Participants were also informed that all information collected would be described in a manner that would prevent their identification - either person or facility included in the study. Participants were informed that they could withdraw from the study at any time.

## **CHAPTER 4**

### **Findings**

The first section describes the theoretical constructs generated from an analysis of the transcripts of study participants. There were three core categories with a number of related properties and descriptors that emerged from analysis of the text (i.e., knowing the resident, assuming the helping role, striving to achieve positive outcomes). The second section discusses the interrelationship between the constructs, and proposes a model to capture the path to effective pain management of residents in long-term care settings.

#### **Pain Management: Long-Term Care Nurses' Experiences**

The interview transcripts provided a rich data base on participants' experiences with striving to achieve effective pain management of residents living in long-term care settings. This section presents a discussion on the dominant theoretical constructs generated from the thematic analysis of study data.

#### **Knowing the Resident**

The knowing the resident category emerged from descriptions of developing confidence in addressing long-term care residents' expressions of

pain complaints. Becoming acquainted and spending time were the dominant properties defining this category. Participants' stories portrayed an image of constantly dealing with the uncertainties of diagnosing the nature and extent of residents' pain through verbal reports and/or behavioural cues. As they struggled to determine the physical or emotional basis for pain expressions, participants were impeded or facilitated by how well they knew residents. Adequate understanding of the total person (i.e., physical, emotional, psychological, social, and spiritual) surfaced as a key determinant of effective pain management.

**Becoming acquainted.** How successful nurses were in getting to know residents depended strongly on the presence of good interpersonal relations. Nurse/resident rapport emerged as a pivotal step in diagnosing problems and selecting individual-specific pain management strategies. While becoming acquainted, nurses adjusted to residents' idiosyncrasies and learned about their problems and origins of problems.

Most of the study participants were able to highlight the importance of becoming acquainted with residents in long term care. One nurse discussed how **not** knowing the person interfered with successful problem identification:

Another resident we had always wanted something for pain, she always had a headache. We didn't know what was really wrong with her and what her problem was. . .it was just when she came in [*newly admitted*], I

mean we really didn't know her or what her problem was or whatever.

In contrast, a second participant described how knowing the person facilitated recognition of problems with the emergence of atypical behaviours: "You need to know them, right. . . .And in a long term care facility like this, we know them they're here for years. . . .anything out of the way at all that's not their usual thing, we know there's something wrong." Another participant also emphasized the importance of knowing the person when trying to diagnose a problem and define its parameters:

If it was somebody we know who was complaining of pain we know it either has to be this wrong with her or that wrong with her. You know a lot of the times it's the bowels, for residents that can't tell us. So we check that out and if it's not that then it's something else.

As nurses became acquainted with residents, they were able to recognize and assess subtle problems requiring attention. Knowing the resident was an important context for understanding and interpreting changes in normal behaviours.

Study participants described having more time to develop relationships with residents in long term care settings than with patients in acute care settings. One nurse noted that becoming better acquainted with long term care residents' needs over time was an important differentiating factor:

In a long term care facility you know your residents, you know your people, you know their conditions, you've known them for a long period of

time. . . it's just getting to know the people, I guess, and then you begin to understand the different things. . . It's not like in a hospital when you're in long term care.

A second participant compared pain management in long term care and acute care settings. She believed that getting to know residents was a significant force facilitating or impeding effective pain management.

That's why long term care is different with pain management than acute care because you know them so well. You kind of know what works for a person better. Like at home you know your mother so well, you know what to give her, what helps or whatever. That's kind of like how I feel about long term care. . . you have an opportunity to know them really well.

Still another participant spoke about the difficulties that she encountered while moving from an acute care to a long term care setting. She described the downside of having to adjust her perspective on the importance of developing closer relations with people.

I found it hard because I worked on surgery for 10 or 12 years. You're used to getting them in, getting them treated and getting them out. I had to change how I thought too. . . It wasn't easy for me first because I was used to not having to really get to know the patient. Not that you didn't get to know them, but you only had a couple of weeks and you knew they'd be moving on and you'd get someone else, so you didn't get time to get close. It took time for me to change and to realize that, you know, I had to change, that was hard. The first few months, I said, no I can't work here, I'll have to move on, I'll go back to surgery.

Although repeated clinical encounters may help the nurse get to know residents in long term care, there must be also a commitment "to know". The presence or absence of such deliberate actions dictate how well nurses get to know those

entrusted to their care.

Families were also seen as being instrumental in helping participants become more acquainted with residents. Several participants described how families could help nurses with pain assessment and its management by interpreting for their relatives. Assistance from families was perceived to be especially helpful when residents were newly admitted or had compromised verbal skills.

Family members sometimes can be helpful in that *[pain assessment]*, especially if the resident is new. They can say to us, you know, *[for example]* when Mom was at home or my sister was home before she came in, when she had pain she always did this and she could tell us she had pain, she found this comfortable if she drew her knees up, it seemed to help if she turned on this side or whatever.

The resident could not tell us he had pain, he would always grimace, he would twist in the bed his posture *[changed]*, he would draw his legs up, draw his legs up to his chest and rock in the bed which we felt indicated that he had pain. And his family also said this was something he always did when he had pain.

Study participants recognized the importance of developing good rapport with family members. When resident-specific knowledge about physical functioning and typical emotional responses was limited, families were identified as a significant resource for helping nurses become better acquainted with residents.

With the passage of time, some participants described developing family-like relations with residents. One nurse described the depth of these

relationships in the following manner: "We become almost like second families to some of these people. . . .They get to know us and they're used to us." In certain instances, participants felt that they got to know the residents as well as or better than families, especially when their health status overshadowed other aspects of the self.

Sometimes I think we know the resident better than their families probably do in regard to their medical condition. . . .Sometimes I think we understand more what they are going through and I think the families have difficulty seeing that *[terminal]* side of their parent.

Although the dual role of nurse/family surrogate can be time consuming, it is an accepted role because of its special importance for residents with limited family support.

As advocates, well for a lot of these residents we are the family. A lot of them, we have a good many single men and women here who have no family, maybe a distant niece or nephew and so, we feel that we're the ones who are responsible for taking care of them in their last days and making sure they're comfortable. . . .It's just a role *[family surrogate]* you take on and it's part of it, right, it's quite nice in one way.

As exemplified by the above passages, the family-like analogy is a reflection of getting to know someone through shared experiences. Familiarity is enhanced over time with repeated exposure to residents in variant situational contexts. The key outcome of meaningful interactions with residents and their families is the development of a data base that facilitates problem recognition, as well as the identification of appropriate and timely nursing interventions.

**Spending time.** In order to get to know someone, time has to be spent interacting with him or her. It was readily apparent from the descriptive data that participants believed that it was important to spend quality time with residents. This property of knowing the resident category encompassed deliberate intentions to listen to and observe the person for the purpose of establishing meaningful rapport and gathering an insightful informational base.

In getting to know the resident, the nurse must be interested in learning about the person's individuality. One participant described what was meant by being committed to getting to know residents: "Wanting to get to know them, you can be with someone for years and if you don't want to know them you never will". This participant believed that the nurse must work to facilitate residents' willingness to confide their symptoms and concerns. An approach was described that involved taking a casual and nonchalant stance in order to encourage residents to open up and talk about their pain:

You sit, you don't stand to talk to the residents, that's the way I feel. I always sit down, take the time to sit down and hold on to their hands if I want, because I'm a touchy person. So I like to just let them feel that I'm here, you know, and after I do that I usually ask details about the pain they're having.

Because the relationships that develop are long term, they require a great deal of time and commitment to ensure the most positive outcomes. Another participant emphasized the importance of spending time with residents in order

to get to know them:

You have to take the time to sit and talk and drag things out if you have to or whatever. Sometimes it takes a long time for some people to even get what they want to say out, you know, and you have to have the time and you have to have the patience for it.

This participant also felt that residents do not respond well or “close up” when they are hurried: “And if they [*residents*] see that you’re in a hurry, well the first thing they’ll say, ‘She’s got no time for me, why will I bother’”.

Unless nurses are deliberate in their actions to reach out to residents and convey that they care, any attempt to intervene or facilitate comfort will not be successful. Spending the time to develop good rapport was described by one participant as a pivotal step in not only learning about the resident but also in determining the most appropriate pain management strategy.

You have to reach out to them. . .just let them know you care, you care how they are feeling, you’re concerned about their pain and you care about them as a person. That makes a lot of difference just walking into a person’s room and if you know they are sick or having pain, just holding onto their hands is sometimes enough to start the process of them feeling better by the time you leave the room.

For many of the study participants, quality time could be spent with residents even when the actual time of contact was short. One nurse described how a personal approach facilitated effective interactions with residents.

I go to somebody, just by calling them by name, by really looking at them, leaning down, I can be close to them and let them know they are important to me. . . .when I make rounds in the morning and when I’m

doing medication, I give all my attention to that person.

Another spoke about the usefulness of a two-way sharing of experiences in facilitating communication and openness. She indicated how this type of approach helped her get to know residents.

I want them to share with me, so I have to be able to share with them. So, I tell them what's going on. . . what I'm doing the weekend. . . I'm here seven days, I'm with them more than I'm with my own family, so I mean, you cannot not get attached to them, it's not possible not to.

Sometimes participants found it difficult to establish free-flowing communication with residents. One nurse stressed the importance of spending extra time to get to know residents' who have cognitive deficits:

I think you really need to get to know these residents. Because if a lady in one room is really restless, if I was new on the floor I might not know if this is her usual self or if it's something different, a difference in her behaviour. You need time to get to know the residents, it's like family you know. You get to know almost their every move.

Another nurse indicated that she had to rely on what she knew about the resident in order to determine when something was wrong:

They can't tell you what they're experiencing so that you have to have a way of knowing if they're experiencing pain. . . Lots of times they can't tell you, they might be aggressive or upset, agitated and if you know your resident you'll probably pick that up and from their diagnosis and their history. Maybe it has been going on for some time if it's chronic or if it's just something new.

One participant described in detail how difficult it was assessing the needs or problems of residents who are confused or have communication deficits:

It's really hard you know because they can't tell you they have pain and you got to go and try and find out. Now this person is probably in the bed or is sat in the Geri chair with probably their head down. And, you know, they will probably have their arms folded and rocking back and forth a bit which maybe normally they don't do. Or maybe they're sitting in the chair and they are quiet, you know, alert as they can be and that and you know there is something different, and they are probably calling out. And you say, well there is something bothering this person. Now you can't go over and say, "Have you got pain?" Because a lot of the time they don't understand what you are saying.

**Summary.** Knowing the resident is defined as the outcome of deliberate and skilled actions taken by the nurse. The study data indicated that nurses support taking a personal approach to residents. That is, the personal approach to getting to know the person involved deliberate actions that were taken to facilitate understanding and interpretation of residents' pain. As nurses' experience residents in different situations, they learn to recognize the similarities and differences in their behaviors. This information is then used to help identify subtle but significant deviations from the norm and select appropriate nursing interventions.

### **Assuming the Helping Role**

Participants' articulated, either implicitly or explicitly, what they believed was necessary to facilitate appropriate and timely decision-making in response to residents' expressions of pain. Integral to the process of pain management

was the presence of nurses skilled in interpreting the meaning of pain complaints. The assessment phase is a key component of the application of the nursing process and, as such, nurses must interpret the assessment findings prior to planning care.

The assuming the helping role category emerged from participants' descriptions of how they sorted through verbal complaints and/or behavioral cues to define the type and severity of residents' pain. The data suggests that nurses require good listening and observational skills in order to be confident with proceeding with appropriate interventions. As well, the diversity of traits and characteristics of the resident population required that nurses become keenly aware of individual idiosyncrasies. Participants indicated that engagement with the total person in his/her world was pivotal to care planning. Participants perceived the interpretive phase as an important, preliminary step in strategizing for pain management.

**Developing listening and observational skills.** The experiential grasp of variant expressions of pain was heavily influenced by participants' ability to conduct meaningful assessments of pain behaviors, to identify appropriate interventions, and to evaluate intervention effectiveness. Several participants described the difficulties encountered when trying to develop an accurate picture of the meaning of pain complaints for the elderly person. One participant

discussed the differences between managing and diagnosing pain thus:

The difficulty I find is not so much managing pain as in identifying pain. Once you identify that the person is in pain, then usually there's not a great deal of problems in getting the right kind of management, be it psychiatric, analgesic, physiotherapy, or whatever. That's not so much a problem in the very elderly as in identifying it, because it can be so easy to miss.

Even when great care is taken to interpret the meaning of pain complaints, the nurse is never completely sure that the resident's presentation of pain was understood.

One participant highlighted the problems with interpreting residents' expressions or verbalizations of pain in the presence of confusion or forgetfulness. Her exemplar indicates that becoming adept with assessing and making sound judgments is highly dependent on knowing the person.

I'll say, "Do you have pain?" [*Resident replies*] "No my dear." Then I'll stop for a few seconds and say, "[X] put your hand where the pain is". And she'll put it there. . . .I know one day. . .by the time I had gotten to her the pain was gone. She didn't have any evidence of pain. Like her face was relaxed. . .or she wasn't tense or holding a part of her body or in any kind of position that would indicate that she was having pain anywhere. But there were times that I've gotten to this same lady and she had the look of pain on her face or she might have had her hand on her arm.

A second participant also spoke about the difficulties that she encountered when trying to reach an accurate assessment of cognitively impaired residents' pain status.

Quite often in the long term care setting that I've worked in for the last 8

years most of the people are not cognitively well so they quite often give inappropriate answers. Like, we had people who have answered no to everything. . . .But they probably do have pain. So you have to look for all the little signs and symptoms yourself.

What is required in these situations is the development and honing of skills that will allow the nurse to clarify the message (pain complaint) sent by the patient.

Other participants identified the problems inherent with interpreting pain for residents with no obvious signs of cognitive impairment. One participant noted that the situation is very different when pain is expected, for example following surgery, versus when it is unexpected as a response to subtle but significant changes in physical status.

Sometimes you get residents who have had surgery, hip replacements or other types of surgery especially on admission and their pain is more obvious because you know they had surgery two weeks ago, so you expect pain. Where it *[assessment]* becomes difficult is when it *[cause of pain]* is not obvious. When somebody has developed a cancer and they are not diagnosed, but their behaviour has changed and then you are looking for what's wrong with this person.

Adequate understanding of residents' needs requires giving recognition to salient features of their persona. One participant commented thus: "She seemed to be having severe pain because she started crying, so if somebody cries, they cry for a reason and we felt her pain was real".

Participants differentiated between pain types - "real" and non-physical pain as well as levels of pain. Real pain is verified, as such, if it is relieved by

medication, whereas, discomfort or mild pain can be relieved by comfort measures. In order to make this differential diagnoses, the nurse first institutes comfort measures and monitors their effectiveness before proceeding to dispense analgesics.

It's not always medication that they need, maybe they just need to be turned on their other side, or they just need to be sat up. . . .It's comfort measures. Maybe sometimes it's not actually pain, maybe they're just lonely and need a bit of company or they just need the comfort measures and these things will work. But if it's actual pain maybe, they won't settle down, so then if I give them their prescribed medication, well and it goes away, well then I know this was real pain. I would go through all these other routines first before I'd give them medication.

The resident complains and the nurse must be able to determine whether real, as opposed to non-physical, pain exists and the level of that pain. When in doubt, the nurse sometimes defers to the resident.

I find it very difficult to determine if it's real pain or if it's attention [*seeking*]. But you have some residents who, like every night, they'll want Atasol, you know, and they don't seem to have pain, but every single night they want something for pain. I find that difficult. . . .I would try the other strategies also, the comfort and maybe encourage them [*to try to*] do without it for a little while. But if they're adamant, I would give them the Atasol. You know, if she's telling me she's got pain, who am I to say, "No, you don't?".

The approach to managing pain will be determined by an assessment of other factors surrounding the resident besides the voiced complaint. These other factors include the situational context and the individual voicing the pain complaint.

**Being cognizant of salient patient traits.** Decisions about pain

management strategies were often influenced by the individual character traits of residents. The data suggest that the interaction of personality traits with different illness types, as well as levels of acuity, made assessment of the pain situation a laborious process. Certain residents were described as being stoic, concealers, or complainers.

It was apparent from the comments of several participants that an anticipatory approach to pain management was used with residents who demonstrated stoic behaviors. The following passages capture how participants described their approach to such residents:

Some patients or residents are really stoic, they won't say that they have pain. You have to be really alert for that too. If I have a cancer patient or a patient that's got some type of injury, before I did their a.m. care, I know that they're going to be really uncomfortable and they're not going to be up to me turning them and lifting them and that type of thing. I would give them something for pain, say half hour or so before I would even attempt to do a.m. care. I've come across loads of residents like that or others that, you know they're not going to sleep well at night unless you give them something for pain and they won't ask. . . .I would make sure they had something for pain before they settled.

Another participant also spoke about the stoic behaviour of some residents:

They're having some deep seated pain that they can't even verbalize that they're internalizing, that they're living with. . .martyrdom that's the word. The old long suffering woman *[who says]*, "I've suffered all my life, I'm not going to be telling that young pup *[nurse]* now that I can't handle this bit of pain, I'll stick with it, I can handle this pain".

Other participants commented on the difficulties in managing residents' pain when they deliberately concealed pain episodes. One participant described her frustration when she discovered that some residents had been experiencing pain all day but failed to inform her about it.

Once I chat with them a few minutes about the fact that they're not feeling well and get some details about where it is, how bad it is, and how long has it been there. If it was there all day and they didn't tell me about it (*pain*). . . if that's the case that means they have been suffering all day and haven't discussed it with me and I didn't know they were having pain. Of course that bothers me. . .it really bothers me because for some reason they didn't want to bother the nurses, or everybody was busy or some other reason.

Another nurse suggested that residents who did not wish to bother staff often conceal their pain:

I've seen it, I've seen it over the years, I've seen people that didn't want to be a bother. . .they would go as long as they could, because they didn't want to be a bother, they didn't want to be a burden, you know. It's sad but that's the truth, that some people do think that way.

The chronic complainers stood in stark contrast to those who were perceived as being stoic or concealers. Participants generally saw chronic complainers as exhibiting attention seeking behaviours. One participant described what this label meant to her in the following manner:

*[A chronic complainer]* would be somebody that can come out and tell you. . .I've got a pain here in my stomach and my throat is sore. And every time they meet you in the hall they're stopping to tell you really. And you've got a feeling that it's attention getting behaviour.

Other participants applied the complainer label to residents who were generally unhappy, and continuously complained of being in pain.

She wasn't one bit happy about coming in and ever since she's been in here it's been one thing after another. If she hasn't got a sore nose, it's a sore ear, or a sore eye, or a sore leg and she's not happy with the meals - everything she eats upsets her stomach.

We have people who are never happy, we got one now that's not very happy, but she's not happy in that she goes from one *[complaint]* to another. If you treat her sore spot on her nose before you get that straightened up she's got an upset stomach and before that *[is cured]*, then. . .her eyes are bothering her. *[She just]* doesn't seem happy.

The "complainer" elicited negative responses from nurses entrusted with their care. The comments made by one participant illustrates this kind of reaction.

She's a complainer and still complains a lot. Right now she's been sent out to a heart specialist who ordered a lot of testing on her. I feel - it's my own opinion - that it's not necessary, because to me she's taking the spot of somebody who's got a legitimate problem and could be treated.

Another participant expressed frustration at the inconsistent responses of certain residents to nursing interventions:

We have some who complain of pain all the time, you know, they're always saying they have pain. If you give them a couple of Atasol, now, I'm not saying they don't, but I mean, one lady in particular is always, day and night, saying she has pain. If you give her Atasol or something for pain, one minute she'll say, "Oh, yes, that worked fine". Then you'll ask her five minutes later and she'll say, "No, it didn't work". So then you don't know what to be doing.

As a result of an unwillingness to seriously consider the complaints of such

residents, less emphasis is placed on conducting detailed assessments or implementing effective pain management strategies. One participant's comments captured this line of reasoning: "I think there is a role for placebos for anyone that is a chronic complainer and you're not quite sure if they have pain or not".

Although some participants may dismiss the complainer's verbalizations as being unfounded, others will search for possible reasons for residents' constant pain complaints. One participant suggested that underlying psychiatric illness may result in an exacerbation of negative emotions. In her experience, when depression was diagnosed and treated, this resulted in less pain complains.

We would have some chronic complainers that would always be looking for something for pain. . . .Somebody who's extremely depressed is very prone to pain because they're so inward that even the smallest thing is magnified. . . .And when they [*doctors*] start treating them for depression the frequency of analgesic requirements is lowered. . . .They stop thinking about themselves totally, then they didn't magnify what is going on in their own bodies.

On the other hand, some participants did not look for other causes or attempt to change the resident's behaviour despite doubting the medication's effectiveness.

One participant commented thus:

I mean they don't have pain, I know they don't have pain, but they are so dependent on their Atasol, without it they're in dire straights. We have a lady here that's on Atasol every four hours. . . .She never complains.

She's not in pain, but she wants them regularly. If somebody forgets to give them to her at 6 o'clock, the next *[day]* she's telling me, "I really had some pain last night, such and such a person forgot to give me my atasol". . . .I mean to me what atasol does for her is more psychological than physical.

Residents may not be honest in their reports of pain; nurses may not be successful in managing pain because of the complexity of the resident's distress.

However, it seemed that most participants believed that time should be taken to search for other causes before labeling a person as a chronic complainer.

**Tending to the total person.** The elderly population in a nursing home has a wide range of disabilities with extremely complex problems. These people have unique needs and require a nursing approach that shows evidence of caring: spending time, reaching out, engaging in meaningful conversation, and showing compassion. This requires engagement with the total person in their world.

Nurses get to know their residents through observations as well as from conversation and questioning. Study participants indicated that time had to be spent clarifying the message sent by residents who complained of pain.

Residents' pain complaints may be expressed as physical distress but the cause may or may not be due to the presence of physical pathology. As several participants indicated pain complaints may not always mean physical distress - it sometimes meant misery and loneliness:

I find in long term care there's a lot of loneliness and that doesn't help them any, you know, but like I say there is a time for [*pain*] medication and there's time that you need to spend with the patient, you know, but you need a combination of the two of them.

I can think of a resident here who's having a lot of pain and she's miserable and the family don't come very often, but if they do come, the pain leaves and they are chatty.

When you get to know them and you get to know the personality, sometimes you do feel like the person may be, not that they don't have pain, but they're probably exaggerating a little bit or they are looking for someone to sit and talk to them, or they are looking for some reassurance about something. . . . I'm not saying they never had pain, but there's been times when we've noticed that the family members may not have been in for awhile, you know, gone on holidays probably, and they're feeling depressed and down and feel left out and sad. And you know that's normal. We'd probably feel the same way.

What was important to these participants was differentiating between physical distress and the presence of unmet emotional or psychological needs.

Most participants placed high value on taking the time to determine whether the resident's verbalization of pain could be a signal for attention and companionship. This position was clearly articulated by one nurse:

A lot of times. . . they'll ask for something for pain, just to get you in [*their rooms*], I mean they are really lonely and a lot of the elderly don't have a lot of family to visit and I mean they want somebody to sit down and talk to them to do things with them.

Such clarification was important in selecting appropriate interventions, and certainly before implementing strategies to manage pain.

The messages conveyed by residents and the appropriateness of pain management strategies become clearer as nurses develop familiarity with them and their needs. This perspective was clearly articulated by one participant.

Because I don't like to just give them a pill and *[assume]* that's the answer. I like to get to know them and is there some other reason why they're bothered with the pain and sometimes, I find, if I spend time with them and we're talking and, it seems to ease up the pain more than the pill would do. Sometimes they're so lonely, not that they're not having pain, but I think it gets worse as they are getting lonely and they are sitting there thinking about it and there is nothing to occupy their minds at that time.

A second participant voiced a similar perspective on the insight gained from just being with residents.

But I know we have residents here that are like, *[they]* say they're really miserable today, this hurts and that hurts and all they're doing is, they're by themselves and they're lonely and they're thinking about themselves. A little ache turns into a big one because they think nobody cares and the pain gets worse and worse. All they sometimes need is for you to sit down or just rub their leg or rub their arm with. . .a little moisturizer. But, they think, you're there you care and that helps them relax too and when you're relaxed then of course pain seems to be lessened.

Participants indicated that they used different ways to assess residents' pain besides listening to verbal complaints. One participant discussed in detail the importance of observing the resident in his/her environment in order to more accurately monitor and assess behaviours associated with pain.

Yes, I'll know from her mood or her actions that that's not the lady I know, but you really got to know your patients, and over time you get to know

them. You got to spend time with them and talk to them and listen to them because there's more to it than just giving a pill, to me it is.

The nurses then strategize according to their knowledge of previous responses by the resident, by awareness of the contextual factors that impinge on the person suffering, and by evaluating the variant responses to pain management strategies.

**Summary.** It was apparent from participant descriptions that nursing actions taken to address pain complaints were guided by practical, more so than theoretical, knowledge. The rationale for the heavy reliance on practical knowledge was, in part, attributed to the complexities of residents in long term care settings. In choosing appropriate courses of action to address pain complaints within long term care settings, the data suggest that nurses must assess and evaluate pain behavior, attend to individual residents' character traits, and develop an awareness of the total person. This process does not occur in a vacuum and can be influenced by the attitudes and beliefs of nurses.

### **Striving to Achieve Positive Outcomes**

In describing actions taken to facilitate positive outcomes for residents experiencing pain, study participants' indicated that they often faced a number of challenges posed by the realities of the long term care setting environment. In

particular, participants' stories highlighted their struggles with achieving success in a complex environment, amidst the reality of insufficient human and other resources, inadequate knowledge about effective pain management strategies, and negative attitudes. The striving to achieve positive outcomes category was defined in terms of becoming aware of the situational context, recognizing the influence of attitudes and knowledge, and continually attending to residents' pain.

**Becoming aware of the situational context.** Decisions about pain management did not occur in a vacuum but were influenced by the situational context of residents' pain experiences. The chronicity of disease processes characteristic of many long term care residents, the complexity of care needs due to the interaction of different diseases with individual idiosyncrasies, and the scarcity of resources surfaced as significant forces influencing the selection and timely implementation of pain management strategies.

Participants' comments clearly identified the significance of disease chronicity as a source of intermittent, and sometimes constant distress, for residents. The following excerpts capture the diversity of conditions identified as possible causal factors for residents' discomfort and pain:

Here, like all nursing homes, you have arthritic patients who are in constant pain most of the time. . . .Of course there's all kinds of conditions that cause pain - chronic constipation, osteoporosis, chronic migraines,

chest pain, general malaise. . . .With the elderly, aches and pains and things they might not have had as a younger person. . .it seeps in, muscles are aging and you don't have the same muscle tone, and all these things that go with immobility.

We have *[residents off]* all ages. Our youngest is 36 up to 105 with all different diagnoses, different conditions. Most of them are elderly. A lot of them are plagued with arthritis. Arthritic pain is a big thing in long term care - joint and bone pain. We have a lot of *[residents with]* abdominal problems, coronary, CVA's and there's different pain associated with that. We have *[residents with]* skin conditions, severe psoriasis and a lot of discomfort *[results]* from that.

The complexity of residents and their disease processes often made strategizing for effective pain management a difficult task. Quite often a more realistic goal was striving to achieve temporary relief rather than complete pain control. One participant articulated this reality in the following manner: "Sometimes with chronic arthritis it doesn't matter what you do. You can do it for awhile *[ease the pain]*, but the pain is still there. . .when you walk away, or when you leave work and you've done everything".

Against a background of diverse disease processes participants also had to deal with resident variations in coping styles, pain experiences, and personalities, among other things. In order to achieve the most positive outcomes possible, participants felt they had to assess other extenuating circumstances that might be responsible for residents' pain or suffering. This approach is captured in the following commentary:

Our pain at night is different, too. If you get a resident that's restless and moaning, they're not sleeping, usually we look for other causes before we medicate and then you wait. Do they need a change of position? Do they need a drink or mouth care? We do that, if it doesn't work, we'll crush an atasol and give it to them.

Participants implemented a series of steps in response to pain complaints, while always recognizing that there was no guarantee of success. One nurse commented thus: "First you get the doctor to assess the resident and get them on something if you can. . . .You normally check everything, of course, like. . . check the vital signs, the blood pressure and hope for the best".

Significantly, the amount of medications elderly people consume was presented as a rationale for using a cautious approach when dispensing analgesics. Some participants preferred to do a detailed assessment before dispensing medications. The following passage captures participants' concerns about polypharmacy use with elderly residents:

I don't like medications, for myself or anybody else, especially the elderly. I really think a lot of them are over medicated. . .but that's a personal thing. Before I give medications, I like to be sure that the pain is severe enough, that they really don't just want you to sit down and have a chat.

The above comments provide some insight into why certain strategies were implemented and why there could be a delay in offering residents pain control medications.

A number of participants identified companionship as a necessary and

effective pain management strategy. One nurse clarified how she differentiated between the resident's need for companionship and his/her need for different measures to manage pain:

Somebody will come to me and they'll say, "I want such and such for pain". You talk to them a little bit and a person who is really in pain, they won't focus on you the same way. . . .Some people they want company. . . you can always tell by a person's eyes how much pain they are in. . . .I'm sure in their minds some of them think they're in pain . . . .But when you go and sit down by a bed and talk to a person, let them have a cup of tea, be kind and nice to them. . .[or] you have to take their blood pressure and pulse and whatever and then you need to get in touch with the doctor.

Use of diversional activities was also found to be useful, depending on the context. One participant commented thus:

Lots of times they are so preoccupied with their pain that *[it helps]* if you give them a diversion. . . .The longer *[you are]* in long term care, the more you learn there are other things to do besides medication. . . .I can think of a resident here who's having a lot of pain and she's miserable and the family doesn't visit very often, but if they do come the pain leaves. They are chatty and *[appear pain free]*. So with that type of resident. . .you can give them a diversion. No doubt they do have some misery. . .but sometimes they need a lot of diversion and we do try to give it *[appropriately]*.

Participants also noted that long term care settings did not always have adequate resources to facilitate pain management. One nurse commented on the negative impact of the absence of the necessary resources for managing residents' pain:

That was one resident, I don't think that we managed his pain. . . .I think that we should have been able to do more for the resident. I would have

liked to have seen a consult go out to a pain management specialist and get her in and see what she had to say. . . .We sort of used up all our resources here. . . .We couldn't find anything that would keep him pain free.

Another participant commented on the barriers to effective pain management posed by the physical infrastructure. She suggested that when privacy was compromised, this added to residents' distress:

Our biggest problem is that we only have eight private rooms on the floor *[44-bed unit]*. . . .We find the *[lack of]* privacy difficult. . . .Ideally it would be nice to have all private rooms. . .but they won't let a room go *[empty to be used as a palliative care room]* because of monetary costs.

Many participants recognized that there were numerous strategies that could be utilized to treat residents pain but the general lack of openness to using traditional, or even alternate therapies, impeded successful pain management.

One nurse described her perception of the situation in certain nursing homes as follows:

It's very narrow, the scope *[of usage]* of analgesics in long term care, I mean it's lip service, you don't see any TENS units on geriatric units. . . . we don't have devices. I don't see a regular regime of somebody coming over and using hot or cold therapy. . .or anything to alleviate pain.

Some participants attributed the problem of ineffective pain management to the tendency for long term care settings to maintain the status quo and not to be pro active in this area.

As the above commentary indicates, the inadequacy of pain management

strategies in long term care settings was either attributed to the complexity of residents' disease processes, restricted diagnostic capabilities, the physical infrastructure, or limited knowledge about or acceptance of available treatment modalities. Participants acknowledged that often alternate pain control strategies were attempted before residents received analgesics.

**Recognizing the influence of attitudes and knowledge.** The attitudes of health care providers toward managing residents' pain was identified as a significant barrier to effective pain management. Participants believed that staff attitudes had not changed to keep pace with the changing needs of residents upon entry to long term care facilities. One participant clearly articulated this position: "And I think the hardest part here is changing the staff's thinking about how these residents now are coming in to us much sicker and with a lot more *[pain]* problems".

Some participants felt that negative attitudes and insufficient education were responsible for the inconsistencies, as well as inaction, observed among co-workers and physicians. One nurse commented on how differing opinions resulted in variations among coworkers' approaches to pain management:

I think everybody is different and certainly everybody has their own ideas *[about managing pain]*. I find, like maybe, not all of the nurses on the unit agree. One might say, "Oh, she doesn't have pain, she just *[complains]*. Every time her mother comes in, her mother says she has pain, she's fine." So you do find times when there's difference of opinion among staff.

Participants also described situations where their opinions differed from physicians regarding utilization of pain medications. One nurse commented on how her assessment of a resident's pain was based on "knowing him well", whereas physicians did not have a similar understanding of his needs:

I don't really feel that our doctors felt that his *[resident]* discomfort was as bad as we felt it was and his family felt it was. But they didn't see him, they only come in for one visit, you know, daily visit or three or four times a week and see him for a few minutes. He might be in one of his better times when they were around, you know.

Still another participant suggested there was a problem with physician complacency due to stereotyping in some cases: "There's no expediency to it *[managing pain]*. It's not an emergency type thing, it's more expected. . . .It's many different mind sets and I would say prejudices. Physicians have the same attitude".

Other participants were concerned that physicians' prescribing practices had the potential to cause residents unnecessary distress. To a certain degree physicians were seen as being responsible for delays in implementing appropriate pain management strategies. One participant described the frustration she often experiences while trying to convince physicians that residents' are really in distress:

One doctor in particular, I have nothing against her, she's a wonderful doctor, but she just doesn't, I don't think, believe in ordering strong

analgesics in the elderly. I don't know why. . .if you ask her to go in and see them or something like that. Maybe it might be a day when they're comfortable, you know, and that's a killer, because here you are, battling all week probably and saying, "Look how miserable they are". Then you bring the doctor in one day and she looks at them and she says, "They don't look like they are in pain." That happens. She won't order it [*pain medication*] then.

A second participant also commented on physicians' tendency to not rely on nurses' assessments of residents' pain status:

The doctor is not always sympathetic and doesn't listen to us sometimes. If you say [*the resident*] has been having pain all week and what we are giving is not any good, [*the doctor*] will say, "Well, keep it up, we'll see next week." To me that's no good.

Besides coworkers and physicians participants identified residents' attitudes as posing barriers to effective pain management. In certain situations participants believed that interventions were warranted even when residents disagreed with recommendations. Ambivalence towards the effectiveness of certain pain control strategies is captured in the following commentary:

It's like this morning I was getting a resident up out of bed and she was saying, "I don't think I can get up, my arthritis is too bad." I said, "Well the only way to relieve the pain from your arthritis is to get moving." That sounds terribly cruel, but she knew she had to get up and walk to the bathroom, but she didn't know how she was going to do it, because she was so miserable with this arthritic pain, and that it was kinder for me to leave her in bed. But I said to her, "You got to get up and get moving".

When perspectives between residents and nurses differed, nursing judgements were sometimes used to ensure that the resident benefited while still maintaining

a degree of control:

She said, "No, I don't think so [*take pain medication*]. But I knew she was having a lot of pain, so I gave her Atasol. You just got to make these judgements. . . . Usually when someone says no, like I never insist, what's the sense right? But sometimes they say no and they really do need something. And usually the next time you go back they may say, "Yes, I will take it".

In contrast, there were times when participants felt that nursing interventions fell short of what was needed by residents. One participant commented on how her inability to establish a good rapport with a resident interfered with successful pain management:

There's one man down there who will get up and periodically have a headache and he'll just come and ask for something for his headache. [*I'll ask*], "Where is it in the back or the front?" [He'll answer], "No, it's all over, just got a headache." So you'll give him an atasol or whatever and he goes on, doesn't even try to think why he has a headache, maybe he didn't sleep last night or maybe something was going on in his room or whatever. . . . So I mean we don't have much of a chance [*of successful pain management*] with him really. Even to discuss it, he doesn't seem to want to bother, just get a pill for his headache and go on.

A similar sentiment about the questionable effectiveness of pain management strategies with certain residents was expressed by another participant.

Lots of times she probably doesn't need it [*pain medication*], it's just for emotional reasons that she needs this. . . . But I don't know if we're doing her a favor or not by giving them to her regularly every day, or if we should hold and give them to her when she's really distressed, but then her emotional distress is distress too.

As participants' comments indicated, health care providers require a broad knowledge base concerning pain issues in elderly people and pain management strategies. The successful realization of positive outcomes was highly dependent upon the scope, as well as practical utility, of assessment skills and intervention strategies.

Several participants identified limited staff education as a significant problem within long term care settings. One participant was concerned that co-workers could inadvertently prolong residents' distress because of inadequate knowledge about pain and its management.

I find it very difficult to see a resident in pain. I don't want to see them in pain and I find a lot of time there's a lack of understanding even by my co-workers. They don't really understand what you can give a resident for pain, what measures you can give and I find that really frustrating. . . . They don't really understand, so I guess the answer to it is education.

Another participant emphasized the importance of continuing education to improve nursing's role in managing pain:

I think it's our job as an advocate for the resident to say. . .we know what we want for her kind of thing, but it's hard sometimes, sometimes it's a battle. We haven't had as much education as we would like. . .for pain management and we've only had the butterfly infusion [*parenteral medication*] here only a year and a half which is not very long. In a long term care institution we should have been into that a lot before this.

Other participants also highlighted how the nursing staff would benefit from pain management education sessions:

I think you can make a real good seminar on pain, educating nurses on relief of pain or assessing pain. I think it would help the nurses. . . because I don't ever remember going to a seminar on pain and how to assess it. It's only what I've read and what I've experienced myself. I think it could be helpful [*pain management education sessions*] I mean I think there's always room to learn, you know, more about anything that could be helpful to the residents.

There's more than one way of dealing with pain, right, more than one method. As nurses we have an obligation to be interested in learning about anything new that comes out and. . .avail of, especially in long term care. In long term care you kind of tend to get in a little rut. I think we should make every effort to attend seminars or do whatever.

As the above comments suggest some participants felt strongly about the importance of identifying ways to compensate for inadequate knowledge.

Continuing education on pain management for the nursing staff was identified as one approach to deal with the complacency observed in long term care.

Some participants' commented on the need for formal preparation in pain management for staff working in long term care settings. As one participant noted, theory would not only provide the nursing staff with greater insight into residents' needs but also help modify attitudes:

I think we have a long way to go yet, mainly with education to get everyone on the same mind set. That this is it - this is the way we're going to do it now and something is set up [*pain management protocol*]. . . . Some of us are starting a palliative certificate program. We'd like to see this kind of a program set up. . .even if one nurse on every unit was further educated [*about pain management*] she'd go and assess the resident for the team.

Another participant acknowledged that staff deficiencies due to limited pain

management education could be corrected by increased exposure to others with developed expertise in such areas as palliative care.

There has not been a lot of education on managing pain in long term care. I've worked on a palliative care type of unit and I found that I learned a whole lot there - they're *[nurses in palliative care]* invaluable.

Still another participant identified ways in which nurses could better prepare themselves to attend to residents' needs in long term care settings:

I'm doing this course from Algonquin College on palliative care. I figured I really needed it to help my patients . . . .Certainly they are not going anywhere, they are going to die here on this unit. So if I can help them in a better way - to make them more comfortable, I would certainly want to learn and I am learning from it, I find it good.

Given the complexity of residents' health status and somewhat limited resources, study participants were of the opinion that nurses require a broad knowledge base about disease processes and a good understanding of appropriate psychosocial and emotional interventions.

**Continually attending to residents' pain.** Participants' comments emphasized the importance of continuously attending to resident's pain. In order to ensure the presence of a useful approach to pain management, nurses were required to engage in ongoing evaluation of the effectiveness of nursing actions. Managing pain effectively was seen as an indicator of degree of quality of life enjoyed by residents. One participant described her perspective thus:

People should not live their last few days or weeks in so much severe

pain that they have no quality of life [*a quality*] that's taken away from them because their pain is so severe. You have to try to [*maintain*], as much as possible, the highest quality of life they can have even when they are dying. If you can relieve pain for an hour or two at a time so that they can spend time with their family you do whatever it takes.

The strategies chosen to manage pain were many and varied, and included such things as comfort measures, medications, and therapeutic interventions. The specific measures described by participants included appropriate use of humour, companionship, socialization, and diversion. One participant described a scenario of activities that she could possibly initiate to achieve successive pain control thus:

Well, each and every thing you do will take a certain amount of the pain away. So you give them something for their pain, like pharmacology wise. They're still miserable because the arthritis is really acting up, so you'll give them their Atasol. Then probably some deep cold - rub it on all their joints, you know. After a while [if] they are still miserable, you can tell they're still miserable, they're still in pain, they might ask you for something else. A hot pack might help you know, just a massage of the joint might help, a hot cup of tea might be something else that might help them. Just to sit and talk to them for a few minutes and that might take their mind off it for awhile long enough for them to tell you a little story about what happened when they were young. That will take it away for a short while even if it's only taken away while you're there, the pain is gone for a temporary time.

Evidence of the need for continuing efforts to relieve resident's pain is also captured in the following commentary by another participant:

If we don't get [*stronger analgesia*] ordered, we try atasol plain or we try other kinds of comfort measures, like sheepskins, massages, heat packs, anything. You know, we get physio sometimes to come up and look at

them and give them some heat packs or cold packs or whatever they need. We don't use hot water bottles any more, we did at one time. But, we'll try any of that first and if we don't think that's working then we'll ask for something stronger like an analgesic.

Strategies used to manage pain were mostly characterized as individualized interventions. The particular strategy initiated was shaped by ongoing assessment of each resident. One participant provided the following example of initiatives taken to promote residents' comfort:

Sometimes if it's a positioning thing we might refer to an occupational therapist, *[and ask]* if *[residents]* can get an adjustment to their chair. This lady can stay up longer because she's more comfortable in her chair. We don't have to give her pain medication now because she's got a better chair.

The individualized approaches of nurses were varied and often unorthodox. The following excerpts capture the diversity of approaches used by participants to ensure that residents' were as comfortable as possible:

I find humor very good. Like I carry on and sometimes I'm acting foolish really. But they, a few of them, love it and it distracts them and they like for you to carry on and tell them a joke and they'll tell you one back. I find humor very helpful, you know.

I try to *[communicate]* in a humorous way. *[The resident will]* say, "I'm some glad you're here *[nurse]* I never got nothing for pain since you left." But you know she did. . .she wants confirmation she's at death's door, you see. *[She'll say]*, "Check my pulse *[because]* it's racing out of my body, I'm sure I'm going to die, it's racing out of my body." *[I'll say]*, "Hold on let me check your pulse. . .it's wonderful, I wish I had such a pulse, 80 per minute, it's the pulse of a great hockey player, Gordie Howe." She *[responded]*, "Yea, the pulse of a hockey player, he must be a dead one!"

Continuing efforts to manage residents' pain also became evident from participants' descriptions of their experiences with medications - opioids and other analgesics, as well as a combination of different drugs. Participants often dispensed a variety of medications in their efforts to manage residents' pain.

I got a lady who's blind and she's got her Braille watch and she was going through a period of time where she was having pain on a regular basis, extremely obese lady, her neck was hurting, her main source of discomfort and she would be brought to tears. We went through the regime of the Atasol 325's and the Atasol 500's and it worked for a short period of time. Then it wouldn't work and you'd up the frequency, or give it more often. She needed it. Really, really needed it. She knew if it was Q6, she'd time when she got it and right to the minute she'd buzz for the next dose because she wanted to maintain that level of analgesia. Now we got her on Robaxacet so she gets the muscle relaxant along with the analgesia. . .and it works!

While attempting to provide a resident with some reprieve from phantom pain, one participant described using a combination of medication and non pharmacological strategies.

We have a lady who just had a second amputation, she's having a lot of phantom pain. She came to us with a long history of having had Atasol with Codeine and she had an addiction to it and one was never enough. She was one who bugged and nagged a lot to have her medication. She would say, "How much longer and when can I have my Atasol 30's. I need two instead of one." She'd get up at night and say, "The doctor should order more at night." She was very depressed, and we gave her some antidepressant. By putting her on antidepressants we were able to cut down on her Atasol 30's to one at night and the rest of the day she's taking plain Atasol. . . .Now she still got up at night with some pain but we got her a cup of coffee and gave her a hot pack and gave her a little massage and she settled.

Another participant described how steroid therapy was used as an effective strategy with one resident:

She had excruciating pain in her jaw and face and we didn't seem to manage her pain very well with different medications and heat didn't seem to help, cold didn't seem to help. The doctor prescribed a number of pain medications and nothing seemed to help. We decided to send her out to a dentist. . .and the final decision seemed to be that it was a nerve thing from MS. . . .I think they did finally treat that [*pain*] with steroids.

Study participants identified Atasol plain as the medication of choice in long term care settings where they worked. The descriptive commentary indicated that Atasol was used as a sedative on a trial and error basis, or as an analgesic for a range of complaints and conditions from cancer to minor aches. The heavy reliance on Atasol is captured in the following quotation: "We are great believers in plain Atasol, we give a lot of plain Atasol". However, some participants questioned the effectiveness of this medication for relieving residents' pain:

She's saying she's got pain. So I'll say, "Here's a couple of Atasol for you, now that should help you." Then you ask her about 20 minutes later, "Did the pills I gave you help?" And she'll say, "Oh, yes, they're fine." Then probably 10 minutes later, when you are going around with the pill cart, she'll say, "Oh, my knees are killing me".

When Atasol failed to provide pain relief, it was often followed by stronger analgesia. One participant commented on the steps taken to address one resident's pain complaints:

Her bones were so osteoarthritic [osteoporotic] that one night just rolling her over in bed cracked her femur. She had a lot of pain with that and they put her on Atasol 30's. That didn't seem to be working because we couldn't get it into her. . . .She wasn't getting her pain medication which subsequently meant you couldn't go near her to touch her or do anything for her. So they put her on some MOS, then we put in a butterfly and that helped her, but now she didn't last very long after that.

When residents are unable to communicate clearly due to the presence of confusional states or dementia, the emphasis is placed on being attentive to visual cues, such as agitation, and conducting physical assessments. Trial and error surfaced as the dominant method of pain management. Participants did physical assessments of body systems, consulted physicians and depended on past successes in managing pain. One participant described pain management approaches with these types of residents thus:

If one of your Alzheimer's [*resident's*] suddenly cries and favors some area, obviously they've got something wrong. Well you got to investigate and see what is going on. You just can't medicate, you know, you'd have to find out what the problem is. Either it could be abdominal pain through constipation or. . .there is some problem with voiding. . . .If it goes on for a couple of days we'll have to get the doctor in and maybe do some blood work. We've had to do that and investigate.

Although participants never questioned the presence of pain, despite the varied presentations in people with cognitive impairments, the assessment and management of pain seemed to be much more difficult than with the non-cognitively impaired.

In strategizing for successful outcomes and striving for better pain

management, participants may have to make arrangements for the resident to be transferred from the long term care setting to a more appropriate setting where needs would be better served. Nurses had to be cognizant of these other facilities and advocate on behalf of their residents. Participants described situations when these transfers were necessary: "They have really good pain control there [*at a local hospital*] for malignant and terminal patients. Our residents don't stay with us very long after they have to go on this pain procedure [*to manage pain*]".

**Summary.** Participants recognized the impact of care giver attitudes toward pain and its management, as well as the positive effects of the presence of collaborative relations among health care providers, accurate knowledge about pain management, using an individual approach with each resident, and engaging in ongoing evaluation of the effectiveness of interventions.

Because of the resources necessary for effective action, participants had to constantly advocate for pain management consultants (either physicians or programs). When they felt that their actions were ineffective, participants believed that residents suffered needlessly because of inadequate resources on site.

For some participants a pain free state was the goal of treatment, whereas for others partial control of residents' pain was seen as a more realistic

goal. Regardless of the goal of treatment - total or partial pain relief - all nursing actions were implemented to provide residents with some measure of comfort. The process of pain management seemed to be fairly consistent across study participants - initiated by getting as much information as possible about the resident and then conferring with other team members on appropriate strategizing measures. The decision to offer or increase analgesics was made by nurses and then recommendations were made to physicians. However, both nurses and physicians seemed to be reluctant in offering maximum dose analgesia to combat patients' pain. Nurses seemed to prefer to err on the side of caution by favoring comfort measures before using pharmacological approaches.

### **Interrelationships Among Theoretical Constructs**

The emerging theory suggests that the constructs of knowing the resident, assuming the helping role and striving to achieve positive outcomes exert independent and interactive effects on nurses' abilities to manage residents' pain in long term care settings. Based on theoretical insights gleaned from the data it is postulated that "overcoming barriers" is the common thread intersecting and joining the constructs. The proposed interrelationships among the theoretical constructs are outlined in Figure 1.

Within the current context, overcoming barriers is defined as gaining control over things perceived to impede or restrict nursing efforts to manage long term residents' pain. The data suggest that nurses not only recognized the presence of barriers but also identified measures to overcome them. Barriers to successful pain management existed in the pain presentation of residents and the complexity of their situations; communication, listening, and observational skills; the attitudes and biases of co-workers, as well as the adequacy of their knowledge about pain assessment and its management; and, the setting itself, where limited human and physical resources, forced nurses to constantly adapt their approach to achieve some degree of success in managing pain.

Nursing's attention and efforts were focused on overcoming the barriers posed by residents' pain presentations and the complexity of their situations. The difficulties experienced by nurses in achieving positive outcomes were influenced by residents' behaviours (i.e., tendency to be stoic, or to conceal or complain, about pain episodes), cognitive status (i.e., varying degrees of lucidity), and health status (i.e., levels of acuity and chronicity). The findings suggest that spending sufficient time to become acquainted with residents was an important first step. The importance of spending quality time with residents in order to achieve effective pain management is captured in the following statement: "You really have to know your resident, and over time you get to know

them. You got to spend time and talk to them and listen to them because there is more to it than just giving a pill". An additional barrier was posed by the situational context of residents (e.g., acuity/chronicity of disease processes, possibility for partial or complete pain control, availability of resources, dangers of polypharmacy, etc.). The successful achievement of positive outcomes required that participants constantly evaluate and alter pain management approaches to overcome situational barriers.

Before nurses could assume the helping role they had to overcome barriers preventing them from getting to know their residents. Successful pain management was dependent upon establishing effective dialogue and developing and fine-tuning listening and observational skills. Nurses described overcoming communication barriers through constantly readjusting pain management approaches. One nurse shared the following experience:

I talked to a woman today who had a really bad headache. She had a bad headache yesterday. . .and when I found out, I went down and talked to her. I said, "You really look worried." She was worried because she had paid all the bills in her house for years and she forgot that she was not going home. I told her where she was and explained to her that all her bills were taken care of. She was so relieved - it was unbelievable and within 5 minutes her headache was gone.

Nurses also had to differentiate between unmet psychological or emotional needs and physical needs by becoming cognizant of salient patient traits before planning individual specific strategies. This required continuous effort, especially

with residents who had communication deficits or cognitive impairments. This aspect is captured in the following excerpt: "You always keep on trying. . .you do a lot of very careful talking to them. You sort of go on a little search mission and when you are doing something else or moving the resident you ask did that hurt?" Nurses also stressed the importance of not using a task oriented approach to pain management. By tending to the total person, the nurse works under the premise that pain is not an isolated entity but only one part of the person experiencing it. One participant commented thus: "I don't think it's discrimination *[that prevents success with pain control]* as much as it is that caregivers become task oriented and don't see the *[whole]* person".

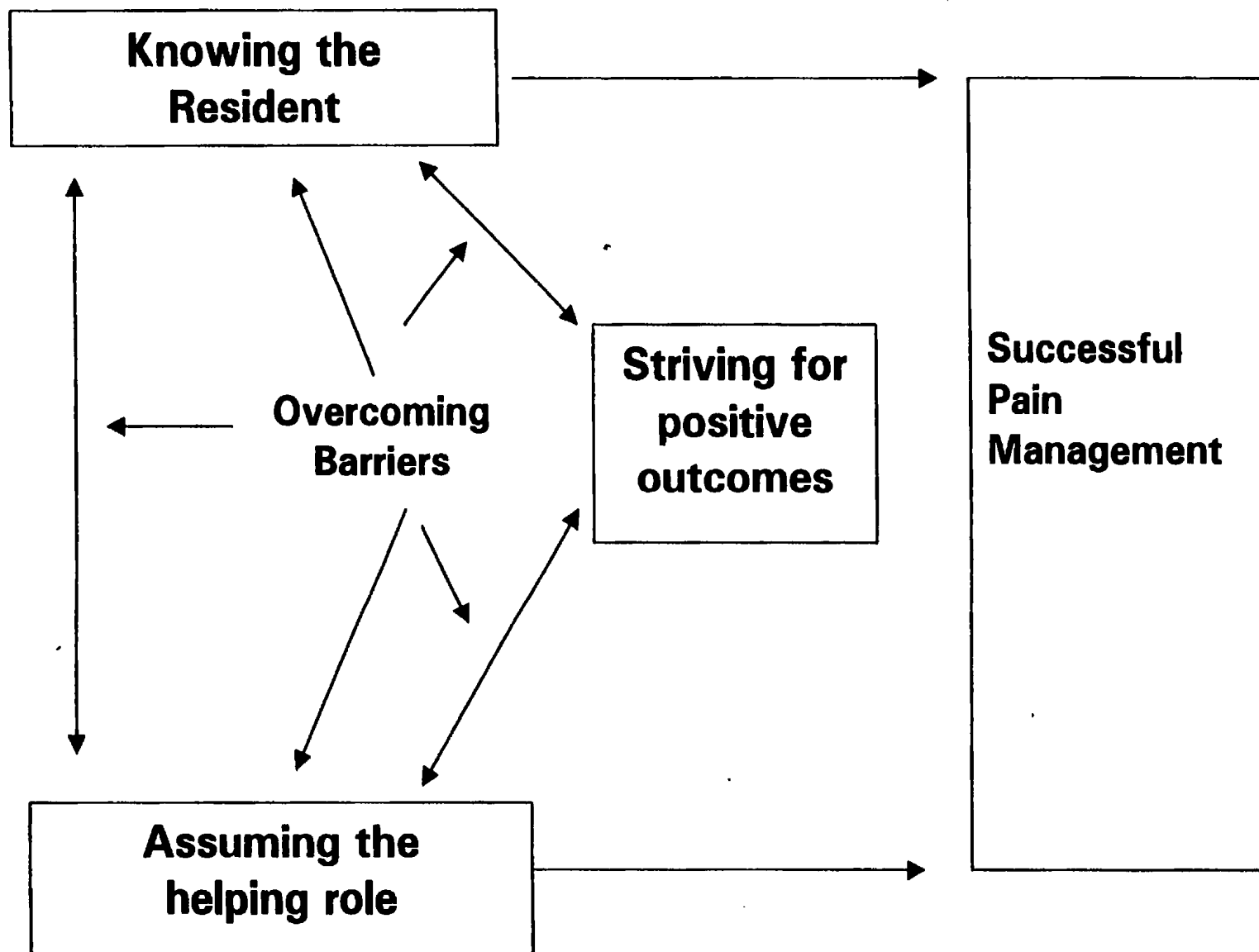
By recognizing the impact of attitudes and knowledge levels on the effectiveness of pain management, participants stressed the importance of tending to and overcoming the barriers posed by individual biases of nurses and physicians, high degree of subjectivity involved in certain approaches, differing nurse/patient perspectives, physician analgesia ordering practices, and the practice environment. One nurse described an approach used to overcome physician barriers: "Our doctors are still not keen, not quick *[to order morphine]*. You have to phone the doctor and say, 'Look, the resident needs it, she's dying, she needs morphine'. The doctor has to be encouraged to order". Another nurse acknowledged the usefulness of using a team approach to achieve

**effective pain management:**

**Every strategy is individualized. What works best is the team effort on your unit where you have nursing assistants and nurses who get together and talk about what's going on with the residents. Everybody gives, not their opinions of the pain, but their assessment and their input into what's going on with that particular resident.**

**Another way to overcome barriers to successful pain management was being cognizant of the importance of having pain theory and recognizing the positive effects of being equipped with a broad knowledge base.**

**In summary, knowing the resident and assuming the helping role had a significant impact on the extent to which nurses continued to strive to achieve positive outcomes. The barriers (i.e., emotional, psychological, and cognitive characteristics of health care providers and residents; and physical resources) present in the practice environment were identified as significant forces exerting a negative impact on successful pain management. Study participants emphasized the importance of ongoing efforts to overcome barriers to ensure that residents living in long term care settings enjoyed a good quality of life.**



**Figure 1: Model of Nurses' Experiences with Pain Management of Elderly Residents in Long-Term Care Settings**

## **CHAPTER 5**

### **Discussion of Findings**

This qualitative study used a grounded theory methodology to explore nurses' experiences with pain management. The discussion highlights the similarities and differences between the current study's findings and those presented in the literature. The presentation is organized according to the dominant theoretical constructs generated during data analysis.

#### **Pain Management in Long Term Care**

While this study's findings provide new insights into nurses' experiences with pain management in long term care settings, there is also support for research findings presented in the literature. The current study's findings reinforce the importance of getting to know the resident and the situational context in shaping nurses' interpretation and management of pain. All of the participants gave recognition to the challenges of attending to residents reports or expressions of pain and choosing appropriate courses of action. What surfaced as a central component of nurses' experiences was the need to confront and overcome the barriers to getting to know residents, assuming the helping role, and striving to achieve positive outcomes.

### **Knowing the Resident**

As described by study participants, getting to know the person is crucial to achieving an understanding of residents' pain expressions. Repeated clinical encounters in variant situational contexts provide nurses with the opportunity to become acquainted with those entrusted to their care in long term care settings. However, getting to know the person requires something more, meaningful and involved interactions with residents and their families. Tanner, Benner, Chesla, and Gordon's (1993) phenomenological analysis of intensive care nurses' narrative accounts of caring practices identified knowing the patient as a person as central to skilled clinical judgement. As in the current study, these authors found that getting to know the patient requires that the nurse assume an involved, attached stance as opposed to a detached one. When patients are unable to communicate their needs, interactions with family members are identified as essential to helping the nurse come to know the patient as person (Tanner et al., 1993).

Other authors have emphasized the importance of using the shared experiences from nurse/patient encounters to get to know the person which, ultimately, improves clinical decision making. As one of the five dimensions of caring, Swanson (1991) described knowing the patient as striving to understand

the meaning of events for another. Swanson's position is that nurse/patient interactions provide nurses with a forum for acquiring highly specific, situated knowledge about the patient as a person. Radwin (1995) also identified nurse/patient interactions as an important context for developing familiarity and intimacy - core components of knowing the patient. Using the constant-comparative method to analyze interview transcripts of nurses responsible for direct patient care in a cardiology specialty unit, Radwin describes how nurses' understanding of particulars are derived from the information that patients share about themselves, as well as nurse observations of patients' behaviours.

While there are a number of theoretical perspectives and a few qualitative studies highlighting the importance of knowing the patient as prerequisite for making skilled clinical judgments, the literature is rather limited on the significance of this construct for understanding and managing pain in the elderly.

A recent study by Parke (1998) provides support for the current study's findings on knowing the resident. Parke applied the constant-comparative method to interview transcripts describing nurses' and nursing assistants' experiences with assessing and managing pain for cognitively impaired older persons residing in long term care settings. Knowing the person emerged as a key construct and was defined in terms of familiarity with particular personal characteristics, patterns, and preferences. It is through familiarity that nurses become aware of

what is meaningful for the person and are able to recognize when something is different or wrong. As with the current study, Parke discovered that spending time with the older person over a number of years provides a historical context for interpreting pain expressions. That is, time spent with older adults enabled nurses to become familiar with particular idiosyncrasies and to use deviations from the norm as cues to identify the presence of pain.

### **Assuming the Helping Role**

The assuming the helping role category was defined in terms of being cognizant of salient patient traits, developing listening and observational skills, and tending to the total person. This category has similar thematic content to Benner's (1984) the helping role domain of nursing practice and Clarke and Wheeler's (1992) essential structure of caring. Comparatively, Benner's helping role requires competence in providing comfort measures and preserving personhood in the face of pain; presencing or being with a person; interpreting kinds of pain; and selecting appropriate strategies for pain management and control. Clarke and Wheeler define caring in terms of being supportive (valuing people, awareness of patients' needs, having concern), communicating (listening, touching, hugging), pressure, and ability.

Participants emphasized the importance of sorting through what they

knew about residents to highlight key aspects of situations that could signal departures from normal behavioural patterns. To be effective in the assessment phase nurses were required to have good listening and observational skills. Similarly, Tanner et al. (1993) argue that knowing the patient's typical pattern of responses is central to skilled clinical judgement. The authors assert that the skills of involvement and recognizing salient changes in patient status are developed and refined from the experiential knowledge that nurses gain from multiple clinical encounters with similar groups of patients.

In the current study, participants talked about the difficulties inherent in making decisions about the presence and intensity of pain in residents despite knowing these people for a number of years. Their words suggest that these difficulties stem, in part, from encounters with individuals with unique character traits, a range of illness states and levels of acuity, variant health needs (i.e., social, emotional, psychological, and physical), and different levels of cognitive awareness. The complexity of the resident population meant that study participants often had to base their interventions on inadequate understandings of residents' pain states. The important influence of nurses' understanding of patients' unique characteristics in determining the possibilities for individualized care choices is supported by Radwin (1995), Tanner et al. (1993), and Parke (1998).

Findings from the current study suggest that participants rely more on practical rather than theoretical knowledge. In the current study, participants stressed the importance of spending time to tend to the total person. This was seen as an important prerequisite to grasping the meaning of pain expressions. Similarly, Gordon (1986) asserts that with experience nurses began to see the patient as a whole and not a set of problems. Further, Benner and Wrubel (1982) define experience as the transformation of preconceived notions and expectations by encountering actual practical situations. Expert nurses become skilled in recognizing and discriminating aspects of outward appearances by spending time caring for patients with similar problems. As such, they are capable of making perceptual assessments (i.e., using the senses of sight, touch and smell) and interpreting patients' physical, verbal and behavioural expressions.

What came through as a crucial component of assuming the helping role was forging therapeutic interactions with residents which was achieved through tending to the total person. Participants' descriptions indicated that a caring approach involved spending time, reaching out, engaging in meaningful conversations and showing compassion. As participants stressed, the importance of any one nursing activity depended on the interaction between the situational context and residents' expressed needs or observed behaviours.

Other authors echo similar sentiments (Bottoroff & Morse, 1994; Bottoroff & Varcoe, 1995). In a qualitative ethological study, Bottoroff and Morse (1994) examined the verbal and nonverbal behaviours of nurses during interactions with cancer patients. During data analysis, four types of attending behaviours were identified: doing more (i.e., making contact or reaching out beyond usual care requirements), doing for (i.e., personalized approach to non-treatment related requests or needs), doing with (i.e., collaborative approach - information giving and receiving while focusing equally on tasks and expressed needs/concerns), and doing tasks (i.e., routinized approach to care without patient involvement). As these authors indicated any single nurse-patient interaction could consist of several attending behaviours. In a subsequent analysis of this data set, Bottoroff and Varcoe (1995) examined patterns of transition from one type of attending to another and their importance within nurse/patient interactions. Weaving proficiency with presence emerged as the dominant pattern, with sensitive responses and creating openings surfacing as additional patterns. Notably, the nurse's ability to make the transition from one type of attending to another dictated the therapeutic usefulness of the nurse-patient interaction.

Once salient traits suggesting a possible change in resident status were identified, study participants described taking a sequential and highly individualized approach to pain management. Nurses in this study emphasized

the necessity of knowing each individual in his/her own world rather than as part of a group requiring a general set of pain management interventions. Support for these findings is also found in the literature (Benner, 1984; Parke, 1998; Radwin, 1995; Tanner et al., 1993). Radwin (1995) argues that when nurses have limited familiarity with patients' unique particulars (i.e., experiences, behaviours, feelings and perceptions), interventions can not be highly individualized and are limited to empathizing and matching a pattern (i.e., derived from previous experiences). Conversely, when nurses have extensive knowledge about patients' particulars, they are capable of strategizing by developing a bigger picture, as well as balancing patients' care preferences with potential difficulties from certain choices (i.e., discomfort and risk to patients).

From a slightly different perspective, Parke (1998) emphasizes how nurses integrate objective, scientific knowledge with intuitive knowledge to assess pain states in older persons. This author stresses that individualized knowledge is critical because each person, even those with cognitive impairments, provides the nurse with his/her own set of pain cues. Through relationships with many such residents, nurses develop intuitive perception and, eventually, are able to recognize change, understand the meaning of change and cluster pain cues. Parke concludes that knowing by diversity defines intuitive knowing, whereas knowing the particular shapes knowing the person.

### **Striving to Achieve Positive Outcomes**

The current study findings show how participants approached pain management with residents in long term care settings. Integral to managing pain was the realization that success could only be achieved with continuous effort. The themes of becoming aware of the situational context, recognizing the influences of attitudes and knowledge and continually attending to residents' needs highlight the numerous barriers to and facilitators of pain management, as well as the diverse efforts expended by participants in striving to achieve pain control.

The situational context in the current study refers to the environment experienced by residents in the long term care setting. Participants' descriptions revealed that residents have a multitude of chronic conditions and experience differing pain levels and intensities on a regular basis. Studies on pain prevalence and pain causing conditions in elderly residents living in institutions concur with this study's findings (Ferrell, Ferrell, & Osterweil, 1990; Mobily et al., 1994; Roy & Thomas, 1986).

The complexity of care needs of residents with cognitive deficits described by study participants has also been discussed by other researchers (Ferrell, Ferrell, & Rivera, 1995; Parmalee, Smith, & Katz, 1993). One key factor

which influenced participants' pain management strategies was the individual coping styles of residents. Crow, Olivet, Burry-Stock, and VanderMeer (1996) suggest that nurses actions are dependent upon individual patient coping styles.

Participants in this study admitted being cautious in dispensing analgesic medications to elderly residents. The articulated rationale was being fearful of contributing to an existing problem of polypharmacy in elderly people. Significantly, participants saw overmedication as a salient problem in the long term care environment. In a longitudinal study of elderly people's medication practices, Rumble and Morgan (1994) found that the number of medications per person increased over time. These researchers assert that the drug regimens of elderly people should be frequently reviewed to ensure that only the minimum number of effective drugs in the simplest regimens are dispensed.

In sharing their pain management experiences, participants maintained that the attitudes and knowledge base of coworkers greatly influenced outcomes. They saw negative attitudes and insufficient pain education as a pervasive problem in long term care settings. Such barriers were identified as being responsible for an inconsistent approach and/or inaction in intervening to ameliorate or eliminate pain. These findings concur with other studies that explored nurses' attitudes and knowledge base toward managing pain (Brunier et al., 1995; Closs, 1996; Fagerberg & Ekman, 1997; Hamilton & Edgar, 1992;

Lander, 1990; McCaffery et al., 1990; Watt-Watson, 1987).

Study participants admitted that limited staff education was responsible for less than optimal outcomes in managing pain. The results of this study support previous research which indicated that nurses have inadequate knowledge of pain theory and pain management strategies (Brunier et al., 1995; Clarke et al., 1996; Fothergill-Bourbonnais & Wilson-Barnett, 1992; Hamilton & Edgar, 1992; McCaffery et al., 1990; Vortherms et al., 1992; Watt-Watson, 1987). In the current study, participants clearly articulated a strong need for ongoing continuing education on pain issues. This need was based, in part, on experiencing greater success with pain control after learning new pain management techniques and approaches. These results are comparable to other study findings that suggest education, preparation and development and implementation of pain management programs are successful in assisting nurses with pain management (Ferrell et al., 1993; Francke et al., 1996; Hauck, 1986; Mazzuca, Barger, & Brandt, 1987).

### **Interrelationships Among Theoretical Constructs**

Participants' accounts of caring for residents who had pain generally portrayed a sense that the task was never easy. The challenge was to recognize barriers that existed within the recipient of care (resident), as well as

the physical and social environment (i.e., families, caregivers and the practice setting). Participants' accounts of barriers to effective pain management are consistent with those reported in other studies. Using an interactive case study approach, Brockopp, Brockopp, Warden, Wilson, Carpenter, and Vandever (1998) reported that nurse and physician teams identified seven major barriers to pain management: lack of knowledge, non-facilitative attitudes, inconsistent leadership, poor working relationships, cultural and religious biases, physicians' fears of legal repercussions and a lack of resources. Wallace, Reed, Pasero, and Olsson (1995) examined staff nurses' perceptions of barriers to pain management and self-ratings of skill level around specific pain knowledge issues. Although nurses rated their knowledge of legal/political and financial issues around pain as inadequate, they believed that they had adequate knowledge about and understanding of ethical and practice issues concerning pain.

Study participants stressed the significance of nursing efforts directed toward overcoming barriers to effective pain management. The first step involved getting to know the person within the context of his/her environment. As described by participants, concerted attempts were often required to overcome barriers posed by the residents themselves, especially those with cognitive impairments. Study findings appear to validate other studies that

suggest that it is possible to accurately assess pain in people who have cognitive deficits. Participants reported using numerous approaches to determine residents' needs in situations where cognition was compromised. The necessity of using multiple assessment strategies in persons with cognitive impairments in order to construct a more accurate profile of pain compares favorably with the conclusions of other studies (Ferrell, Ferrell, & Rivera, 1995; Parmalee, Smith, & Katz, 1993; Simons & Malabar, 1995).

Nurses have the responsibility to manage residents' pain but face continuous barriers that threaten successful intervention. These barriers must be dealt with in order to achieve effective pain management. Nurses described the intricacies and difficulties in getting to know people as the first barrier to be overcome. Overcoming barriers of getting to know residents meant better understanding about what to do to be effective in assuming the helping role. As discussed by Jenny and Logan (1992), the development of a trusting relationship between the nurse and patient is strongly dependent on the nurse's intention to get to know the patient. Knowing the patient is presented as a process for acquiring and using clinical knowledge, and as such is an intrinsic dimension of nursing that permits the individualization of patient care. Failure to utilize the knowing process can result in a lack of patient trust which can effect therapeutic outcomes. Several authors assert that getting to know the patient is a pivotal

step to effective nursing interventions (Bottoroff & Varcoe, 1995; Parke, 1998; Radwin, 1995; Tanner et al., 1993).

In order to overcome barriers to assuming the helping role nurses had to set and meet the goal of knowing the individuality of the person and adapting individual strategies accordingly. Participants reported success in pain management only when strategies were individualized. This finding concurs with other research. Donovan and Laack (1998) suggest that it is essential to match the therapy to the individual rather than offering a standardized therapeutic approach to all individuals who experience chronic pain. Based on patients' perspectives on what was effective or not effective in the treatment of their chronic pain syndromes, Donovan and Laack found that regardless of the therapy type what was highly effective for some actually increased the pain for others and/or produced intolerable side effects. Thus, a standardized approach could, in effect, constitute a barrier to effective pain management. From a somewhat different perspective, Bottoroff and Morse (1994) found that the type of attending used by a nurse could change several times during a single interaction depending on the patient's reactions. This finding supports the importance of matching strategies with resident needs and ensuring the presence of continuous effort to determine residents' reactions to individualized pain management strategies.

In striving to succeed and manage pain nurses had to assess many factors besides the verbal complaints of pain. This necessity of clarifying the message sent by residents in order to differentiate between physical distress and emotional/psychological needs is comparable to findings reported by Paulson, Danielson and Norberg (1999). In a phenomenological-hermeneutical study of nurses' and physicians' narratives about long term non-malignant pain among men, participants' indicated that there was so much more to a patient's pain complaint than physical distress. The authors conclude that assessment and management of pain requires attention to the total person. Further, the establishment of positive relationships between nurse/physician and patient are pivotal to successful outcomes in pain control.

In the current study, most participants indicated that both individual and organizational efforts were required to overcome the barriers posed by insufficient education and negative attitudes around pain management. In a comprehensive review of nursing studies dealing with pain management knowledge, McCaffery and Ferrell (1997b) found notable improvement in nurses' knowledge of pain assessment, opioid dosing and likelihood of addiction. However, the authors emphasize the need for continuing education on pain issues.

The current study participants felt that an organizational approach should

be used to overcome barriers posed by negative attitudes and/or inadequate education. Other authors suggest that equal attention must be given to organizational involvement in pain issues. Miaskowski, Nichols, Brody, and Synold (1994) investigated patient satisfaction with pain management practices as outlined in the quality assurance standards of the American Pain Society (APS). The findings indicated that although patients were satisfied with the pain management care received, they were experiencing moderate to severe pain and often had to wait for medication. The authors recommend that organizations should establish benchmarks for each specific area of pain management and evaluate progress toward achieving set goals. As well, Ferrell, Whedon, and Rollins (1995) suggest that quality assurance and quality initiatives based on current knowledge of pain management can improve the care provided to patients experiencing pain. Finally, Barnason, Merboth, Pozehl and Tietjen (1998) evaluated the effectiveness of a structured intervention based on clinical nursing standards that complied with APS and AHCPR guidelines. The study findings concur with the results of Miaskowski et al. (1994) that setting standards or developing standards based on direction from APS, or similar evidence based benchmarks, appear to improve practice.

**Summary**

Although most of what has been found in the present study does reflect what is previously reported in the literature, this study extends the important findings of other studies. Significantly, this study demonstrates the importance of recognizing and overcoming barriers to getting to know residents, assuming the helping role, and striving to achieve positive outcomes. When nurses successfully master all of these aspects of care, effective interventions result which lead to success in managing pain.

## **CHAPTER 6**

### **Limitations, Recommendations and Conclusions**

This chapter presents the limitations of the study, recommendations for further research and conclusions based on the data.

#### **Limitations of the study**

The study sample represents a convenience sample of nurses who work in nursing homes in St. John's. Other studies, using a similar methodology, are needed with nurses working in both urban and rural long term care settings to further validate the theoretical constructs identified in this study.

One limitation of the current study is the small sample size ( $N = 16$ ). Sandelowski (1995) suggests that 25 to 50 subjects may be needed to achieve theoretical saturation of emerging categories. Although there did not appear to be any new themes surfacing in the data following the first 10 to 12 interviews, this could have been a function of the fact that participants worked in nursing homes located in one city and operating under similar policies.

Although nurses were asked to relate their experiences with managing residents' pain, it is not possible to guarantee that nurses actually do what they say they do. The responses by nurses may have been given in a socially acceptable manner due to fear of being judged by the interviewer. Further,

interviews were conducted during the nurses' working shifts and the need to return to work may have impacted upon or shortened renditions of experiences. However, none of the nurses offered further information when contacted by the interviewer at later times.

Responses may have been influenced by the interviewer's approach to eliciting commentary. A more experienced interviewer may have given more focused prompts to expand on conversations or channeled conversation to gather more insightful data. However the inexperience of the interviewer did not appear to stifle free flow of thought or conversation.

Study findings are limited to beginning formulation of a substantive theory about nurses' experiences with pain management in elderly people. Although an important link has been forged among the theoretical categories, it does not represent a comprehensive profile of pain management strategies. It is especially important to carry out other investigations that are directed toward determining the perceptions of the residents themselves, and perhaps the families of residents who experience pain.

### **Recommendations for Research**

The perspective of knowing the patient and assuming the helping role has been identified as core concepts defining the caring relationship in both the

theoretical and research literature. However, less emphasis has been placed on identifying the intricacies of how nurses master this process, especially in managing pain.

For over two decades the literature suggests nurses have a poor knowledge base on pain issues and, only now, are we beginning to see any perceptible improvement in this area. The mostly quantitative research has not clarified how nurses perceive the concept of pain or how they structure interpersonal relationships with patients/residents who are experiencing pain. This study's findings suggest that the forging of meaningful interactions with residents is important in getting to know the person, assuming the helping role, and striving to achieve positive outcomes. Further qualitative research studies are obviously needed on documenting how this interaction component works best in different clinical situations. A triangulated data collection approach that combines interviews with participant observations would not only generate a more comprehensive data base on how to develop therapeutic interactions but also serve to clarify how best to overcome identified barriers to pain management in long term care settings.

The concept of utilizing pain theory to direct assessment and intervention did not emerge as a strong component of nurses' action. Participants' descriptions seemed to favour practical knowing over theoretical knowing.

Although participants indicated that they recognized the need for more pain education, there was no direct reference to requiring more information on pain theory in order to augment physiological assessments and, ultimately, choose more appropriate and effective interventions. Further inquiry is obviously needed to document nurses' use of (or lack of) pain theory in strategizing for pain control in long term care settings. A more extensive knowledge base may lead to the creation of more effective nursing approaches aimed at better pain control. It is also necessary to have more studies, utilizing both qualitative and quantitative methods, that focus on developing and testing instruments sensitive enough to adequately assess and monitor residents' pain states, particularly those residents who present with cognitive impairments. Utilization of such instruments would eliminate much loss of time in evaluation of effectiveness of pain strategies.

Study participants identified many barriers that prevented them from getting to know their residents and assuming the helping role. Nurses are required to overcome these barriers in order to achieve any success with managing pain. Qualitative research studies are needed to gain the perspective of other nurses and other members of the health care team in both long term care and other practice settings. It is also vital that qualitative studies be done to document the residents' perspectives on appropriate pain strategies and

perceptions of nursing actions taken to manage their pain. As well, it is important to examine the perspective of families or significant others regarding residents' pain issues. Understanding various perspectives can facilitate the construction of a more comprehensive pain management model to guide health care providers in the management of pain.

### **Recommendations for Nursing Practice and Education**

Nurses' perspectives reveal that barriers to effective interventions in managing pain lie within the attitudes and beliefs of staff and residents and within the long term care setting itself. In order to provide a better quality of life for elderly residents, it behooves the organization to have a coordinated approach to review policies, to educate and involve all levels of administration and staff, as well as residents and families, about pain issues. The organization must focus on the specific problem of pain and the management practices and reinforce a commitment to regular monitoring and ongoing policy review and/or policy revision.

It is also recommended that attention to pain issues be regarded as a key practice initiative within quality assessment and quality initiatives programs. Standards in the area of pain management principles and skills must be set according to evidence based information, and be used to guide the development of clinical practice guidelines to direct health care providers' efforts. The

resources (both human and material) identified as necessary should be provided to support nurses in their ongoing exposure to patients/residents in pain.

It is also recommended that a concerted effort be made to engage nurses in self-analysis of their attitudes and biases regarding managing residents' pain. It is through a critical reflective process that nurses develop a greater appreciation of how negative attitudes diminish care quality.

### **Conclusions**

The purpose of this study was to investigate factors that influence nurses' pain management practices with elderly people in long term care settings. A second purpose was to identify, describe, and provide a theoretical basis for nurses' experiences with pain management in this setting. Despite the limitations of the study design the following conclusions have been reached based on the data analysis and theoretical insights.

Nurses' perceptions of their experiences in managing residents' pain revolved around the need to first develop therapeutic relationships in order to get to know each person individually. By combining knowing the person with becoming aware of the situational context of the person complaining of pain, the nurse gathered insightful information which could be used to facilitate pain management. There may or may not have been a reliance on pain theory to guide and direct nurses' actions. However, study findings suggest that

knowledge of the residents over time - time spent together forging the nurse/resident relationship - served to guide and direct nursing actions.

Nurses had to overcome numerous barriers on a consistent basis. The ability to avoid or modify barriers was the most significant factor influencing positive outcomes. Administrators and clinical leaders need to be aware of the impediments that exist within their organizations and explore possible ways to overcome them.

The perceived degree to which barriers can be overcome will reflect the nurses' abilities to be successful with pain management interventions. Nurses' actions (i.e., learning about and coming to know the resident; adapting the nursing approach to care; evaluating and modifying behaviours; and advocating on behalf of the residents) can help determine the quality of life (i.e., mild, moderate, severe pain state, partial pain control, or pain free state) for residents living in nursing homes.

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**APPENDIX A: Permission to Access Participants and Study Summary**

Administrator  
Nursing Home  
St. John's, NF  
A1B 1F5

Dear \_\_\_\_\_:

I am seeking permission to conduct a research study, "Nurses' Experiences with Pain Management in Long Term Care Settings: A Grounded Theory Approach," as part of the requirement for a Master's Degree in Nursing. The proposed study is under the supervision of Dr. Christine Way. I have attached a summary of the proposed study for your information.

The study population under focus is registered nurses working in the long term care practice area. In consultation with you, I would like to identify potential study units and the appropriate nurse managers. I would also like to speak with the nurse managers of the units in your facility by telephone and have them introduce this study to their nursing staff. I am requesting permission to interview approximately six to seven registered nurses working in your facility.

Permission will be sought from the Human Investigations Committee, Memorial University of Newfoundland before the start of this study.

I would like to meet with you to discuss this process. I would assure you that you are under no obligation to grant any permission; however your cooperation will be greatly appreciated. I can be contacted at the above address and/or telephone number.

Thank you,

Mary Ellen Dominie

### **Summary of Nursing Study**

**Title:** Nurses' experiences with pain management in the long term care setting: a grounded theory approach.

**Investigator:** Mary Ellen Dominie

**Supervisor:** Dr. Christine Way

**Purpose:** To explore the experiences of nurses regarding pain management in the long term care setting.

**Objectives:**

- 1) Identify and describe nurses' assessment techniques when managing pain in patients who have acute and/or chronic pain;
- (2) Identify and describe nurses' intervention strategies with these clients;
- (3) Identify and describe nurses' evaluation of patients' responses to interventions;
  
- (4) Determine perceived barriers to effective pain management.

**Rationale:** Nurses' knowledge, attitudes and beliefs influence the pain management strategies used with their patients. The literature suggests that nurses do not always use effective assessment and evaluation techniques when managing patients' pain, have poor knowledge about analgesics, and are erroneous in their assumptions about patients and their pain. There are few studies on nurses who work with geriatric clients, especially those located in long term care facilities.

**Brief description of the Study:** This study will use a grounded theory design that seeks to generate conceptual categories and a theoretical model that captures nurses' pain management experiences with long term care clients. Approximately 25 nurses who work in the long term care setting will be interviewed. Each nurse will be interviewed twice - 60 minutes for the first and 30 minutes for the second interview. Taped interviews will be transcribed within 48 hours and checked for accuracy by the researcher's thesis committee members. The constant comparative method of analysis will then be applied to each data set by the researcher under the tutelage of the thesis committee.

**Procedure for obtaining consent:** Potential participants will be initially contacted by the nurse manager of the unit where they work. Those who express an interest in participating will then be contacted by the researcher who will explain the study more fully. Participants' written consent will be obtained by the researcher prior to the interview.

**Proposed starting date:** September 9, 1996

**APPENDIX B: INFORMED CONSENT**

**School of Nursing, Memorial University of Newfoundland,  
St. John's, NF**

**Consent to Participate in Nursing Research**

**Title of the Study:** Nurses' Experiences with Pain Management: A Grounded Theory Approach

**Investigator:** Mary Ellen Dominie, R.N., M.N. (candidate)

You have been asked to participate in a research study. Participation in this study is entirely voluntary. You may decide not to participate or may withdraw from the study at any time.

Confidentiality of information concerning participants will be maintained by the investigator. The investigator will be available during the study at all times should you have any problems or questions about the study.

**Purpose of the study:** You are being asked to participate in a research study of nurses' experiences with pain management. The purpose of this study is to explore nurses' perceptions of pain management in long term care settings and to identify factors that impede or facilitate pain management efforts.

**Description of the Procedure:** You are being asked to participate in two interviews which will be conducted at a place and time that is convenient for you. Interviews will be audiotaped (with your permission). The tape will be used solely to assist the interviewer in remembering details of your conversation, and will be made available only to the researcher.

During the first interview you will be asked to describe your experiences with pain management of your patients. You will be asked about how you assess, intervene and evaluate your efforts at pain management. You will also be asked to identify possible barriers to and/or facilitators of effective use of both pharmacological and non-pharmacological pain management strategies.

Within two months following the first interview, you will be contacted for a second interview. At this time you will be asked to read a summary of the first interview and confirm whether it accurately reflects your experience with pain management. You will be given the opportunity to provide any additional information.

**Duration of interview:** The first interview will take approximately 60 minutes, the second approximately 30 minutes.

**Foreseeable Risks, Discomforts or Inconveniences:** There are no expected risks from participating in this study. You may refuse to answer any questions which make you feel uncomfortable, and terminate the interview at any time. All information that you provide will be kept strictly confidential, secured in a locked file and accessible only to the interviewer. Neither your name nor the name of your unit or facility will appear on the audiotape or written copy. Any names you might mention during the interview will be removed from the transcript. All tapes will be erased following study completion.

**Benefits:** You may not derive any direct benefits from this study. However, the information that you provide may help nurses develop more effective pain management strategies.

**Other information:** Findings from this study will be available to you and other health care professionals upon request.

**Your signature on this form indicates you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigator from her legal and professional responsibilities.**

I, \_\_\_\_\_, the undersigned, agree to participate in the research study described.

Any questions have been answered and I understand what is involved in this study. I realize that participation is voluntary and there is no guarantee that I will benefit from my involvement. I acknowledge that a copy of this form has been given to me.

\_\_\_\_\_  
Signature of participant Date

\_\_\_\_\_  
Signature of witness Date

I, \_\_\_\_\_, the undersigned agree to be audiotaped during the interviews.

\_\_\_\_\_  
Signature of participant Date

\_\_\_\_\_  
Signature of witness Date

To the best of my ability I have fully explained the nature of this study to the participant. I have invited questions and provided answers. I believe that the participant fully understands the implications and voluntary nature of the study.

\_\_\_\_\_  
Signature of interviewer Date

\_\_\_\_\_  
Telephone Number

**APPENDIX C: Interview Schedule**

### **Interview Schedule**

I am interested in your experiences with pain management in a long term care setting. You have probably had numerous instances in which you have had to deal with your patients'/residents' pain, and had to determine strategies to assist your patients. I would like for you to take some time to reflect upon these experiences and tell me about it. Feel free to talk about whatever comes to mind concerning pain management with your patients/residents.

#### **Examples of Questions/Probes:**

1. Tell me how you try to assist your patients with pain management?
2. What strategies do you usually utilize to assess patients' pain?
3. What interventions do you implement with these patients? I am interested in both pharmacological and non-pharmacological strategies.
4. How do you evaluate your patients' responses to your interventions? How do you know when your strategy has been successful?
5. Are there identifiable factors that could serve as facilitators/barriers to effective pain management?
6. What knowledge base is necessary for effective pain management?

**APPENDIX D: Letter of Approval from HIC**



# Memorial

University of Newfoundland

Office of Research and Graduate Studies (Medicine)  
Faculty of Medicine  
The Health Sciences Centre

26 August 1996

**TO:** Ms. Mary Ellen Dominie

**FROM:** Dr. Verna M. Skanes, Assistant Dean  
Research & Graduate Studies (Medicine)

**SUBJECT:** Application to the Human Investigation Committee - #96.120

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The Human Investigation Committee of the Faculty of Medicine has reviewed your proposal for the study entitled "Nurses' Experiences With Pain Management: A Grounded Theory Approach".

Full approval has been granted for one year, from point of view of ethics as defined in the terms of reference of this Faculty Committee.

For a hospital-based study, it is your responsibility to seek necessary approval from the Health Care Corporation of St. John's.

Notwithstanding the approval of the HIC, the primary responsibility for the ethical conduct of the investigation remains with you.

\_\_\_\_\_  
Verna M. Skanes, Ph.D.  
Assistant Dean

cc Dr. K.M.W. Keough, Vice-President (Research)  
Dr. E. Parsons, Vice-President, Medical Services, HCC  
Dr. C. Way, Supervisor

**APPENDIX E: Support Letter**

## St. Patrick's Mercy Home

146 ELIZABETH AVENUE

St. John's, Nfld.

Canada

A1B 1S5

23 August 1996

Ms. Mary Ellen Dominic  
21 Halifax Street  
St. John's, NF  
A1A 2P6

Dear Ms. ~~Dominic~~:

*Mary Ellen:*

This letter is in response to your request for permission to interview registered nurses of St. Patrick's Mercy Home as part of a research study pertaining to Pain Management in Long Term Care Settings.

St. Patrick's Mercy Home is honoured to be part of this nursing research and most interested in your future results. Please feel free to contact Mrs. Dorothy Power, Director of Nursing (726-2687 Ext. 280) at your convenience to initiate your interview schedule. You are invited to access interview space at this facility, also at your convenience. Please do not hesitate to ask us for any further assistance. Nursing research in Long Term Care is essential if we are to continuously improve upon our services to seniors and their families.

I wish you success in your research, but most importantly I hope you enjoy your efforts. Please do not hesitate to call me personally, for moral support if nothing else.

Sincerely,

KATHERINE TURNER  
Administrator

KT:lds

cc: Mrs. Dorothy Power  
Director of Nursing





