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NURSES' PAIN MANAGEMENT PRACTICES IN ONTARIO LONG-TERM CARE HOMES

by

JUSTIN OLUWASEGUN ROJAYE

Submitted in accordance with the requirements
for the degree of

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at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF. M.M. RAMUKUMBA

NOVEMBER 2019

Student Number: 6082 558 8

DECLARATION

I declare that **NURSES' PAIN MANAGEMENT PRACTICES IN ONTARIO LONG-TERM CARE HOMES** is my work and that all the sources that I have used or quoted have been indicated and acknowledged using detail references and that this work has not been submitted before for any other degree at any other institution.

NOVEMBER 2019

Justin Oluwasegun Rojaye **Date**

DEDICATION

The Almighty God

My wife; Florence Abiodun Rojaye, and

My children; Augustine Ibidamola Abimbola, Pius Oyinkonsola Abimbola

and Esther Moyosolaoluwa Abimbola.

ACKNOWLEDGEMENTS

I give all the glory to God, for the great things He has done. Without Him, I could not have finished this dissertation.

I firmly believe it would not be worth talking about this work without acknowledging various important people whose uncountable and infinite contributions have brought this study to a conclusion. My very first sincere thanks go to my Lord Jesus Christ for granting me the grace and mercy to see the end of my programme, for the gift of an excellent supervisor and research participants whose responses made this study a success.

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I sincerely thank all the nursing staff of the nursing homes for their participation in this study. I appreciate their preparedness to share personal experiences and recommendations for the sake of improving the care of institutionalised elderly adults.

NURSES' PAIN MANAGEMENT PRACTICES IN ONTARIO LONG-TERM CARE HOMES

STUDENT NUMBER:	**6082 558 8**
STUDENT:	**JUSTIN OLUWASEGUN ROJAYE**
DEGREE:	**MASTER OF ARTS**
DEPARTMENT:	**HEALTH STUDIES**
SUPERVISOR:	**PROF MOKHOLELANA MARGARET RAMUKUMBA**

ABSTRACT

Pain is the most prevalent medical problem that elderly persons experience in a long-term care home. Nurses play an essential role in managing their pain. The purpose of this study was to explore nurses' pain management practices in Ontario long-term care homes facilities. The ultimate aim was to recommend measures for effective pain management in aged people.

The setting for this study was a selected long-term care home in Ontario, Canada, a 160-bed nursing home for aged people offering various medical care services. Semi-structured focus group interviews, averaging approximately one hour, were conducted. The population of this study was 45 nurses. The researcher used a purposive sampling method to select a sample of 25 nurses. Open-ended questions were used to explore pain management practices and to find barriers to effective pain management. Qualitative data analysis was used to review the data to identify common issues that recurred, and they were summarised in a narrative form.

This study demonstrated the importance of recognising and overcoming barriers to the effective management of pain and reinforcing good practices in long-term care homes. Therefore, improved pain management practices are required to manage pain in a long-term care home effectively.

Keywords: *Long-term care home, nurses, pain, pain management practices, pain management guidelines.*

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LIST OF ABBREVIATIONS

AMDA	American Medical Directors Association
BP	Blood Pressure
FG1	Focus Group One
FG2	Focus Group Two
FG3	Focus Group Three
FPS	Faces Pain Scales
HR	Heart Rate
IASP	International Association for the Study of Pain
KASRP	Knowledge and Attitudes Survey Regarding pain
LTC	Long Term Care
NRS	Numeric Rating Scales
O2	Oxygen Saturation
PRN	When Necessary
PSW	Personal Support Workers
R	Respiratory Rate
RNAO	Registered Nurses' Association of Ontario
RN	Registered Nurses
T	Temperature
UNISA	University of South Africa
VAS	Visual Analog Scale
VDS	Verbal Descriptor Scale
WHO	World Health Organisation

CHAPTER 1
ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Pain is the experience that emanates from injury or harm to any part of the human body, which includes four processes: transduction, transmission, perception, and modulation (Urden, Stacy & Lough 2013:67). Pain management is the process of decreasing the pain experience or reducing pain to a level that is tolerable to the affected person. Effective pain management includes two basic types of nursing strategies, namely pharmacologic and non-pharmacologic. Dealing with pain calls for interprofessional efforts; however, nurses play a crucial and multifaceted position in pain management in hospitals (Registered Nurses' Association of Ontario (RNAO) 2013:18). Nursing interventions, inclusive of continuous assessment of the effect of pain treatment, standardised pain assessment, and the proper use of pharmacological and non-pharmacological strategies for pain comfort, are the basics of effective pain management (Saslansky, Rothaug, Chapman, Bäckström, Brill, Fletcher et al. 2014:494). Aged people in long-term care homes need to have access to effective pain management. This requires nurses with the right attitude, the necessary beliefs and skills to provide excellent pain management.

This chapter presents the background, purpose, and specific objectives of the study. Also, a general view is presented of the justification for conducting the study and its implication to nursing practice at the long-term care home. Therafter, the research methodology is summarised as details are provided in Chapter 3.

1.2 BACKGROUND OF THE STUDY

According to the International Association for the Study of Pain, pain is an unpleasant sensory and emotional outcome related to tissue injury (Fleckenstein 2013:52). To improve pain management and provide adequate nursing care, it is vital to develop effective pain management pathways. This can be achieved when nurses' interpretation of the aged person's pain expression and factors related to pain

management in a long-term care home are identified. There is considerable and unequivocal proof that the Canadian populace is ageing at a rate that is unsupportable by current social and healthcare facilities (Busby & Robson 2013:16). As per Statistics Canada (2013:2), the fastest developing age amass is that of senior nationals (those matured >65 years). It was determined that five million Canadians were 65 years old or older in the year 2011 (Statistics Canada 2013:2); this number of elderly Canadians is expected to triple over the next 20 years, and by the year 2051, roughly one out of every four Canadians are likely to be older than 65 (Statistics Canada 2013:2).

One of the concerns is that increasing age is related to an increased rate of morbidity. It is also believed that with growing age, there is an unavoidable decrease in the effectiveness of the use of human body parts due to medical problems (Lee-Meyer 2016:104). This prompts an understanding of the general wellbeing of older adults, and the capacity to oversee comorbidities and maintain a decent personal quality of life (Lee-Meyer 2016:104). For instance, joint inflammatory diseases, hypertension, diabetes, osteoporosis, and Alzheimer’s are illnesses related to the ageing process and regularly thought to be inescapable (Lee-Meyer 2016:104). An estimated 45% to 80% of older adults in long-term care home facilities experience significant chronic pain. Inadequately managed pain negatively affects bodily and emotional health and impairs the overall quality of life in this population. Additionally, the results of untreated or undertreated pain add to the burden on healthcare resources. Most elderly individuals in long-term care homes have dementia, comorbidities, and communication problems (Reid, O’Neil, Dancy, Berry & Stowell 2015:29).

In recent years, it has been established that pain in older people is a particular area of unmet need (Keogh 2014:1927). The interest in improving geriatric pain management has developed alongside the increasing number of aged people, which has prompted research on this topic (Keogh 2014:1927). Pain management in aged persons in long-term care homes is grounded on a need to provide all-inclusive care and support throughout their stay in long-term care homes. Pain can result from disease itself or painful diagnostic procedures or treatments (Boehmer 2016:197). Furthermore, if the pain is not treated, it can prompt and cause an inability to partake in routine social activities which may then negatively affect daily living activities (Law, Groenewald, Shou & Palermo 2017:43).

Nurses are the primary healthcare providers in Ontario’s long-term care home facilities (Almost, Gifford, Doran, Ogilvie, Miller, Rose et al. 2013:1). Adequate pain management information and understanding that includes the use of research evidence in clinical decision-making are thus needed to optimise nursing practice and promote positive health outcomes within Ontario’s long-term care home settings (Almost et al. 2013:2). The complex health needs of aged people in long-term care homes require nurses to have specific pain management competence, and reliable assessment and clinical decision-making skills to care for aged people who may notably need healthcare, but may not be aware of how to meet their health needs (Almost et al. 2013:1). Responsibilities for nurses in long-term care homes include aspects of outpatient care, rehabilitative nursing care, emergency nursing, mental health, occupational health, and community health. Additionally, while healthcare delivery is vital, there may be an ongoing barrier to pain management among the elderly’s health needs (Almost et al. 2013:2).

Many aged people in long-term care homes have multiple diagnoses ranging from substance abuse, physical ailments, and mental health disorders. These individuals often come from communities that have poor health promotion and disease prevention practices due to a lack of education and limited income (Baybutt & Chemlal 2016:70). Additionally, diverse individuals, constituting a multi-professional group, are included either directly or indirectly in the management of pain in long-term care homes. Nurses, as compared to other multidisciplinary team members, take a leading position in the management of pain. This is due to the nurses’ proximity to patients. They are in a position to alleviate pain and improve comfort through assessing, designing care practices to alleviate pain, documenting, and monitoring (Birchenall & Adams 2014:144). Nurses also offer emotional and individualised help to aged people in long-term care homes. In stressful situations, nurses coordinate the care by referring aged people to physicians or professionals who specialise in pain management (Birchenall & Adams 2014:145).

In their study that explored nurses’ knowledge and barriers regarding pain management in Taiwan intensive care units, Wang and Tsai (2014:3192) found that the level of knowledge of pain management is significantly related to barriers to effective pain management. Therefore, effective pain management for aged people is

grounded on a need to provide all-inclusive care and support that is multi-sectional and includes physical, psychological, social and spiritual aspects (World Health Organisation (WHO), 2015:4). At the long-term care home selected as the setting for this study, a team of physicians, nurses, physiotherapists, dieticians, recreational therapists, and social workers provide medical services to aged people. When these elderly people return to the long-term care home from the community or hospital, they are assessed by a nurse at intake in the assessment unit. Their healthcare needs are mapped out, and any necessary appointments are made. A comprehensive healthcare plan is also developed in collaboration with the client and family to meet their health needs (WHO 2015:5). According to the Canadian Nurses' Association Code for Nurses (Van Harten 2013:48), the aged person who is admitted to a long-term care home frequently comes from social and cultural groups whose traits and behaviours may evoke negative responses from their caregivers. However, this study primarily focused on registered nurses' beliefs and attitudes towards the pain management of aged people living in long-term care homes.

1.3 STATEMENT OF THE RESEARCH PROBLEM

Relieving pain and discomfort are regarded as the primary duty of healthcare workers, including nurses; it is an ultimate human right for all long-term care home residents (Wykle & Gueldner 2013:145). Nurses in long-term care homes are expected to provide effective, appropriate health care to those in pain. Yet pain management among older adults residing in long-term care homes continues to present multifaceted challenges to healthcare practitioners and researchers. Nurses who deliver health care to aged people are challenged to do so in a kind relationship that will support their clients' health and healing (Christensen 2014:2). Stockler and Wilcken (2013:1907) found that pain is ineffectively controlled and more than 73% of hospitalised aged people with pain continue to suffer from uncontrolled pain. However, pain inherently involves a degree of subjectivity. It is therefore often ignored and undertreated in older adults residing in a long-term care home (Salmanowits 2015:140). Thus, assessment and decisions regarding pain management can be influenced by the biases and personal values of caregivers (Salmanowits 2015:142).

The researcher observed that although pain can be effectively managed, there seems to be under-treatment of pain in the long-term care home. Questions thus arose regarding how nurses perceive and respond to pain expressions by their clients in a long-term care facility, how they assess and manage their clients' pain, and lastly, how contextual factors influence their pain management practices. Hence, the need for this study.

1.4 PURPOSE OF THE STUDY

The purpose of this study was to explore nurses' pain management practices in Ontario long-term care homes. The aim was to recommend measures for effective pain management practices among older adults.

1.5 RESEARCH OBJECTIVES

The objectives of this study were:

- To explore nurses' interpretation of an aged person's pain expression in the long-term care home facility.
- To describe nurses' responses to an aged person's expression of pain.
- To examine nurses' beliefs and attitudes to pain management in a long-term care home facility.
- To identify factors related to pain management in a long-term care home facility.

1.6 RESEARCH QUESTIONS

The questions driving this study were:

- How do nurses interpret and respond to pain expression by aged people at a long-term care home facility?
- What are nurses' beliefs and attitudes about pain management in a long-term care home facility?

- What are the factors related to the effective management of pain among aged people at a long-term care home facility?

1.7 SIGNIFICANCE OF STUDY

This study may add to the overall awareness surrounding possible reasons why current pain management within long-term care homes is viewed as suboptimal (Herman, Johnson, Richie & Parmelee 2014:1258). The recommendations of this study will offer insights into how nurses interpret and respond to an aged person's pain expression in the long-term care home facility. The study also highlights nurses' beliefs, attitudes, and factors related to their management of pain in this context.

This study may help to guide the path for future pain management of an aged person living in a long-term care home facility. The researcher's findings may also contribute to the broader discourse on pain management practices and generate questions that will lead to further study on evidence-based pain management practices in long-term care home facilities. The study is expected to benefit society by providing insights that will strengthen nursing practices, thus ultimately improving the quality of healthcare provided to aged people.

Moreover, the study results may contribute to advancing the nursing profession and the recognition of their role in the Ontario long-term healthcare systems, and offer insights into various levels of policy in the Ontario long-term healthcare delivery system. Pain assessment and management are necessary components of nursing care for aged people in a variety of settings. With the many advances in pain management options over the last 20 years, it is interesting that nurses continue to ineffectively manage aged people with pain (Valeberg, Kolstad, Småstuen, Miaskowski & Rustøen 2013:430). Consequently, the study may serve as an initial step in assessing long-term care home needs for enhancing the quality of nursing care being delivered to aged people in Ontario long-term care home facilities. Also, the researcher proposes significant areas for future research in Chapter 4.

1.8 DEFINITIONS OF KEY CONCEPTS

- **Aged person:** Old age encompasses "the latter part of life; the period of life after aged and middle age, usually concerning deterioration" (WHO 2016). The United Nations has agreed that 60+ years may usually be regarded as old age (WHO 2016). In this study, an aged person is one living in a long-term care home and older than 65 years.

- **Attitudes:** Attitude is a settled opinion and behaviour based on aware or subconscious intellectual views evolved through an individual set of unseen actions (Davis 2016:189). Attitude is a way, disposition, feeling, or the role of a person or component; it is tendency or orientation, specifically of thoughts. In this study, attitude is the set of behaviour nurses exhibit when providing care to an aged person in pain.

- **Beliefs:** Belief is defined as something that is generic, considered to be actual, or held as an opinion. It is something believed as the conviction of the fact of some statement, or the fact of some being or phenomenon, primarily based on an examination of evidence (Schneemann, Ehn, George, Vicky, Alison, Ishmael et al. 2013:3). In this study, belief is the set of opinions nurses have towards the pain management of an aged person.

- **Interpretation:** Interpretation can be defined as the critical analysis of a patient's history and complaint to assist with clinical decision-making (Johansen & O'Brien 2015:42). In this study, interpretation is referred to as the summary of decisions a nurse takes in managing pain in aged people.

- **Long-term care home:** A long-term care home relates to where aged or older people are living in a community. Such facilities care for individuals who can no longer adequately care for themselves (Anjaria 2013:3). In this study, a long-term care home is a setting where nurses provide various in-patient nursing care services to aged people who cannot meet their daily health needs.

- **Nurses:** The Canadian Nurses Association defines the "Registered Nurse (RN) as individual self-regulated health-care professionals who provide nursing services to individuals, families, groups, communities, and populations to achieve their ideal levels of health" (The Canadian Nurses Association 2015:13). In this study, a nurse refers to registered nurses working within a long-term care home located in Ontario, Canada.

- **Pain:** According to the definition published in 1979 by the International Association for the Study of Pain (IASP 2014:2), pain is defined as an unpleasant sensory and emotional experience related to real or capacity tissue harm, or it can be described in terms of such damage. In this study, pain is defined as an unwanted physical sensation the aged person experiences while they are in a long-term care home facility.

- **Pain expression:** Pain expression is the various ways in which pain is communicated through verbal or non-verbal communication. In this study, the pain expression is typically the way in which an aged person makes their pain known through self-reporting and nurses' observations.

- **Pain management practices:** Pain management is an all-inclusive pain management approach that includes pain assessment; appropriate pharmacologic and non-pharmacologic interventions; education of the patient, family, and caregivers about the plan; ongoing assessment of the treatment outcome; and regular reviews of the treatment plan with evaluations of the outcome (Oliver, Coggins, Compton, Hagan, Matteliano, Stanton et al. 2013:172). In this study, pain management practices refer to the interpretation and responses among nurses to pain expressed by aged people in a long-term care home.

- **Resident:** A resident is a person who permanently resides in a place or on a long-term basis. In this study, the resident refers to an aged person living in a long-term care home facility because they cannot conduct necessary daily living activities as a result of illness or old age. They maintain the same rights as an individual in the broader community.

- **Response to pain:** In this study, response means the set of actions a nurse plans to initiate to help the elderly meet their health needs. Pain response will vary not only according to the individual experiencing the pain but also depending on the internal and external stimuli at hand within the context (Stolsman, Danduran, Hunter & Bement 2015:2436). The response to pain in this study is a set of nurses' actions implemented for the benefit of an aged person in pain.

1.9 RESEARCH METHODOLOGY

In this study, a qualitative research approach was utilised. The research methodology outlines the research design, sampling and sample characteristics. The instruments, data collection and analysis approaches that were utilised to achieve the research objectives of this study are also included. The study utilised a qualitative approach using the non-experimental, exploratory and descriptive method. The research methodology is a systematic scientific method to solve a problem; it involves techniques used to structure the study and gather and analyse information (Polit & Beck 2016:391). Brink, Van der Walt and Van Rensburg (2014:199) further explain that the research methodology tells the reader how the research was carried out; in other words, what the researcher did to find solutions to the research problem or to answer the research question. The qualitative approach was appropriate for this study as it was used to obtain an in-depth understanding of nurses' current pain management practices for aged persons in the long-term care home. A detailed discussion is provided in Chapter 3.

1.9.1 Research design

The research design refers to a general plan for conducting a research project that includes data collection, sampling, ethics, and analysis (Vogt, Haffaele & Gardner 2013:340). The study used a qualitative, explorative, descriptive research design. A detailed discussion of the research design is provided in Chapter 3.

1.9.2 Population

The population of a research study comprises the whole group of individuals that one wants to describe and understand (Gideon 2013:53). The target population of this study was all 45 nurses in the selected long-term care home. Nurses were considered to be useful and relevant participants, as they were directly involved in the management of pain for elderly persons.

1.9.3 Sampling and sample

Sampling entails the selection of particular participants in studies from the entire population or the method by which a sample is taken (Cottrell 2014:125). As a result of the qualitative nature of this study and the need to obtain in-depth information that applied to the research questions and objectives, the researcher used a non-probability sampling approach to select the study participants.

1.10 RESEARCH SETTING

The selected long-term care home is a 160-bed facility with 24-hour nursing and personal care, access to the family physician and other health professionals. Since it opened in 2004, the selected long-term care home has been providing nursing services to aged people. It offers a flexible, comfortable home environment.

1.11 DATA COLLECTION

According to Saldana (2014:31), data are collected to understand the participants' experiences and to document the meanings that participants have created of those experiences. The researcher used a semi-structured data collection approach, such as focus groups, which means that only broad suggestions were used to direct the data collection method. The rationale for this method is that it allows for greater in-depth, more significant, thoughtful responses. Experiences are no longer based entirely on preconceived answers, and they are appropriate for explanatory studies as they provide a wealth of diverse information (Saldana 2014:31). Data were collected

with the assistance of a scribe who took notes on all responses so that the researcher was able to lead the focus group discussion.

1.11.1 Data analysis

According to De Vos, Strydom, Fouché and Delport (2014:399), data analysis in qualitative research is a process of inductive reasoning. It is completed during and after data collection. The study followed a thematic analysis to examine data and discover themes that recurred, and these were summarised in a narrative form. An in-depth account of the data analysis strategies is provided in Chapter 3.

1.12 MEASURES TO ENSURE TRUSTWORTHINESS

Trustworthiness is described as the conceptual validity applied to research on qualitative data (Vogt et al. 2013:355). Lincoln and Guba's methods (1985) were used to ensure reality, applicability, consistency, and neutrality. These measures were taken to ensure the trustworthiness of the study, and are discussed in more detail in Chapter 3.

1.13 ETHICAL CONSIDERATIONS

Research ethics comprise of principles, standards, and values that drive appropriate conduct in research decisions (Cottrell 2014:331). It can also refer to applied ethics that seek to ensure that the welfare of the research participants is protected (Terre Blanche, Durrheim & Painter 2014:563). Additionally, Grove, Gray and Burns (2015:100) claim ethics are basic rights that include self-determination, privacy, anonymity and confidentiality, fair selection, fair treatment, and protection from discomfort and harm.

1.14 LIMITATIONS

First, the study was focused on one central long-term care home facility belonging to a chain of long-term care home facilities, and therefore the generalisability of the discussed results is not feasible. Secondly, the current study focused primarily on

registered nurses' perspectives regarding current pain management practices for aged persons. Other pain management dimensions of the nursing practice were excluded. In this qualitative study, the researcher was not interested in the generalisation of findings, but in gaining in-depth information about the pain management practices from registered nurses' perspectives, and identifying factors related to pain management.

1.15 OUTLINE OF THE STUDY

Table 1.1 presents an outline of the study.

Table 1.1: Outline of the study

Chapters	Content	Content Description
1	Orientation to the study	This chapter describes the problem, background, purpose, and significance of the study. The research design and methodology are discussed, and the key terms used in this study are defined.
2	Literature review	This chapter offers a presentation of the broad perspective on nurses' pain management practices.
3	Research design and methodology	The chapter describes the research design and methodology employed during this research.
4	Presentation and description of the findings	The chapter presents data analysis, research findings and the comparison to literature.
5	Interpretations, discussions of the research findings, recommendations, and conclusion	This chapter centres on the interpretations and discussions of findings, makes recommendations for practice and further research, and concludes the study.

1.16 SUMMARY

This chapter outlined the problem, aim, and objectives of the study and defined key terms. It highlighted the background of the research problem and the significance of the study. It further outlined the research design and research methods. Chapter 2 discusses the literature review.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

The review of associated literature entails the systematic identification, location and evaluation of documents containing data related to the research problem (Aehwa & Myungsook 2014:561). The literature review has several important functions that make it well worth the effort and time. The principal motive for reviewing the literature is to determine what has already been accomplished that relates to the study topic (Aehwa & Myungsook 2014:562). This chapter presents the literature on pain management practices related to a long-term care home. The chapter gives an overview of pain as it relates to an aged person living in a long-term care home in the first section. The second section focuses on pain management practices, and the third section reviews the nurse's role in pain management. The fourth section focuses on barriers to pain management. The researcher was aware of the debates around a separate literature review chapter in qualitative studies. A stand-alone literature review is thus presented to give brief and broad perspectives regarding pain management practices among the elderly in long-term care homes (Creswell 2014:64).

2.2 OVERVIEW OF PAIN

Pain is an individual subjective negative experience and multi-dimensional process related to physiological, sensory, affective, cognitive, behavioural, and socio-cultural aspects (Cho & Whang 2018:53). Pain is a common occurrence of human existence and may be experienced by humans of all ages, cultures and social statuses in a given community (May, Brcic & Lau 2018:250). Nevertheless, most nursing curricula do not include enough data on pain identification and the type of data required to efficiently describe pain therapy (Plalsance & Logan 2016:167). Additionally, understanding the complex process of pain etiology is necessary for suitable pain assessment and management. Therefore, this study also believes that pain is a subjective experience reported by residents in a long-term care facility. Pasero and McCaffery (2014:37) have defined pain as "whatever the experiencing person says it is, existing whenever

she/he says it does". This definition indicates that a person is a trustful primary origin of pain reporting. By itself, the person's statements are the primary indicator of pain, and some scales may help to define the severity of the reported pain.

An internationally recognised definition by the International Association for the Study of Pain states that "pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage" (IASP 2014:4). Pain causes many patients to look for medical attention, and is classified either as acute or chronic. Acute pain is short-term and is usually resolved by treatment. It is a symptom that has an identifiable cause and biological function (Yavus 2014:54). By contrast, chronic pain is long-lasting; the cause is often unidentifiable and is a response to unknown peripheral or central changes in the somatosensory cortex (Yavus 2014:54). In aged people, the most common causes of pain are musculoskeletal disorders (Reid et al. 2015:32).

2.2.1 The prevalence of pain in the aged people

Pain impacts more than 50% of older men and women living in long-term care homes and more than 80% of those who live in nursing homes (RNAO 2013:23). Extended suffering may additionally cause inaction and a failure for the affected person to perform regular social activities and daily living roles, which may result in anxiety and sleep issues (Law et al. 2017:43). Treating pain in older people can be challenging because of an accelerated range of comorbidities; thus, they have more than one etiology (Pasero & McCaffery 2014:11).

Within the long-term care setting, pain management appears to be suboptimal. Several researchers have documented a high prevalence of undertreated pain in long-term care, which could indicate shortcomings in current pain management techniques (Tse & Ho 2014:682; Reid et al. 2015:34; Paice 2018:2). In addition to being undertreated, it has been stated that pain is regularly underreported and unrecognised in long-term care settings (Tse & Ho 2014: 684). Those shortcomings tend to be more significant and frequent in people aged 85 years and older, and among people with cognitive impairment (Tse & Ho 2014:4).

Pain prevalence increases with increasing age among elderly people (Satghare, Chong, Vaingankar, Picco, Abdin, Chua et al. 2016:2). Individuals with cognitive impairment associated with dementia, depression, and delirium present a barrier to pain management because older adults with these conditions may not be able to communicate their pain. Another study stated that pain in older men was associated with increased frailty. It was also indicated that mood might be a more significant factor in the relationship between pain and frailty than physical illnesses (Quach, Gagnon, Dugan, McLean, Yang, Cho et al. 2017:492). The prevalence of persistent pain has been shown to rise with age and has been recognised in approximately 65% of the older adult population (> 65 years of age) living in the community, and 80% of older adults living in long-term care facilities (RNAO 2013:19).

2.3 NURSES' PAIN MANAGEMENT PRACTICES

Pain management indicates pain-free action such as taking pain medication or applying cold or hot compresses. Pain management includes a mixture of pharmacological and non-pharmacological measures (McPhee & Papadakis 2014:72). According to RNAO (2013:19), nurses have an important role in pain management practices in the long-term care home. Although other healthcare providers are directly or indirectly involved in the assessment and management of a resident's pain, nurses spend more time in direct contact with residents receiving health care. This responsibility places nurses in a unique position to assess for pain, and, if the assessment shows that there is pain, to move forward with the implementation of comprehensive pain management (RNAO 2013:19). When implementing an assessment for the presence or risk of any pain, it is critical for the nurse to ask direct questions about pain rather than assuming the resident or their family will voluntarily disclose it (RNAO 2013:19).

Kaasalainen, Brasil, Akhtar-Danesh, Coker, Ploeg, Donald et al. (2013:667) conducted a study on interdisciplinary pain interventions designed for long-term care facilities. A pain protocol evolved based on excellent practices from the American Geriatrics Society (2014:14) and was implemented in four long-term care facilities in southern Ontario. Final measures covered resident pain rankings and a team of nurses' reviews regarding pain-associated issues. Documentation of pain indicators,

which include an assessment of pain on admission and the use of standardised pain assessment scales, could improve the effectiveness of pain management in long-term care homes (Kaasalainen et al. 2013:668).

In a study conducted by Mehta, Cohen, Eser, Carnevale and Ducharme (2013:39), the results revealed that aged persons were under-medicated since nurses were concerned about addiction and respiratory depression. Moreover, the specialty nurses and general nurses based their decision on the aged persons' self-report of pain. Their conclusion was that an aged person's lifestyle factors, specific to socioeconomic status, could influence the nurse's decision about pain management (Mehta et al. 2013:47).

As mentioned, pain management practice is usually problematic in long-term care homes. The practice of having nurses apply pain management strategies can be categorised into three different models: the biomedical model, the non-pharmacological interventions model, and the alternative medicine model, including such treatments as acupuncture (Stewart & Cox-Davenport 2015:499). These elements affect the nurse when assessing, evaluating, and interpreting residents' statements, behaviour, physical reactions, and appearance. The greatest barrier to the resident receiving effective pain management may thus be nurses (Stewart & Cox-Davenport 2015:500).

2.3.1 Pain relief practices

The problems associated with pain can greatly reduce the quality of life for older adults. Quality care is a compound problem that calls for simultaneous focused development efforts in more than one area of nursing home operations. Changes in approaches to pain management in a long-term care home and subsequent assessment of resident results, sustained over time, will enhance residents' quality of life (Russell, Madsen, Flesner & Rants 2014:54). Studies show that using an evidence-based procedure for the selection of pain-relieving medications has demonstrated to be most effective. Even though pain-relieving medications are the pillar of pain management, better methodical use of non-pharmacological pain strategies has also been found to be valuable to the elderly. Heat and massage/vibration has been reported as being

particularly effective strategies among the elderly (RNAO 2013:15). The long-term care facility must have a screening method in place for identifying pain; either by regularly asking residents if they are experiencing discomfort or observing residents for specific behaviours suggesting its presence. All direct care staff, as well as other employee groups in the facility (dietary staff, environmental services), can be taught to recognise and report possible pain to the nursing staff. Adequate pain assessment is thus a precondition for successful pain management in long-term care homes. Inadequate pain management may lead to sleep deprivation, anorexia, depression, anxiety, agitation, reduced activity and functional status, delayed healing, interference with relationships and reduced general quality of life (RNAO 2013:15).

Doctors' reluctance to refer residents with pain to other healthcare experts, including pain specialists, chiropractors and supplementary medicine practitioners, and residents' readiness to seek such care, may be affected by bias, uncertain information and the accessibility of care (Pisso & Clark 2014:198). Variables related to genetic makeup, age, race, and sex, as well as social and cultural beliefs, influence people's approach to pain relief. Given the numerous negative outcomes related to chronic pain, interdisciplinary assessment and treatment might also produce positive outcomes in a long-term care home (Pisso & Clark 2014:199).

2.3.1.1 Pharmacologic and non-pharmacologic interventions

Once an initial assessment is complete, a treatment strategy that includes both non-pharmacologic and pharmacologic approaches to pain management needs to be developed. Pharmacologic treatment is an integral component of pain management for most residents and is particularly important in the cognitively impaired population where non-pharmacologic techniques based on self-management are not as feasible. To achieve adequate pain relief, the intensity of treatment needs to match the intensity of the pain (RNAO 2013:15). The pain management strategies to be implemented ought to be customised, since not every resident will benefit from the same remedy. The mixture of non-pharmacologic with pharmacologic treatment will provide quality results (Yusuf 2016:114).

Nurses are educated on the medical procedures of opioid, non-opioid and adjuvant drug therapies (including dosages, side effects, and drug interactions) most efficient for the most likely causes of an individual's pain (Stewart & Cox-Davenport 2015:501). Regarding non-pharmacological interventions, physical exercise is a well-established approach, even in people with dementia and institutionalised older adults (Simpson, Kovach & Stetser 2014:132). Non-pharmacological interventions are the first-line therapy for responding to pain due to the high risks and limited effectiveness of analgesic medications for treating symptoms. However, nursing home providers need to be equipped with easily available instruments to identify and implement non-pharmacological procedures (Simpson et al. 2014:135). Non-pharmacological interventions must therefore be better introduced into individualised care in all nursing homes to achieve the goals of the pain management initiative (Fitssimmons, Barba, Stump & Bonner 2014:14).

2.4 NURSE'S ROLE IN PAIN MANAGEMENT

According to Kaasalainen et al. (2013:544), nurses' roles focus on a wide range of pain management activities that included assessing, planning, implementation, consulting, monitoring, advocating, educating and evaluating. Brown (2013:300) agrees that nurses play a vital role in the care of people living with pain throughout their lifespan from birth to death. They provide essential services that strongly affect the quality and effectiveness of a pain care plan. The duty of the nurses in pain management in a long-term care home is therefore important to improve the quality of residents' lives (Brown 2013:302).

Nurses are responsible for handling residents' pain efficiently through adequate medication administration, non-medication approaches such as heat, cold, change of position, easy massage, motion, bracing and communication with other pain management team members (Michael-Silbermann 2015:4). A nurse generally coordinates many aspects of pain care, such as consulting with other members of the care team. If the current treatment plan is not effective, nurses directly relay that information to the treating physician. Nurses are often instrumental in suggesting and securing a consultation with a pain management specialist or other experts (Brown 2013:300).

Nurses are also the communication bridge that links residents and the outside world. They arrange and plan appointments, such as outpatient physical therapy. In stressful situations, nurses help to coordinate care by referring residents to doctors or professionals who specialise in pain management (Birchenall & Adams 2014:145). They provide advice on how to lessen pain because they know their resident routines, such as using medication or non-medication-based therapies in advance or following activities that may cause pain (Michael-Silbermann 2015:4). They teach individuals in pain how to incorporate wellness ideas (diet, motion, relationship, and finding purpose) into the pain therapy plan and provide guidance and monitor the use of pain-tracking instruments such as a pain diary or activity log (Brown 2013:300). Moreover, they assist in the provision of emotional and individualised help to their residents.

Nurses are responsible for assuring that all residents who are experiencing pain are taken care of through effective pain management practices, both in terms of the assessment and treatment of pain using current evidence-based nursing practices. They act as a bridge between the residents and physicians; therefore, nurses should be able to convey information in a manner that enables a proper understanding of the resident's pain experience (Marchildon 2014:36). Nevertheless, this will only be done if the nurse has the necessary understanding and attitude as descrived next.

2.4.1 Nurses' competencies and skills

The College of Nurses of Ontario ensures that registered nurses and registered professional nurses are safe, able and moral practitioners by administering a quality assurance programme and enforcing standards of practice and conduct. According to the College of Nurses of Ontario (2014:1), the conceptual framework arranges nurses' competencies into four top categories of the nursing process: assessment, planning, implementation, and evaluation. There are seven broad standards stipulated by the College of Nurses of Ontario, namely accountability, continuing competence, ethics, knowledge application, leadership, and relationships. The subject of relationships is broken down into two sections: therapeutic nurse-resident relationships and professional relationships. Each standard has the same importance, and they are all interrelated. An indicator used to illustrate one standard, such as knowledge, may also demonstrate the application of another standard (College of Nurses of Ontario

2014:2). Nurses' competencies and skills must be adequate for them to be able to manage pain effectively in long-term care homes. The services provided by nurses in various contexts are meant to meet the health needs of all residents for the duration of their stay at the long-term care home. According to recent research, the competencies that are reflected in nursing practice now require a more varied range of skills and nursing beliefs to allow nurses to integrate and apply these within practice (McCabe 2013:292). Additionally, the nurse's role must focus on holistic care of the resident.

2.4.1.1 Assessment of pain

The assessment of pain is the process of identifying pain, including location, the cause of pain, and intensity through an evidence-based systemic approach (RNAO 2013:15). Assessing a resident's experience of pain is an important component in providing effective pain management practices in a long-term care home. It is a systematic process and evaluation that enhances the nurses' ability to achieve effective pain management practices (Tait 2013:625). During the assessment stage, the nurse gathers information about a resident's psychological, physiological, sociological, and spiritual status. The assessment may be performed through physical examinations, referencing a resident's health history, obtaining a resident's family history, and general observation. The self-reported pattern is strongly recommended as the most valuable method for assessing a patient in pain, as the patient's expression of their pain is the best form of communication (Van Dijk, Vervoort, Van Wijck, Kalkman & Schuurmans 2016:266).

To positively relieve pain and discomfort, correct and continual pain assessment is critical. However, the evidence shows that pain assessment is often inadequate, with many nurses not assessing pain correctly (Machira, Kariuki & Martindale 2013:343). In developing a proper pain management plan of care for aged people, the assessment must include pain intensity, as well as the pain's origin (Ferrell & Coyle 2014:47). Furthermore, the writers propose a detailed assessment for all medical and surgical patients, including the following elements: detailed history, including assessment of pain intensity, features and impacts on body functions; any history of prior analgesics used; physical examination with full neurological examination,

especially if neuropathic pain is suspected; assessment of psycho-social and cultural status; and adequate diagnostic examination to identify the cause of pain (Ferrell & Coyle 2014:47). Pain assessment is a critical method to help nurses; it can result in them offering prompt and effective treatment to residents in pain (Kunnumpurath 2014:28).

The nurse utilises a systemically appropriate, standardised pain assessment tool that includes pain measurement features. For those residents who cannot self-report, traditional pain assessment tools should include behavioural observations with or without physiologic measures (Stewart & Cox-Davenport 2015:499). The nurse should be educated regarding the difference in pain classifications (i.e., acute, chronic, breakthrough). The nurse assesses the resident's pain behaviour, including the pain experiences, means of expressing pain, cultural influences, and how each resident deals with pain (Stewart & Cox-Davenport 2015:501). Additionally, pain assessment depends on many factors that are independent to the individual resident (Pasero & McCaffery 2014:274). Other variables that can affect pain assessment include age, ethnicity, religious affiliation, marital status and social support (Gilson 2014:602).

Nurses are in a superior role in establishing the existence of pain among the aged persons in long-term care facilities (Birchenall & Adams 2014:146). By assessing pain, nurses can provide adequate methods of managing pain and measuring the results of the pain management strategies being applied. Establishing the existence of pain should thus be achieved because not all those suffering from pain are willing to disclose it, unless openly asked by healthcare professionals or family members (Maryann-Godshall 2015:1187).

Since some residents cannot convey their pain to the nurse, the utilisation of traditional instruments in measuring pain is considered critical (DeGooyer & Callglurl 2014:1). Pain is subjective, and individuals have difficulty describing the discomfort and often use other terms to convey their pain (IASP 2014:5).

a) Assessing older adults

Assessing older adults requires know-how of normal age-related physical changes so nurses can identify when changes might be due to illness. Assessing older adults' pain will help nurses to develop comprehensive pain management practices to meet the health need of the residents in a long-term care home through dismissing positive assessment findings as signs and symptoms of old age, or mistaking regular age-associated modifications as pathological (Bolts, Parke, Shuluk, Capesuti & Galvin 2013:441). To effectively assess older adults' pain, nurses must follow the head to toe assessment method.

Assessing an older adult requires more reasoning and preparation to guarantee efficient communication. Nurses should first gain the resident's attention and consider age-related physiologic changes, such as hearing loss that can be barriers to communication when assessing older adults' pain (Clarke 2014:54). Nurses must be aware that older residents may report that they can hear, but they might not fully comprehend what nurses are saying. According to Herr, Bursch, Ersek, Miller and Swafford (2014:25), many tools are available to quantify residents' pain intensity such as psychometric evaluation of pain intensity scales, numeric rating scales (NRS), verbal descriptor scales (VDS), face pain scales (FPS), and the visual analogue scale (VAS) (Herr et al. 2014:26). As mentioned, a precondition for choosing a suitable pain assessment scale involves ensuring the individual's capacity to read, hear and comprehend how to complete the evaluation instruments. For individuals with unique needs, however, nurses may need to match or adopt a scale to meet the person's capabilities (Herr et al. 2014:25).

2.4.1.2 Pain assessment upon admission

While it is imperative to assess for pain during every admission to a healthcare setting (acute or long-term care) or during visits with any nursing or medical professional until, it has been determined that pain is not a focus of care (RNAO 2013:15). On admission into a long-term care home, nurses must perform a head to toe assessment, including determining an effective pain management practice and early diagnosis for any resident who might be suffering from pain. This is done in collaboration with family and

residents at the time of admission. Nurses will then use the findings from the admission assessment to create a comprehensive nursing care plan for the resident. A person's pain and intensity of pain may alter over time as a health condition and medical status improves or deteriorates, particularly with individuals with chronic circumstances such as cancer, constant non-cancer pain, osteoarthritis, fibromyalgia or advancing age (Spence, Puccinelli, Grewal & Roggeveen 2014:12). As a result, pain assessment upon admission helps nurses develop a comprehensive nursing care plan and arrange for all required nursing care resources to effectively manage pain (RNAO 2013:20).

2.4.1.3 Pain assessment before, during and after a procedure

Residents are at risk for developing pain if they undergo procedures known to cause pain such as skin-breakage due to incontinence or an overstay in bed, injection, surgery, drainage tube insertion or removal, and falls (fractures) (Herr et al. 2014:18). Pain assessment before, during and after a procedure is thus crucial to the success of procedural pain management that allows nurses to anticipate and plan for situations that may create pain and anxiety (RNAO 2013:18). As noted earlier, pain can be the result of the sickness itself or painful diagnostic strategies or remedies (Boehmer 2016:197); nurses thus need to establish a plan that will help the residents cope with each stage of the medical procedure and promptly refer to an appropriate procedural support team (Glowacki 2015:30). Nursing interventions, which include continuous evaluation of the impact of pain remedy, standardised pain examination, and the proper use of pharmacological and non-pharmacological modalities for pain, are the fundamentals of effective pain control (Saslansky et al. 2014:494).

2.4.2 Nurses' responses and perceptions of pain

Each person's perception of pain is based on their individual pain sensitivity and how they express their feelings; such as pain thresholds and the intensity involved in their physiological and psychological responses (Van Dijk, Vervoort, Van Wijck, Kalkman & Schuurmans 2016:264). In terms of healthcare professionals' perception of a patient's pain, most prefer to rely on patients' self-reporting of pain (Herr et al. 2014:20). Crucial points in maintaining quality of care consist of the patients' expressions of pain, which

are also included in the evaluation. Likewise, it is important to improve the nurses' ability to perceive that patients are in pain to achieve effective pain management.

Effective pain management by nurses after surgery improves the patient's recovery, decreases the length of hospitalisation, and increases patient satisfaction (Rad, Sayad, Baghaei, Hossini, Salahshorian & Sare 2015:56). Nurses' perception of a patient's pain is based on the identification information of the individual that relies on internal and external factors. Such information is gathered through the senses, including sight, hearing, taste, smell, and touch (Johnson, Mahaffey, Egan, Twagirumugabe & Parlow 2015:256). Perception is when nurses notice a resident in pain, and use their ideas and comprehension of pain assessment to interpret pain through mostly visual indices of discomfort and anxiety. For example, clues from facial expressions such as a grimace or frown, clenched jaw, quivering chin, or acting disinterested can all be indicators of pain (Johnson et al. 2015:258). Nurses' responses and perceptions of pain, residents in pain, and pain management all affect the quality of care. Such perceptions and responses are most likely to be based on nurses' own experiences, cognition, and emotions in relation to pain, as well as their knowledge and experiences as nurses (Johnson et al. 2015:254). Rad et al. (2015:57) state that it is important for nurses to understand the concerns of a resident in order to manage pain therapeutically. Nurses must develop therapeutics that include good interpersonal skills such as active listening, acknowledging and valuing the resident's and family's perspectives, and demonstrate empathy (Johnson et al. 2015:258).

2.5 CULTURE AND NURSING PRACTICE

Culture is embedded in individual character and affects healthcare practices, traditions, values, and health decision-making. At the organisational level, culturally competent care involves appropriate care that will respect the resident's cultural values and practices, and it is an ongoing process for identifying and implementing innovative strategies (Kaida, Moyser & Park 2015:306). The organisational strategy includes implementing culturally appropriate practices in all areas of policymaking, administration, planning, programming, practice and healthcare service delivery (Kaida et al. 2015:308). The influence of culture on health is critical and deserves most of the nurses' attention, especially in long-term care homes in Canada. Individual

culture affects perceptions of health, disease and death, beliefs about disease etiology, techniques of health promotion, how disease and pain are experienced and expressed, where patients seek assistance, and the types of patient therapy. Both nurses and residents are thus influenced by their cultures (Veillard et al. 2015:25).

According to Peacock and Patel (2012:6), increasing cultural diversity means healthcare professionals are regularly required to satisfy the needs of residents from different cultures and offer culturally congruent healthcare services. Consequently, there may be a growing necessity to recognise the influence of culture on pain management practices in long-term care homes. Cultural factors influence beliefs, behaviours, perceptions, and emotions, all of which have important implications for health and health care (Peacock & Patel 2012:8). Healthcare providers need to scrutinise competencies around cultural competence and patient-centred care by exploring, respecting and improving the quality of care (Veillard et al. 2015:28). When planning care for residents with a culture different from their own, nurses need to be aware of and respect such cultural preferences and beliefs; otherwise, residents may consider nurses to be insensitive and indifferent, possibly even incompetent. Moreover, nurses must not accept that all residents share the same culture and express pain in the same way; in other words, do not stereotype people (Long 2015:336).

Andrews and Boyle (2016:24) define cultural assessment as a systematic assessment or examination of the cultural convictions, values and procedures of individuals to identify specific nursing requirements and procedures in the cultural context of the individuals being assessed. Culturally appropriate care includes the ability to be flexible in meeting the resident's cultural values and practices and developing an ongoing practice for identifying and implementing pain management strategies (Cragg 2017:4). The common relationship between pain and culture is formed by experience, learning, and culture (Peacock & Patel 2012:6). Three concepts of culture in long-term care include cultural competence, cultural responsiveness, and cultural safety.

Cultural competence is described as the procedure through which people and systems respond respectfully and successfully to human beings of all cultures, languages, instructions, races, ethnic backgrounds and religions (Cragg 2017:4). Rikard, Hall and

Bullock (2015:227) define cultural competence as the technique by which nurses operate effectively within the cultural context of a resident, family or community. Cultural competence describes nurses and long-term care home administrations' ability to work effectively within their own culture and with cultural groups different from their own to meet the healthcare needs of all residents (Rikard et al. 2015:226). According to Andrews and Boyle (2016:24), nurses need cultural consciousness to scrutinise biases against inhabitants of distinct cultural backgrounds and have the ability to gather appropriate cultural information about resident pain. Competent cultural knowledge relates to the comprehension of health care by nurses within the cultural belief of the residents. An awareness of all residents' culture in long-term care homes may enhance effective pain management practices (Andrews & Boyle 2016:25).

Cultural responsiveness is about relationships with the resident, their values, the support they receive in the community and the community they come from (Cragg 2017:4).

Finally, cultural safety is described as a set of actions which recognise, respect and nurture the unique cultural identity of a resident (Rikard et al. 2015:227). Effective pain management must include practices for residents from other cultures based on what they themselves or their family determine. Unsafe cultural pain management practices comprise any action which diminishes, demeans or disempowers the cultural identity and wellbeing of residents (Cragg 2017:5).

Cultural safety helps to improve health services delivery through a culture-safe workforce by recognising the power relationship between the nurses and the residents who use the service. For example, someone who feels unsafe may not be able to take full advantage of all services and may need more complex pain management interventions (Cragg 2017:5). Nurses need to understand the diversity within their cultural reality and the impact of that on any resident who differs in any way from themselves. Nursing in the long-term care home is more than controlling pain. It is about relating and responding effectively to the pain of residents with diverse needs and strengths so that people using the service can be defined as safe (Rikard et al. 2015:227).

2.5.1 Cultural systems predominant in Canada

Culture is the way that thoughts, customs and behaviours are shared by specific people or societies, and it continually evolves. The speed of cultural evolution varies. It increases while a group migrates to and carries components of their new lifestyle into their culture of origin (Veillard et al. 2015:15). Culturally, health professionals in Canada are increasingly diverse. Canada's cultural population includes aboriginal people who own the land, Canadians who were born in Canada, immigrants who became Canadian, and also individuals who were born in Canada but who align themselves with the culture of the country of their family origin. The majority of aged immigrants have different languages, income and health profiles than Canadian-born older adults.

According to Cragg (2017:6), the majority of aged immigrants live in Toronto, Montreal, and Vancouver (30%, 10%, and 12%, respectively for a total of 55%). Demographic adjustments in Canada are accelerating because of population growth and an increase in immigration. These demographic adjustments account for 53% of Canada's population growth (Statistics Canada 2013:5). According to Statistics Canada (2013:5), in 2001, 3.6 million Canadians were over 65, and 261,155 older adults were of a visible minority (Statistics Canada 2013:4). Within the past ten years, Canada's visible minority population has doubled; it will reach an estimated 15% by the year 2025 (Statistics Canada 2013:4). Those immigration tendencies have induced demographers to project an even greater increase in the number of older adults of varying ethnic backgrounds in the future (Statistics Canada 2013:6). There is thus an increased possibility or potential for cultural misunderstanding between residents and staff, between family members and staff, and between the staff of different ethnic and professional cultures. In addition, tolerance and acceptance of people from different cultures may be affected by the effects of dementia (Cragg 2017:33). Nurses play an important role in accommodating the culture of residents' pain management.

2.5.2 Nurses' belief system and pain management

Nurses' beliefs determine not only their practices but also their behaviour during the evaluation and treatment of residents in pain (Willens 2014:555). Pain is the most

familiar complaint and is often a topic of discussion between residents and nurses. The nurses' attitudes and beliefs about pain in terms of biomedical belief have an impact on nurses' communication with residents and other team members (Willens 2014:556). Pain assessment and control are among the primary capabilities of nurses imparting care for residents identified as experiencing pain, but researchers have stated that nurses generally tend to underestimate residents' pain (Pasero & McCaffery 2014:44; Atee, Hoti, Parsons & Hughes 2017:140). It is therefore important to understand nurses' cultural beliefs and practices regarding pain management. De Silva and Rolls (2014:422) also found a positive correlation between nurses' ideas, attitudes, beliefs and practices of effective pain management.

2.6 BARRIERS TO EFFECTIVE PAIN MANAGEMENT

Barriers to effective pain management in long-term care facilities are numerous and pervasive; notwithstanding the fact that pain remedies are viable for approximately 90% of residents, studies have verified that pain is frequently undertreated and poorly controlled (Sawyer, Haslam, Daines & Stilos 2014:46). Many barriers can impede pain management. These barriers can be classified into three broad categories: a) healthcare provider barriers (nurses); b) resident barriers; and c) healthcare system (organisational) barriers. These barriers are discussed in the subsequent sections.

2.6.1 Barriers to healthcare providers (nurses)

Several studies have examined a lack of knowledge concerning pain control among nurses (Sawyer et al. 2014:48; May et al. 2018:22). Yilmas and Bolat (2017:5) identified a lack of nursing knowledge of pain assessment and management as one of the barriers to pain management. This could be due to a lack of access to information about medication, including the mechanisms of action, dosage and the side effects of medications (Sawyer et al. 2014:49). Other problems identified in terms of beliefs include fear of addiction when using opioid analgesics, as well as a fear of respiratory depression when high doses of opioids are used (Eid, Manias, Bucknall & Almasrooa 2014:14). Studies have found that many nurses have certain attitudes or beliefs concerning pain and pain management (Lee-Meyer 2016:104; Machira et al. 2013:344). Different studies have also discovered that nurses felt reluctant to accept

a resident's self-report as the most reliable indicator of pain (Pasero & McCaffery 2014:45).

Research has shown the need for an interdisciplinary group (nurses, medical doctor, and pharmacist) involvement in pain control to ensure more appropriate pain control (Lee-Meyer 2016:104). However, a lack of effective communication between healthcare providers, specifically with physicians, is an obstacle to pain control (Wang & Tsai 2014:3190). Poor communication among nurses and physicians was thus cited as a significant barrier to pain management (Reid et al. 2015:276). Nurse-resident communication is similarly essential to correctly assess the residents' pain; poor communication between nurses and residents leads to insufficient pain management (Elcigil, Maltepe, Eşrefgil & Mutafoglu 2014:23).

2.6.2 Resident barriers

Many aged persons are reluctant to report their pain to healthcare providers, mostly because they have a mistaken belief about pain medication (Oldenmenger, Sillevis Smitt, Van Dooren, Stoter & Van der Rijt 2013:1374). Many residents and households believe that pain remedies inclusive of opioids hasten demise; they feel opioids mean they are approaching near-death (Silbermann 2014:3). There is also the concept that increasing pain severity may show the advancement of the underlying disease and a consequent horrible prognosis. As a result, these residents may slowly decrease their degree of pastime and use other coping strategies to avoid inducing extra pain and the need for analgesia. Moreover, Edrington, Sun, Wong, Dodd, Padilla, Paul et al. (2014:665) revealed that the residents' barriers included fear of addiction to pain medicine.

2.6.3 Healthcare system barriers

The organisational barrier is another factor that can affect pain management practices in a long-term care home. Simmonds, Finley, Vale, Pugh and Turner (2015:728) showed that there is complete insensitivity to pain in residents, allowing inadequate pain strategies to continue. Improving the overall long-term care environment where nurses practice would perhaps lead to a greater sensitivity to residents' pain.

According to Hadjistavropoulos, Kaasalainen, Williams and Sacharias (2014:750), there was a lack of positive attitudes from nurses, and positive attitudes could be addressed by improving the workplace environment to enhance pain management practices. The authors further indicated the means by which current long-term care environments could be improved, including knowing the residents, involving the family in care practices, and demonstrating understanding, compassion, and teamwork.

Additionally, Tripathi and Kumar (2014:61) indicate that introducing measures to improve the workplace environment may also serve to help in retaining nursing staff through enhanced working conditions, such as feeling respected and accommodating nurses' personal needs.

Lack of resources is another context barrier to effective pain management in a long-term care home; these include inadequate time, insufficient medication dosage or availability of pain relief medications, and high patient/nurse ratios (Brorson, Plymoth, Ormon & Bolmsjo 2014:318). Lack of resources can hinder nurses' ability to adequately complete pain assessments and administer appropriate pain relief medications.

2.7 SUMMARY

This chapter described the literature review and provided an overview of pain and pain management practices in long-term care homes. The nurses' role in pain management and barriers to effective pain management in long-term care homes were also discussed. The chapter presented information on the culture and nursing practice related to pain management. The following chapter presents the research design and methodology.

CHAPTER 3
RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter outlines the methods used to explore nurses' pain management practices. The research methodology outlines the research design which was exploratory and descriptive, and the methods used to accomplish the objectives of this study. The features of the setting where the study was conducted, the population and the sample of the study, the recruitment of the participants and main data collection measures, are also provided. Subsequently, this is followed by a description of how the data were achieved and analysed. The process for obtaining formal ethical approval and trustworthiness is also presented.

3.2 QUALITATIVE RESEARCH

Qualitative research involves an emerging design as the study unfolds (Polit & Beck 2016:505). It identifies "the characteristics and significance of human experiences as described by informants and interpreted by the researcher at various stages of abstraction" (Silverman 2015:97). Qualitative research highlights the dynamic, all-inclusive and individual aspects of human experiences and efforts to capture those aspects in entirety, within the framework of those who are experiencing them (Polit & Beck 2016:504). The researcher was able to capture nurses' pain management practices in long-term care homes as it related to their interactions with residents. In qualitative research, the interviewer is an important part of the study (Johnson & Christenson 2013:34). The researcher was able to lead and direct the focus group interview to collect pertinent and relevant data for the study.

Qualitative research allows the researcher to keep direct contact with the participants, namely registered nurses, so that the researcher could picture and analyse data as it occurred (Sutton & Austin 2015:227). The qualitative design allowed the researcher to emphasise essential subjectivity to understand nurses' practice of pain management and responses to the residents' expressions of pain. Finally, this technique gave the

studied phenomenon flexibility and clarity (Polit & Beck 2016:20). In this study, the researcher sought a thorough understanding of the nurses' views about their pain management practices through interview questions and discussions. A trusting relationship was built, and participants were supported during the interactions. The researcher developed and built collaboration with the registered nurses to ensure that participants provided authentic responses to the questions.

According to Polit and Beck (2016:504), an interpretive strategy enables better knowledge of the social interaction of reality or the way individuals make sense of their life and experiences. In conducting this study, the researcher's continuous interpretation of data helped as a basis for deciding on future courses of action or areas of focus. As the study progressed, the researcher continuously reflected on what arose and made ongoing decisions on the focus and method of data collection (Sutton & Austin 2015:227). The researcher asked open-ended questions to gain the views and opinions of the participants regarding their pain management practices (Creswell 2014:186), and the overall design was thus exploratory and descriptive.

3.3 RESEARCH DESIGN

A research design can be defined as a set of plans or an outline of how to carry out a study (Babbie & Mouton 2012:74). A non-experimental, qualitative, exploratory and descriptive design was used in this study. The exploratory design is a way of understanding and gaining awareness into a situation, community, individual or phenomenon being studied (Silverman 2015:95). The descriptive design focused on 'how' and 'why' questions to present a picture of a specific situation, social setting or relationship (Silverman 2015:96).

3.3.1 Exploratory design

The exploratory design is a way of understanding and gaining access to a situation, community, individual or phenomenon being studied (Silverman 2015:95). Exploratory research allows the researcher to be able to answer how nurses interpret and respond to expressions of pain by aged people at a long-term care home. It also provided the researcher with the information needed to explore nurses' pain management practices

in Ontario long-term care homes. The exploratory design focuses on the discovery of ideas and thoughts. The methods of data analysis are textual, and findings are not generalised (Silverman 2015:97). An exploratory design was deemed suitable for this study as it allowed the researcher to obtain an in-depth understanding of nurses' pain management practices in long-term care homes through focus group interviews among nurses. This promoted free communication during discussions.

3.3.2 Descriptive design

As mentioned, a descriptive design emphases 'how' and 'why' questions to present a picture of a specific situation, social setting or relationship (Silverman 2015:96). The main purpose of a descriptive design is to observe, describe, and document the part of a condition as it naturally occurs (Polit & Beck 2016:505). A descriptive research design contributes significantly to the formulation of principles and makes predictions of the possible future based on findings on prevailing conditions and correlations (Silverman 2015:95). A descriptive design was used as illustrated by the fact that methods or practices that nurses used in the detection of pain were systematically described and possible deficiencies that might lead to underdiagnosis of pain in long-term care homes were identified. This design allowed full descriptions of the nurses' pain management practices (Silverman 2015:96).

3.4 RESEARCH SETTING

The research setting can be regarded as the physical, social, and cultural site where the researcher conducts the study. In qualitative research, the focus is particularly on sense-making, and the researcher studies the individual participant in their natural setting (Hashimov 2014:110). This study was conducted in a natural setting, namely the healthcare environment where registered nurses work and manage elderly people who experience pain. The setting was a selected long-term care home located in Ontario, Canada. The chosen long-term care home is intended for older adults who need access to on-site 24-hour nursing care not accessible in their respective family homes; assistance with activities of daily living (i.e. eating, bathing, toileting and recreational activities); and monitoring for safety or wellbeing. All long-term care homes in Ontario provide nursing and support services, restorative, life enrichment

programmes, nutritional care, access to medical, pharmacy, diagnostic and therapy services. At the selected long-term care home, there are four family practice physicians, 45 nurses, 60 personal support workers, 10 recreational therapists, three physiotherapists, one dietician, 12 cooks, and a receptionist. The selected long-term care facility offers diverse services, including nursing, social work, physiotherapy, occupational therapy, recreational therapy, dieticians' consultations, pastoral services and there is a physician on-site available around the clock. These nursing activities include administering medication, assistance with activities of daily living, bathing, dressing, grooming, eating, and mobility (RNAO 2013:12).

Figure 3.1: Map of long-term care home

3.4.1 Population

A research population is "the entire set of individuals who have some common characteristics and meet certain criteria of interest to the researcher" (Maryann-Godshall 2015:34). Qualitative research entails that the collected data is rich in the description of people and places (Sloan 2013:28). The population of this study was 45 nurses in the selected long-term care home. Nurses were considered relevant, as they are directly involved in the pain management of aged people in long-term care homes.

3.4.2 Sampling

Sampling is the method of selecting participants from a population of interest so that, by examining the sample, the researcher may generalise results to the population from which they were selected (Hashimov 2014:112). Qualitative research is concerned with discovering meaning and uncovering multiple realities, and not to generalise to a target population; thus, it was critical to select informants with high potential for information richness (Polit & Beck 2016:515).

A non-probability sampling method was used, which is defined as any type of sampling where the chosen elements or participants are not resolute by the statistical principle of randomness (Polit & Beck 2016:516). A core distinctive of the non-probability sampling method is that samples are carefully chosen based on the subjective decision of the researcher. In this study, purposive sampling was utilised to select participants through non-random methods. This sampling technique was based on the certainty that the researcher's knowledge about the population could be used to select the participants to be included in the sample (Holloway & Galvin 2016:137-138). Purposive sampling was used to identify and select nurses who were exceptionally knowledgeable about or experienced with pain management practice in long-term care homes (Palinkas, Horwits, Green, Wisdom, Duan & Hoagwood 2013:3). Purposive sampling was regarded as appropriate to this study, and the researcher's judgements were used to select participants according to their involvement in the nursing care of residents of the long-term care home.

The researcher ensured that the sample included both males and females of various age groups. The purpose was to choose participants who were knowledgeable about pain management practices in a long-term care home who would be able to provide rich data on pain management practices. The aim was to gain rich and in-depth data on their responses, attitudes, beliefs, and factors that may influence their pain management practices. Twenty-five participants were purposively selected from a population of 45 nurses in the selected long-term care home based on the eligibility criteria. Researcher selected three participants out of twenty-five to validate data through conference telephone call.

3.4.3 Eligibility criteria

- Permanent and part-time staff employed as registered nurses at the facility.
- Registered nurses providing direct nursing care to residents.
- Registered nurses who have worked at the selected facility for more than six months.

3.4.4 Exclusion criteria

- Registered nurses who have worked in the long-term care home for less than six months.
- Any registered nurses not providing direct nursing care to residents.

3.5 DATA COLLECTION

Data collection is the process of gathering enough information to report a research problem. It is fluid and decisions about what to collect about the study in the field (Polit & Beck 2016: 532). This study used semi-structured data collection methods such as focus group interviews to collect data from the registered nurses because semi-structured interviews allowed the researcher to prepare the interview guide ahead of time (Denzin & Lincoln 2013:124). Qualitative researchers use data collection techniques consisting of interviews, focus groups, observations, and examining written documents and records (Grove et al. 2015:82). The semi-structured data collection method helped the researcher to explore nurses' pain management practices in a long-term care home. LoBiondo-Wood and Haber (2014:274) refer to the interview guide as a list of questions and probes that are used during the interview. For this study, the researcher prepared an interview guide comprised of open-ended questions. These open-ended questions were related to the purposes and objectives of the study.

3.5.1 Focus group methods

Tracy (2013:167) defines ‘focus groups’ as group interviews with between three and 12 participants, in which the interview is characterised by a guided group discussion, questions and answers, and interactive dialogue. Terre Blanche et al. (2014:304) define ‘focus groups’ as group interviews of participants who share the same type of experience and are affected by a phenomenon under study. The authors further stated that group interviews reflect numerous interests inside the parameters of the research topic. A focus group interview was considered relevant to this study as it allowed the participants to freely express their pain management practices in a long-term care home (Brink et al. 2014:158).

In an ideal focus group interview, participants supply insightful self-disclosure and successfully explore their experiences (Tracy 2013:167). Babbie and Mouton (2012:292) explain that group interviews create meaning when the participants engage in discussions and while there is a massive quantity of interaction on a subject in a limited period. They, also state that the focus group interviews are high quality in that the participants are capable of articulating their ideas freely and the discussions provide evidence of similarities and differences within the members’ perspectives on a specific phenomenon.

3.5.2 Preparation for a focus group interview

The participants decided on the time and place of the focus group interviews that were convenient for them. A comfortable and private room was organised to ensure privacy. The seating arrangement allowed participants to face each other. All the necessary equipment were assembled. Participants were informed about the nature and purpose of the study and the method to be followed to conduct the study. Informed consent was sought before the start of the focus group interview, and participants were told they have the right to withdraw from the study at any time if they so wished. The participants were permitted to ask questions for clarity and subsequently confirmed their participation by written consent.

3.5.3 Facilitating focus group

Focus group discussions are regarded as carefully planned discussions that take advantage of the group experiences to cautiously access rich information (Streubert & Carpenter 2014:37). Data were collected after permission was granted by the selected long-term care home (See Annexure C) and ethical clearance obtained from the Department of Health Studies Research Ethics at UNISA. The groups allowed participants the freedom to express their pain management practices, beliefs, and attitudes towards pain and pain management. The researcher was the leader and moderated the discussions. Before the collection of data, the nurse manager and Director of Care informed the researcher that audio recording would not be permitted because of the nursing home policy. The researcher used a scribe to take notes of all responses of each participant while the researcher was asking questions and probing each answer to obtain rich information. The scribe was trained on how to avoid bias and knew that only participants' statements should be recorded without any omission; her own ideas were not included in the transcription. She was also informed about the ethical aspects of research and were not to disclose the identity of any participant, including their statements. Pope and Mays (2013:29) point out that handwritten notes can be quite beneficial.

The focus group interview consisted of three groups, and each group comprised of eight to nine participants. The researcher kept records of all the answers provided by participants during each interview. The interviews were conducted in a quiet place in the healthcare unit of the long-term care home. The environment was conducive to ensure that nurses had established a good rapport with the researcher. The researcher and the participants established a set of rules, such as keeping cell phones on silent and giving each other turns to speak, and to keep information exchanged during the discussions confidential.

The biographic data sheets were distributed and returned to the researcher after completion by all participants. Data were obtained from the nurses on pain management practices, focusing on what they do, the rationale, how they carry out pain management, and why. The purpose was to produce rich information that would

establish insights and understanding of pain management. The researcher asked each question based on the interview guide, probed the answers after each response and participants' responses were written down by the trained scribe (Annexure E). The researcher used communication techniques to probe, reflect on and reformulate until a point of data saturation had been reached. Probing refers to a technique used by the researcher to ask participants for clarity to complete the answer to a question (Babbie 2014:277). At the end of the interview, participants were thanked for participating in the study and were told that what they said would only be used when debating the results and appear in the thesis to be shared with important stakeholders; for example policymakers, health practitioners, researchers and the Director of Care of the selected long-term care home. They were also notified that the study was conducted in fulfilment of the requirements for a dissertation for the University of South Africa.

3.5.4 Method used to validate and confirm findings

The researcher improved data quality by arranging a telephone call with three selected participants. The researcher and the participants agreed on the day, place and time of the telephone conference call. The researcher asked questions and probed the participants to validate data. The researcher used the same scribe to write down all the statements while the researcher was probing the participants and listening to their responses. The telephone was placed on speaker so that the researcher and scribe could hear everyone at the same time. Any new information was merged with the rest of the data from the other focus groups.

3.6 MEASURES TO ENSURE TRUSTWORTHINESS

Trustworthiness implies "the level of assurance qualitative researchers have in their data, assessed using the criteria of credibility, transferability, dependability, and confirmability" (Holloway & Galvin 2016:303). Trustworthiness also refers to the believability of data (Creswell 2014:42). This study used the following trustworthiness strategies:

3.6.1 Credibility

Credibility is established when research findings and interpretations are credible to the participants of the study (Creswell 2014:44). The credibility of the results of this study is rooted in the transparency of the explanation of the research process. The researcher took steps to demonstrate credibility by probing to ascertain the participants' pain management practices (Holloway & Galvin 2016:303). The researcher abstained from demonstrating his beliefs during data collection. The researcher made every effort to avoid giving away any signs of surprise or disapproval to participants' comments during focus group interviews. An explanation of personal beliefs makes researchers more aware of the potential decisions that may occur during data collection and analysis (Streubert & Carpenter 2014:20). The researcher added a conference call with 3 participants to add credibility to the findings.

3.6.2 Confirmability

Confirmability can be referred to as the degree to which the data and interpretations are grounded in activities as opposed to the researcher's personal beliefs or ideas (Holloway & Galvin 2016:303). The researcher ensured that the results mirrored the participants' pain management practices, which they shared during data collection. Notes obtained from the focus group interview were reviewed to ensure that the data represented the views of the participants (Holloway & Galvin 2016:306).

3.6.3 Transferability

Transferability is used to determine the level to which the findings may be applied to other long-term care homes (Holloway & Galvin 2016:306). According to Holloway and Galvin (2016:326), the presentation of the patterns shows nurses' practices to determine applicability in their practice setting. In this study, the researcher provided comprehensive descriptions of the research setting and what he had heard and seen in relation to pain management practices during data collection. The researcher believes that this would enable others to determine the transferability of the findings.

3.6.4 Dependability

To ensure dependability, the researcher made sure that similar questions were asked in multiple ways, allowing the researcher to determine the consistency of participants' responses (Creswell 2014:42). At the end of the interview, the researcher also returned to the original interview transcripts and carefully re-read each one. To enhance the research, the researcher recorded the research method used to improve the dependability of this study. At the end of the focus groups the researcher submitted raw data, transcript reports containing coded data and interpretations to the research supervisor who conducted an audit to confirm the findings. All raw data and the transcript reports were filed away for safekeeping.

3.7 DATA ANALYSIS

The researcher followed Creswell's (2014:42) approach for analysing focus group data, which consists of four fundamentals: script transcription, information encoding, data interpretation, and information reporting. Initially, each interview transcript was read and re-read for general comprehension. The transcripts were then carefully read again to identify significant information. Thematic analysis was used throughout the process of interviewing, transcribing, and reviewing the data. The transcripts and notes were examined line by line, and a key statement regarding participants' responses to aged persons' expression of pain and nurses' interpretation of aged persons' pain expression in the long-term care home were highlighted and coded. Codes were then defined, categorised, and compiled into themes, subthemes and categories. Categories were checked for overlap and any necessary changes were made (Holloway & Galvin 2016:282).

The following steps were followed:

- The researcher went through all focus group interview transcripts as written by the scribe at each focus group meeting.

- After studying the notes, the researcher read the written data again to check for accuracy and immersed himself in the entire dataset, making notes on general impressions.
- Data sections that were participants' opinions were highlighted to develop broad topics abbreviated to the predetermined code. The texts were searched to find, list and cross-tabulate the identified analytical units.
- Coded sections were read again to mark areas that matched the topic and gathered data from the quotes, and classified to develop themes, subthemes and categories. Themes appeared as major headings in the findings.
- A general description of the themes became defined by way of developing emerging meanings into subthemes and categories from individual quotes (Creswell 2014:43).

3.8 ETHICAL CONSIDERATIONS

Ethics comprise principles, standards, and values that guide appropriate conduct in research decisions (Cottrell 2014:331). Research ethics are involved with the protection of the human rights of the participants of the research study. These human rights can be classified as privacy, self-determination, anonymity and confidentiality, fair treatment, fair selection and protection from any harm (Grove et al. 2015:100).

3.8.1 Permission

This researcher sought permission from the selected long-term care home authorities to conduct the research (Annexure B). Permission was granted from the Director of Nursing of the selected long-term care home (Annexure C). The researcher additionally received ethical clearance to conduct the study from the Department of Health Studies Ethics Committee of the University of South Africa (UNISA) (Annexure D).

3.8.2 Informed consent

Informed consent is a voluntary agreement between the researcher and participants to participate in research. It is a method in which the participants understand the study and its risks. To get consent means informing the participants about their rights, the objectives of the study, the methods to be used, the potential risks and benefits to the participants (Slam 2014:2). Before signing permission to participate in the study through the consent form, the nurses were given information regarding the purpose of the study, procedures and the expected duration of participation. Participants were made aware that they were not forced to participate in this study; they had the right to withdraw at any time and not answer any questions that they felt violated their privacy, or could withhold information without being penalised (Annexure A).

3.8.3 Self-determination

Self-determination is described as “the ability to select and to have those selections be the purposes of one's action” (Hui & Tsang 2012:2). The rights of participants to self-determination are routed entirely on the principle of respect for persons, which implies that an individual has the right to participate in a study or not, without any risk of consequence or damaging treatment. The researcher made sure that all participants were allowed to decide if they wanted to participate in the study without any risk or consequence.

3.8.4 Privacy, anonymity and confidentiality

Privacy, anonymity and confidentiality refer to the right of an individual to decide what activities they will or will not take part in; the researcher made sure that each participant decided to participate in the study without any influence from others. The data gathered was handled with the utmost confidentiality, and there was no way data would be linked to study participants. The researcher made sure that all participants were informed that all participants’ identifiers were blocked out and participants were requested not to discuss any information gathered at the focus group interview outside the interview room.

3.8.5 Beneficence

Beneficence is a method that is used for the benefit of others. Beneficent actions can be used to help avoid or eradicate harm or advance the situation of others (Walby & Luscombe 2018:22). It relates to the responsibility on the part of the researcher to fully enhance the benefits for the individual participant while reducing the risk of harm to all participants. The researcher ensured that any information provided by participants were protected so that they were not used against the participants.

3.8.6 Protection from discomfort and harm

The researcher declared that there were no expected risks associated with this study. However, the researcher ensured that participants were comfortable, and any sign of distress was addressed adequately by stopping the discussion and allowing the participants to decide whether to continue or not. The researcher achieved this by providing a quiet room and environment that was free from any disturbances during all focus groups.

3.8.7 Fair selection and treatment

The right of participants to unbiased selection and treatment is routed in the ethical principle of justice, which demonstrates that the researcher must select the study population with fairness. The participants must be selected based on the principle directly related to the research problem (Brink et al. 2014:36). Participants were treated justly, and agreements were respected by adhering to the dates and time of the appointments for data collection.

3.8.8 Scientific integrity

Integrity involves maintaining honesty (Grove 2018:220). The researcher made sure that scientific integrity was preserved. The researcher also made sure that the scribe received training on the expectations of the role of a scribe. Findings were presented accurately and were not misrepresented.

3.9 SUMMARY

This chapter explained the research design and method used in the study that includes the setting, population, sampling, data collection and analysis. The chapter also presented the measures to ensure the trustworthiness and ethical considerations of the study. Chapter 4 presents and describes the research findings.

CHAPTER 4
PRESENTATION AND DESCRIPTION OF THE STUDY FINDINGS

4.1 INTRODUCTION

This chapter gives an overview of the findings that emerged from the data analysis of focus group discussions with nurses working at the selected long-term care home in Ontario, Canada, and literature to control the findings. Themes, subthemes and categories that emerged are presented, along with verbatim quotes from participants. The purpose of this study was to explore nurses' pain management practices in Ontario long-term care homes. The aim was to recommend measures for effective pain management among older adults. Data from all focus groups were merged to form a comprehensive report.

4.2 DATA ANALYSIS

According to De Vos et al. (2014:399), conducting data analysis in qualitative studies is a process of applying interpretation to the data. Narrative data analysis is a process that identifies specific meanings from collected data (Babbie & Mouton 2013:166). Narrative analysis pertained explicitly to the naming and categorising of nurses' pain management practices at the selected long-term care home through carefully examining the data (Polit & Beck 2016:200). Data analysis followed the steps mentioned in Chapter 3 (Section 3.7).

4.2.1 Participants' biographical information

Table 4.1 provides the participants' biographical data that show their specific characteristics. It is a description of participants' gender, age, nursing qualifications, years of experience, years at the long-term care home and employment status.

Table 4.1: **Participants' biographical information**

	FOCUS GROUP 1 (N=8)		FOCUS GROUP 2 (N=8)		FOCUS GROUP 3 (N=9)	
GENDER	Males	2	Males	2	Males	2
	Females	7	Females	7	Females	5
AGE	30-39 years	4	30-39 years	5	30-39 years	3
	40-49 years	5	40-49 years	4	40-49 years	4
NURSING QUALIFICATION	Diploma	5	Diploma	4	Diploma	3
	BScN	5	BScN	3	BScN	5
YEAR OF EXPERIENCE	6-10 years	2	6-10 years	4	6-10 years	2
	11-15 years	2	11-15 years	3	11-15 years	3
	16-20 years	3	16-20 years	3	16-20 years	3
YEAR AT LONG-TERM CARE HOME	1-5 years	4	1-5 years	5	1-5 years	3
	6-10 years	3	6-10 years	4	6-10 years	6
EMPLOYMENT STATUS	Full Time	5	Full Time	6	Full Time	4
	Part Time	3	Part Time	3	Part Time	4

A total of 25 nurses, of whom six were male and 19 were female, participated in the focus groups. As Table 4.1 shows, eight participants had 6-10 years' experience as nurses, eight had 11-15 years' experience as nurses, and nine had 16-20 years. Twelve nurses had 1-5 years' experience working at the long-term care home, and 13 nurses had 6-10 years' experience working at the long-term care home. Across the three groups, there were 12 nurses between ages 30-39 years; 13 nurses were between 40-49 years. Twelve nurses had a diploma certificate, while 13 nurses had a Bachelor of Nursing degree. Lastly, 15 nurses were full time employees, and 10 nurses had part-time employment status. An additional three participants were later recruited and interviewed to validate certain aspects that emerged.

4.3 THEMES

A theme can be defined as a ticket that represents a method of reporting large quantities of data in a simple condensed format (LoBiondo-Wood & Haber 2014:128). Themes that emerged from the data were developed within the sub-categories and categories of the data. The researcher identified the following four themes:

- Theme 1: Nurses' perception of pain
- Theme 2: Nurses' response to pain
- Theme 3: Pain management challenges
- Theme 4: Measures to improve pain management

4.3.1 Theme 1: Nurses' perception of pain

How nurses perceive pain may influence their behaviour in pain assessment and management (Swakhalen, Hamers, Peijnenburg & Berger 2017:178). As such, nurses need to have a good perception of pain to achieve effective pain management. According to Chatchumni, Namvongprom, Eriksson and Masaheri (2016:28), differences in the interpretation of patients in pain affect the outcome of the pain assessment. The participants' accounts of their perceptions of residents in pain and pain management were condensed into two subthemes. These subthemes were: meaning of pain to nurses, and influences on understanding residents' pain. The subthemes and categories of Theme 1 are presented in Table 4.2.

Table 4.2: Nurses' perception of pain

THEME 1	SUBTHEMES	CATEGORIES
NURSES' PERCEPTION OF PAIN	**Meaning of pain to nurses**	• Recognition and interpretation of pain • The legislative framework for pain management
	Influences on understanding residents' pain	• Biomedical influences • Cultural influences on understanding residents' pain

4.3.1.1 Subtheme 1.1: Meaning of pain to nurses

In this subtheme, two categories emerged: recognition and interpretation of pain, and legislative framework for pain management. Each category is discussed in the subsequent sections. All three focus groups' contributions are indicated in the quotations as FG1 referring to focus group one, FG2 referring to focus group two, FG3 referring to focus group three, and FG4 referring to the three additional participants.

a) Category 1.1.1: Recognition and interpretation of pain

All participants from the focus groups described how they recognised and interpreted pain. They used cues such as facial expressions like a grimace or frown, clenched jaw, quivering chin, or lack of interest in any activity. Nurses mainly used medical terms to express their interpretation of pain. They agreed that the interpretation of residents' pain was subjective and based on the individual resident's complaint. All the participants mentioned various methods in which they recognise pain. Participants explained.

> *"I know my residents are in pain when they frank their faces and they are uncomfortable" (FG2).*

> *"…when I see them in discomfort and irritable" (FG1).*

> *"…when I notice that they are feeling anxious and avoiding daily activities" (FG4).*

> *"I identify my resident's pain through pain assessment and close observation, which enable me to know when things are becoming abnormal to residents" (FG3).*

Pain recognition is the first step in ensuring residents' pain is managed effectively. If the pain is not recognised, it is difficult to assess and manage (Rasmi, Awaje & Khraisat 2017:10). According to Lichtner, Dowding, Allcock, Keady, Sampson, Briggs et al. (2016:427), understanding overall residents' pain experiences in long-term care

homes includes investigative work and putting a picture together of an individual's pain pattern. Consequently, many healthcare facilities consider nurses' pain interpretation as the fifth vital sign (Kosier, Berman & Snyder 2013:104). Pain interpretation by nurses is used as a routine check-up in health care; it is a fact that pain is subjective and pain interpretation by nurses covers physiological, behavioural, socio-cultural, and emotional aspects (Kosier et al. 2013:102).

b) Category 1.1.2: The legislative framework for pain management

Participants stated they used a legislative framework for pain management that includes the residents' rights to pain control and an interdisciplinary approach to pain management. Participants elaborated on their experiences related to collaboration with other healthcare professionals in delivering direct services and supporting residents in their pain management decisions and actions based on clinically accepted guidelines.

> *"Our policy on pain management is that all residents be assessed for pain during admission" (FG3).*

> *"The long-term care policy stipulates that all nurses follow and use the pain guidelines during pain assessment, which can be found in random assessment indicator computer" (FG2).*

According to RNAO (2013:6), pain legislative frameworks are systematically established statements to assist nurses in assessing pain during and after admission into a long-term care home. These statements provide evidence-based recommendations for nurses who are assessing and managing pain. RNAO (2013:15) stated that every resident of a long-term care home has a written pain management plan of care. According to Aziato and Adejumo (2015:28), each resident must be assessed for pain on admission and be reassessed quarterly and during any change in health status.

4.3.1.2 Subtheme 1.2: Influences on understanding residents' pain

Data showed that nursing background influenced nurses' understanding of residents' pain. In this subtheme, two categories emerged; biomedical influences and cultural influences on understanding residents' pain. These categories are described next:

a) Category 1.2.1: Biomedical influences

Data showed that nurses' views of pain are influenced by the biomedical perspective, which is based on the understanding that pain or any other diseases are malfunctionings of the body. According to the participants, the pain has a pathological reason which can be described in terms of human anatomical and physiological functions. Some attributed pain to physical malfunction and pathological procedures connected with disease and cell degeneration. The verbatim quotations supporting this follow:

> *"I know pain is caused by disease and degeneration of cells in old age people" (FG1).*

> *"I know injury causes pain, accidents, illness and may lead to complications" (FG2).*

> *"If residents are in pain, their blood pressure and pulse would be elevated. I know residents cannot be in pain and be laughing" (FG3).*

Bendelow (2013:458) agrees with these findings; the biomedical perspective only considers the physiological causes of pain, which does not always take emotional aspects of pain causes into consideration.

b) Category 1.2.2: Cultural influences on understanding residents' pain

Participants stated that the resident's cultural background might influence the way they interpret pain. They claimed that some cultures tolerate pain better than others, which determines how they express pain. Participants said some of their residents would not

express their pain because they believed their pain was due to old age. All the participants agreed that their ability to break through nursing cultural barriers is the key to providing effective pain management. Participants pointed out that cultural differences affect residents' and nurses' responses to pain. The relationship between pain perception and culture is shaped by the cultural experiences of nurses and residents. The quotes below confirm the finding:

> *"I believe that if residents are in pain, they will be able to communicate the location and intensity of the pain" (FG1).*

> *"Sometimes when my residents express, they are in pain, they need companion from me because they are feeling lonely" (FG2).*

> *"Since many of my residents are from different cultural background some are from Indian, China, Jamaica, Poland and Greece they express pain based on what it is accepted in their culture and because many occasions we do not understand the meaning, it gives us different perception" (FG2).*

> *"Understanding residents' pain differs from nurse to nurse because we are from the different cultural background, I found this common among other nurses from another unit during the medical review of resident's file" (FG3).*

This finding was supported by Raman (2015:13), who found that culture affects a person's approach to pain management and the amount of pain deemed abnormal. Nurses' understanding of deficits, biases, and attitudes thus influence the assessment and management of the residents' pain (Undari-Schwartz 2017:64). According to Reade (2018:101), an increase in Canadian ethnic diversity implies that nurses are frequently required to meet the needs of residents from different cultures and offer culturally relevant pain management. Culture influences pain management interventions in terms of what is regarded as 'normal' and 'abnormal', determining the cause of pain, and influencing the decision-making in determining the best method to be adapted for control pain (Reade 2018:103). Raman (2015:15) emphasises the need for nurses to create cultural abilities and culturally appropriate interventions for individuals from culturally varied communities. This process requires nurses to learn

how to conduct a comprehensive, culturally sensitive pain assessment to determine the specific needs and appropriate interventions for the people targeted.

4.3.2 Theme 2: Nurses' responses to pain

Participants indicated that the policy of the long-term care home is to have a pain assessment done upon admission, whether residents are in pain or not. They said this initial pain assessment is used as a baseline for the future nursing care plan. Two subthemes emerged, namely; pain assessment and pain management measures. The subthemes and categories are presented in Table 4.3.

Table 4.3: Nurses' response to pain

THEME 2	SUBTHEMES	CATEGORIES
NURSES' RESPONSE TO PAIN	**Pain assessment**	• Pain indicators • Etiology of pain • Pain assessment tools
	Pain management measures	• The use of standard pain management procedures • Embracing resident-centred care • Implementing pharmacologic and non-pharmacologic strategies

4.3.2.1 Subtheme 2.1: Pain assessment

Participants stated that in any situation where pain is either verbalised or suspected, the first step is to make an assessment. Pain assessment starts from the first day of admission, and they mentioned various ways in which they conduct the assessment. According to Anon (2014:286), the health assessment must contain a complete medication history that includes current and old prescriptions and over-the-counter medications. Three categories emerged from the data: pain indicators, etiology of pain and pain assessment tools.

a) Category 2.1.1: Pain indicators

The participants stated that the residents' self-report is the most accurate and reliable evidence of the presence of pain and its intensity. They also shared that self-report could not be used with residents who have cognitive, sensory, or motor deficits. They agreed that it is crucial first to determine the resident's ability to use the self-report. Facial expressions and body language were common pain indicators among older adults. Participants mentioned that some residents also indicate pain through shaking in their voice, facial expressions, body language and vocal signs. Other indicators are apparent confusion, social withdrawal and apathy. The statements below support the finding:

> *"I always observed residents' body appearance such as skin colour, swelling and tenderness closely to determine when they are in pain or showing any sign of pain because some of my residents are not able to say when they are in pain" (FG1).*

> *"Typically, during the care, when I lift the resident from one place to another, they would be reluctant to move and some grab things tight when I am taking care of them, which could indicate that they are in pain" (FG2).*

> *"I see that residents are in pain through behavioural observation and I would try to compare their current presentation with the past to see if there is any correlation or not" (FG4).*

> *"When residents do not wake up at their normal time, I will try to investigate this further by asking if they are okay, from this, I may know if there is any discomfort or pain that change their pattern of sleep" (FG1).*

> *"I know my residents are in pain through observation of how they walk or lack of interest to partake in activities or by asking them how they are feeling in case of any hesitation to walk or saying 'auch!' when touched," (FG3).*

“When I see my residents are in discomfort, I use simple and concrete questions, for example, does this hurt and where does it hurt, I ask them to point to the body part that hurts, this helps me to determine the severity, and location” (FG4).

“Because some of my residents cannot express in words, I use their facial expression, body language, vocal sounds of pain like ‘auch!’ as an indicator of pain. Sensitiveness to touch, refusing to sit, protecting sore areas, disruptive behaviour, withdrawal, changes in sleep or appetite, increased confusion and crying” (FG1).

The findings are supported by Carpenter and Hirdes (2013:5), who determined that several provinces in Canada are using resident assessment indicator (RAI) assessments in enhancing the pain indicators as part of pain assessment in a long-term care home. However, self-record is the most dependable indicator of pain; every reasonable effort needs to be made to appropriately talk with residents about their pain or discomfort (RNAO 2013:13). The RAI-MDS 2.0 assessment is performed upon a resident’s admission to the long-term care home to give a snapshot of their pain or likelihood of developing pain. This regular snapshot of a resident’s pain over time provides indicators of the resident’s pain (Carpenter & Hirdes 2013:6). All nursing homes need to identify pain indicators for all residents (RNAO 2013:5). Nurses need to be aware of the non-verbal hints of pain, especially among residents who have cognitive or communication difficulties (Carpenter & Hirdes 2013:18).

b) Category 2.1.2: Etiology of pain

Participants stated that for them to assess pain efficiently, they need to know the cause, location, duration and intensity of the pain. They described the techniques they use to identify the etiologic of pain as inspection, palpation, percussion, and auscultation. Some said they do a comprehensive health history and complete physical examination. The following quotes indicate the participants’ verbatim views:

“To ascertain the presence of pain, I do a thorough inspection from head to toe by asking them to show me the pain location and when the pain started” (FG3).

“To determine the cause of musculoskeletal pain, I do an initial inspection that includes evaluation of the musculoskeletal system to be able to know the root cause of the pain. I will also palpate for tenderness, inflammation and trigger points” (FG2).

“…when I suspect a resident is in pain that might be due to arthritis, old fracture site pain and tissue injury, I do gentle rotations and palpations to exclude pain” (FG1).

Gromova and Myasoedova (2016:12) agree that the pathophysiology of pain is multifactorial and complex. Hogan (2014:201) also claims that a comprehensive resident physical examination from head to toe yields etiologic of pain. Causes of pain are important in pain management among older adults because it helps to get baseline physical and mental data on the residents and confirm questions obtained in the nursing history (Hogan 2014:202). Causes of pain also offer information that will help the nurses in determining nursing diagnoses and planning residents’ care through evaluating the suitability of the nursing interventions in resolving the residents’ pain problems (Hogan 2014:203).

c) Category 2.1.3: Pain assessment tools

The participants stated that self-report pain rating scales are most commonly used to quantify pain intensity. They mentioned other varieties of tools they used to quantify pain intensity, such as NRS, VDS, FPS, and VAS for older adults. They also commented on how they combine the scale with measurement of vital signs such as temperature, pulse, blood pressure, respiration and oxygen saturation to be able to diagnose pain. Nurses stated that vital signs could be affected by pain in several ways because a normal body response to pain is an increase in heart rate, breathing rate and blood pressure. All the participants made suggestions that assessment tools should be used by all units so that when a resident is transferred from one unit to

another, the care would not be interrupted by using another pain assessment tool. The verbatim quotes that follow express the participants' views:

> *"I use pain scale tools to determine the level of pain such as the numeric rating pain scale to determine the degree of intensity of the pain, visual analog pain scale to determine the presence of pain and category of pain. I also ask residents to show me on the numeric pain scale level of their pain from range 1-10 because pain rate of 8-10 needs urgent attention and even need to call MDI" (FG2).*

> *"I use behavioural Pain Scale because nurses consider it to be most appropriate for older adults, most especially when verbal communication is not possible to grade their pain. I do vital signs to see if there is any underline factor to pain. When residents are in pain, blood pressure, heart rate, oxygen saturation, temperature and respiratory rate are taken to assess pain" (FG3).*

Pain assessment tools are a broad process involving a clinical decision based on observation of the type, significance, and duration of the individual's pain experience (Manworren & Stinson 2016:192). The tools that are not adequately used can result in ineffective pain control that can adversely affect the physical, emotional, and psycho-social aspects of residents (Undari-Schwartz 2017:64). Selecting pain assessment tools should be a collaborative decision between residents and nurses (Laranjeira & Quintao 2014:1). Therefore, nurses and providers need to consistently use valid, reliable, and practical pain assessment tools that are appropriate for the residents (Booker & Haedtke 2016:69). The assessment and measurement of pain in long-term care homes require a tool that is appropriately worded and easily understood (Flaherty 2012:1). The Numeric Rating Scale is a widely used pain rating scale in long-term care homes (Anon 2014:286).

4.3.2.2 Subtheme 2.2: Pain management measures

According to Lee-Meyer (2016:88), pain management practices denote the activities the nurses perform in order to reduce residents' pain experiences. Participants stated various methods they used to manage residents' pain. Three categories emerged from

the data: the use of standardised pain management procedures, embracing resident-centred care, and implementing pharmacologic and non-pharmacologic strategies.

a) Category 2.2.1: The use of standardised pain management procedures

According to the participants, they use standardised pain management procedures in their various units. They indicated that having user-friendly resources would strengthen the pain control offered by nurses. Participants confirmed that despite the existence of a standard procedure within the long-term care home, many nurses used one they were comfortable with to manage pain. The following statements illustrate these points:

> *"In this long-term care home, different nurses are using different pain assessment measures, depending on the unit preference. When a resident is transferred from one unit to another, there is no continuity of pain management. We need to use the same standard throughout the home" (FG2).*

> *"I think if our management could have more user-friendly tools for pain control, these resources should be made available to all units" (FG3).*

> *"Um, I know that there is a policy on standard pain management, but I find that people are not following the policy because it is complex, and we do not have time, there is work overload. I think it is just a piece of document that needs to be done to show to the ministry that it is what we do in long-term care" (FG4).*

The finding is supported by Anon (2014:285), who state that standard pain management procedure is systematically established to help the nurses and residents in making pain management decisions. These recommendations may be accepted, adjusted, or rejected according to pain management needs (American Pain Society 2013:45). The Registered Nurses' Association of Ontario's best practice guideline (RNAO 2013:12) presents 12 principles for pain assessment and management. The standards stated that residents need high-quality pain control measures because unrelieved pain has a negative implication on resident health and nurses should prevent pain where possible (RNAO 2013:12). In addition, the standard also stated

that nurses are legally and ethically bound to advocate for changes in the pain management plan where pain relief methods are not effective (RNAO 2013:12).

b) Category 2.2.2: Embracing resident-centred care

The concept of a resident-centred approach to pain management was mentioned in all the focus groups. This involved consideration of residents' characteristics when assessing pain, listening to residents carefully and observing behaviour. All the participants agreed that a structured programme for routine resident-centred care allows nurses to evaluate the resident's pain experiences. Participants shared:

> *"In the home, some of our residents cannot tell us they have pain; I look at the behaviours and the presentation of each resident to determine the management to be implemented and incorporated into each resident's unique care plan" (FG1).*

> *"I use a holistic approach because how and when each resident express pain is different, so, I do not conclude that what works for resident A would work for resident B. I also make sure that residents are the centre of care" (FG3).*

Many studies emphasise the importance of resident-centred care and its ability to improve the overall quality of care (Dondi-Smith 2017:159; Edvardson & Innes 2014:840; Payne 2016:307). According to RNAO (2013:20), effective pain management is reliant on an accurate pain assessment and the implementation of an all-inclusive approach to pain that includes non-pharmacological and pharmacological methods.

c) Category 2.2.3: Implementing pharmacologic and non-pharmacologic strategies

All participants stated that they implement pharmacologic and non-pharmacologic strategies to manage their residents' pain. They described various non-pharmacological ways that include repositioning, exercise/physical activity, music, pet therapy and relaxation techniques to manage pain. In addition, they use prescribed

medications such as acetaminophen and ibuprofen. The statements that follow confirm the finding:

> *"Sometimes when residents are in pain I normally give then acetaminophen or Tylenol or Ibuprofen or Naproxen as prescribed by our physician and then monitor them for some hours, and if Tylenol did not work after 2-3 days, then I am going to go up to an opioid if there is standing order as per medical directive or I would call the doctor for new order" (FG3).*

> *"Sometimes I would encourage residents to read newspapers, watching TV, listening to music to divert their attention from emotional pain" (FG3)*

Non-pharmacological and pharmacological therapies play an important role in the pain management approach. While medications are being used to manage the physiological and emotional dimension of the pain, non-pharmacological therapies help to manage the affective, cognitive, behavioural and socio-cultural dimensions of the pain (Jamison & Edwards 2014:52). RNAO (2013:7) indicates that one of the essential nursing care services in long-term care facilities is that of implementing pharmacologic and non-pharmacologic strategies to manage pain. According to RNAO (2013:20), a combination of these techniques with reasonable quantities of drugs at the correct frequency to control pain with essential dosing is a fundamental nursing precept in dealing with pain in the older adult.

4.3.3 Theme 3: Pain management challenges

Participants expressed some challenges to effective pain management in long-term care settings, and these could be described in the framework of the residents, nurses and the facility. Three subthemes emerged from the data: resident-related barriers, organisational barriers to pain management, and nurse-related challenges. The categories are presented in Table 4.4

Table 4.4: Pain management challenges

THEME 3	SUBTHEMES	CATEGORIES
PAIN MANAGEMENT CHALLENGES.	**Resident-related barriers**	• Anxiety about medication side effects • Language barrier • Cognitive challenges
	Organisational barriers to pain management	• Lack of culturally congruent pain guidelines • Lack of physician retention
	Nurse-related challenges	• Work overload • Lack of communication among nurses • Pain misconception

4.3.3.1 Subtheme 3.1: Resident-related barrier

Participants mentioned the resident-related barrier to pain expression as one of the challenges they faced in dealing with pain in a long-term care home. These also include cultural differences between residents and nurses. Three categories emerged from the data, namely anxiety about medication side effects, language barriers and cognitive challenges.

a) Category 3.1.1: Anxiety about medication side effects

Participants stated that some residents are reluctant to report pain because of the fear of side effects from medications. All the participants agreed that anxiety about pain complications prevents the residents from notifying nurses about their painful experiences and numerous strategies might be needed for nurses to collect accurate information about the older person's current pain. The participants explained:

> *"I have seen many of my residents are not willing to express pain because they have anxiety about the side effect of pain medication; hence, they would not verbalize pain early enough. Some of my residents would tell me that they do*

not want to take medication because it would add more problems, so they prefer to do without medication in the hope that their body would work it out" (FG3).

"During pain assessment, residents would tell me that the pain started some days ago, when I asked why they did not inform me, they would tell me they were afraid of medication side-effects" (FG2).

Flaherty (2012:2) agrees that residents themselves normally present barriers to pain assessment. Residents may also be unwilling to tell the nurse that they have pain because of their fear that pain is suggestive of severe pathology or even impending death (Anon 2014:287), the stress of trying to cope with the medical world, and cope with physical changes. Even when diagnosed with pain, the daily demands of living with pain can generate anxiety. Therefore, nurses must not interpret failure to report pain as the absence of pain (Flaherty 2012:2).

b) Category 3.1.2: Language barrier

All the participants agreed that understanding the role language plays is important for nurses in long-term care homes due to an increasing range of linguistically diverse populations. Participants said that many of their residents were unable to speak English; they speak different languages and express pain differently. These quotes confirm the finding:

"Some of my residents do not speak English; they fall back to their mother tongue language, which is difficult for us to understand when assessing their pain" (FG2).

"It was a challenge because we do not have enough nurses who understand the residents' language; hence, we tend to wait on the family" (FG1).

Residents may have language problems, without being cognitively impaired, or they may be cognitively impaired with no language problem (Flaherty 2012:2). According to Attal (2013:985), Canada has become an increasingly multicultural society; nurses see residents from different cultural backgrounds daily, and during nurses'

consultation, misunderstandings and confusion can still occur due to differences in language. Residents from minority groups, particularly those who do not speak the predominant English language fluently, participate less in nursing care and are often given inadequate information (Attal 2013:986).

c) Category 3.1.3: Cognitive challenges

Participants stated that another barrier to effective pain management is cognitive challenges because some residents are not able to report pain to nurses due to loss of memory. They said that when they ask the same question at different times, the answers are always different, which makes it very difficult to know which one to accept. The following statements support the findings:

> *"Many occasions I have seen my resident is in pain through their facial expression, but when I ask them about their pain, they tell me they have no pain, but when I returned after few minutes, they would confirm they have pain and show me the location" (FG1).*
>
> *"I found it very difficult to conclude after I have assessed residents who are cognitively impaired because sometimes, they did not understand my questions" (FG2).*
>
> *"Due to cognitive impairment, some of my residents cannot say where exactly is hurting, but they would only respond that they are hurting" (FG3).*

The findings are supported by Oosterman, Hendriks, Scott, Lord, White and Sampson (2014:752), who claim pain can be hard to assess in cognitively impaired residents because their self-reports of pain can be wrong or difficult to obtain. Nurses often ignored complaints of pain in persons with cognitive impairment because of inconsistent pain reports or an inability to assess pain (Flaherty 2012:1).

4.3.3.2 Subtheme 3.2: Organisational barriers to pain management

Participants mentioned insufficient pain guidelines and physician retention as the primary organisational barriers. Two categories emerged from the data: lack of culturally congruent pain guidelines and lack of physician retention.

a) Category 3.2.1: Lack of culturally congruent pain guidelines

The participants highlighted the absence of culture-based clinical guidelines for managing pain. Nurses indicated that diversity in Canada and the long-term care homes require them to be culturally competent. They need the confidence to manage chronic pain, especially where there are cultural differences between nurses and residents. Below are the verbatim quotes that support this finding:

> *"It is important to me to effectively respond to pain in residents who are from different cultures, but our organization has never introduced a standardized culturally-based pain guideline to us" (FG1).*

> *"I remember one time when I asked the director of care about the guideline on pain management for residents from Greece, she told me to go and check the policy folder under H-drive in the unit computer. I did check, but nothing was available in that folder, and none of my colleagues knew where to locate them" (FG3).*

> *"To manage the pain of residents from a different culture, I need something like a manual and intervention guideline that would help me to be more familiar with actions to take most especially when dealing with chronic pain so that I may feel confident to act upon it" (FG2).*

Corbett, Nunes, Smeaton, Testad, Thomas, Closs et al. (2016:1360) similarly relate that relevant culture-based pain guidelines play a key role in addressing areas where nurses were lacking, particularly in reporting pain and seeking treatment for residents in long-term care homes. Pain management policies can also improve the consistency

of care among doctors, nurses, and across geographical regions (Woolf, Grol, Hutchinson, Eccles & Grimshaw 2014:528).

b) Category 3.2.2: Lack of physician retention

All the participants commented that the shortage of physicians affects pharmacological measures for pain control because, on many occasions, they needed to confirm prescribed medications. All participants expressed that when the physicians left their positions, management could not find replacements. Participants indicated that they could not manage pain effectively using only non-pharmacological interventions. The participants said:

> *"Sometimes limited access to physicians led to a late response to pain because when you paged the physician for a medical order, it takes hours before you would get access to them simply because of shortage" (FG3).*

> *"Many physicians are leaving; this high turnover for us means a struggle with referrals for further management" (FG1).*

According to Booker and Haedtke (2016:55), the physician is an important stakeholder in a patient's health and wellbeing. Lack of physicians' retention is thus a problem for the healthcare system in Canada (Mehta et al. 2013:40).

4.3.3.3 Subtheme 3.3: Nurse-related challenges

Participants stated that the mismatch between staff-numbers, resident-numbers, and workload affects effective pain management and the care they rendered to their residents. Three categories emerged from the data: work overload, lack of communication among nurses, and pain misconception.

a) Category 3.3.1: Work overload

Many participants acknowledged that the number of residents assigned to them was too high to manage the residents' pain holistically. They commented that they have

very heavy workloads, which has impacted their ability to offer high quality, effective care to residents. The nurses argued that an imbalance in the nurse-resident ratio is something that management could address. Participants explained:

> *"Due to the work overload and shortage of nurses, quality of pain management is affected because nurses are burned out, in our unit hardly there is a week that I do not work overtime because we have a shortage of nurses, sometimes you do not even have time for yourself" (FG1).*

> *"I have told our management several times that there are too many residents assigned to one nurse, and nurses cannot cope because we have to attend to all the residents' needs, not only pain, and it can be very stressful" (FG2).*

Nurses' overload is a major factor in early diagnosis of pain in long-term care homes, such as excessive workloads; emotional and psychological exhaustion, also contribute to physical strain (Shahrokhi, Ebrahimpour & Ghodousi 2013:23). Consequently, this overload contributes to nurses' lack of ability to provide pain medication to the affected person, both at the scheduled time or immediately when asked by residents (Shahrokhi et al. 2013:20).

b) Category 3.3.2: Lack of communication among nurses

The majority of the participants acknowledged that communication is an important component in managing pain, especially in situations where patients might have special communication needs. The quotes below confirm the finding:

> *"It has been discussed in so many meetings that our management should develop a way for us to improve communication among nurses because we need to communicate with each other more frequently, especially about the pain management issues" (FG2).*

> *"Communicate through documentation is a challenge because the number of residents assigned to one nurse does not give enough room for verbal communication and documentation to occur at the same time" (FG1).*

According to Miu and Chan (2014:25), nurses with poor communication skills cannot assess pain and be aware that residents who are cognitively impaired have pain. The communication by nurses at some stage in pain evaluation is an essential component in managing pain in those residents (Miu & Chan 2014:25).

c) Category 3.3.3: Pain misconception

Participants indicated some level of pain misconceptions. They said some of the nurses have the perception that if the resident does not complain or show any sign of pain that they are not in pain. They said that this is not always the case because a resident could often not show they are in pain for many reasons. Participants said some nurses have misconceptions about opioids being used due to a risk of addiction, concerns about side effects, and opioids causing respiratory depression; nurses were thus reluctant to give opioids despite high pain scores. Participants stated that some nurses continue giving the same simple pain medication for many days, even though the medications are not working because of the misconception that pain is part of the ageing process. The participants explained:

> *"I have seen many times that nurses will report pain scale of 8-10 on resident medical file and yet resident gets Tylenol for more than two days because many of us believe that strong pain medication may cause another complication even though the resident has a PRN prescription on an opioid, which we should have administered" (FG1).*

> *"Many of my colleagues have told me that due to fear of opioid addiction, they would rather not give any opioid medication, but something like relaxation techniques, exercise, physical therapy and over-the-counter medications such as Tylenol" (FG2).*

> *"Some nurses have also expressed to me that they know that pain is part of the aging process that no one could do anything about it and it is better to manage it with simple pain medication like Tylenol rather than taken opioid medication that will cause another complication" (FG3).*

One major misunderstanding is the belief that pain is an expected and natural consequence of ageing (Flaherty 2012:1). Similar misunderstandings occur regarding pain perception in older adults (Anon 2014:284). It seems clinicians believe that older aged individuals are more prone to pain than young people. While this is not entirely true, it can result in the elderly receiving fewer pain medications than they need (Reid et al. 2014:35).

4.3.4 Measures to improve pain management

Participants stated that effective pain management is an important component of their nursing activities. They recommended various practices that residents, nurses and administrators can implement that may improve pain management. Two subthemes emerged from the data: organisational initiatives and interprofessional collaborations.

Table 4.5: Measures to improve pain management

THEME 4	SUBTHEMES	CATEGORIES
MEASURES TO IMPROVE PAIN MANAGEMENT	**Organisational initiatives**	• Enhance communication • Provide ongoing training for nurses • Increase family involvement in pain management initiatives • Provide adequate resources for optimal pain assessment • Implement a reasonable workload for nurses
	Interprofessional collaborations	• Enhance the existing multidisciplinary team

4.3.4.1 Subtheme 4.1: Organisational initiatives

According to Jamison and Edwards (2014:51), pain management initiatives refer to the appropriate interventions developed to control pain. RNAO (2013:44) claims that

organisations must know that all residents have the right to the best pain management possible by making pain assessment and management a priority. Six categories emerged from the data and more details about each follow:

a) Category 4.1.1: Enhance communication

Participants identified enhancing communication as a significant element in improving pain management practices. They recommended that communication practices, such as adequate communication with residents during pain assessment and with nurses during the end of shift report, could be beneficial. The statements below confirm the findings:

> *"Maintaining open and effective communication between nurses during the end of shift report could help in improving pain management" (FG3).*

> *"During pain assessment, I need to communicate with residents in a way resident can relate to by asking simple and easy pain assessment questions" (FG1).*

The findings were supported by several studies which indicated that improvement is seen when teams embody open communication in pain management (Tingle 2014:28; Kourkouta & Papathanasiou 2014:63; Kaasalainen et al. 2013:667). According to Kourkouta and Papathanasiou (2014:65), communication skills are crucial and a significant component of the nursing profession. Nurses' roles include speaking to residents of varying educational, cultural and social backgrounds, and nurses must do so in an effective, caring and professional manner; especially when communicating with residents and their families (Kourkouta & Papathanasiou 2014:66).

b) Category 4.1.2: Provide ongoing training for nurses

In all the focus groups, participants recommended the need to provide staff with ongoing training opportunities and support in handling complex cases. They believed that this could contribute to nurses' future growth. All participants emphasised the

need to understand and be aware of existing protocols. The statements that follow confirm the finding:

> *"You can only know what you are taught and prepared for; our management must arrange in-service training on pain management to help us improve our skills" (FG2)*

> *"I need to be trained on the new methods and kept up to date with the latest developments and protocols" (FG1).*

Several studies confirmed that long-term care practitioners need ongoing training on pain management (Kaasalainen et al. 2013:667; Tse & Ho 2014:8; Ferrell & Coyle 2014:56; Jones & Sharpe 2014:1570). Empowering in-service training can improve pain management and achieve a greater quality of life for residents (Chaghari et al. 2017:32). The orientation of new staff to the organisation's pain management policies, procedures and practices and ongoing professional development is a necessity (RNAO 2013:44).

c) Category 4.1.3: Increase family involvement in pain management initiatives

Participants suggested that enhanced family involvement in pain management initiatives may improve pain control practices. They believed that nurses needed to engage the family in decision-making, including potential pharmacologic treatments. They recognised the contribution of the family in the provision of essential pain control measures, especially residents with cognitive impairment. The following statements are the verbatim quotes that support the findings:

> *"Family members are a good source of healthcare information during the admission process; they also validate information, I just think that we need to get them more involved when planning pain interventions, to improve the outcomes" (FG3).*

"I will recommend getting valuable information concerning past pain management history from a family member of residents who are cognitively impaired" (FG2).

"Another way is to include family members in annual case meetings to get their support of the pain management plan" (FG1).

The findings are supported by Corbett et al. (2016:1360), who say family members play an important role in addressing aspects where they feel nurses are not meeting their pain management expectations. Sanderson, Cahill, Phillips, Johnson and Lobb (2017:200) posit that family meetings between the resident, family and nurses are important in sharing health information, clarifying the goals of care, discussing the interpretation of pain, discussing the intended pain management plan, prognosis and developing a plan of care for the resident. In addition, Cheatle and Barker (2014:302) indicated that doing the intake/admission assessment with the family encourages collaboration and effective pain management practices.

d) Category 4.1.4: Provide adequate resources for optimal pain assessment

Participants recommended that nurses need adequate resources to use on cognitively impaired residents, and they should be skilled in using them. The participants also suggested that strengthening culturally congruent pain assessment tools will enhance the quality of pain management. The statements below confirm the finding:

"In cognitively impaired residents, I need to be provided with the resources to identify pain and the use of the pain assessment tools" (FG2).

"To improve pain management, I need adequate pain assessment resources, so our management needs to make a provision for resources to provide optimal pain care, which will reduce the challenges I face" (FG3).

"Many of our nurses and residents are from different cultures; to improve pain management, it is very important to develop a cultural resource for pain assessment" (FG2).

Older adults with advanced dementia cannot report pain because of cognitive and verbal deficits; hence, there is a need to develop a method of identifying pain in this population (RNAO 2013:15). According to Oliveira (2018:4), pain assessment in cognitively impaired elderly persons remains difficult and identifying pain continues to be a daily challenge for nurses. The findings were supported by RNAO (2013:10), who agrees that using a systematic, organisational strategy to assess and manage pain through best practice guidelines and resources would enhance pain assessment.

e) Category 4.1.5: Implement a reasonable workload for nurses

Participants suggested that using the self-scheduling system by nursing staff can improve the morale of nurses and, subsequently, pain control practices. They expressed the need for the organisation to implement acceptable, universal residents' and nurses' ratios to improve quality of care, including pain control. The following verbatim quotes support this finding:

> *"If our management explores the use of self-schedule for nurses, this will positively increase nurses' morale and sense of belongings. As a result, it gets out the best from nurses when they are managing residents' pain" (FG3).*

> *"We need to use standardized residents and nurse's ratio when booking nurses for the shift, to reduce nurses' workload" (FG1).*

It is affirmed by Kaasalainen et al. (2013:668) that there are proven benefits in implementing a method that determines skill levels of nurses and balances it with a reasonable number of nurses. According to RNAO (2013:34), a reasonable workload is required for nurses to assist in providing sustainable pain management for older people. Furthermore, employers have a responsibility to provide nurses with reasonable workloads.

4.3.4.2 Subtheme 4.2: Interprofessional collaborations

All participants in the focus groups recommended that interprofessional collaborations need to be improved. Participants said team collaboration is a collective effort by all

nurses to care for all health needs of residents. One category emerged from the data: improvement of exiting the multidisciplinary team.

a) Category 4.2.1: Enhance the existing multidisciplinary team

Participants stated that the enhancement of the existing multidisciplinary team would improve pain control outcomes. The majority of the participants recommended well-structured referrals to other health professionals as a strategy to strengthen pain management. They recognised that all units must use a referral form that can be kept in each unit to help nurses monitor the status of each referral. They mentioned some of the health professionals that can be part of the team such as pain consultants, physiotherapists, massage therapists, acupuncturists and occupational therapists. The below statements confirm the finding:

> *"Holding a multidisciplinary pain management meeting weekly could enhance pain diagnoses, exchanging new ideas, resolving conflict and addressing resident care plans" (FG2).*

> *"To enhance pain management, nursing employees, private support employees (PSW) and physiotherapist method of pain assessment must be improved" (FG2).*

> *"Nurses need to improve their ability to work together as a team in assessment, planning, implementation and evaluation of pain management" (FG1).*

> *"Nurses need to learn how to use a referral form to refer all residents who have chronic or severe pain to MD or Physiotherapist" (FG2).*

> *"Every nursing unit to create a tracking binder to helps them track pain referrals, and this binder may be placed on nurses' desk so that all nurses can have access to it" (FG3).*

> *"Nurses should have knowledge of different professionals in which complex cases can be referred to" (FG1).*

According to the World Health Organization (2015:16), by implementing multidisciplinary collaboration, accepting working together and respecting one another's perspectives in healthcare, many disciplines can work more efficiently as a team to help improve residents' pain management outcomes. Caring for aged residents receiving pain interventions requires the nurses to include the primary care provider (physician) and all disciplines involved in the residents' ongoing pain management care (Anon 2014:286). The multidisciplinary team enables a positive environment and encourages good relationships among nurses (Comer & Rao 2015:66). A study by Webster (2016:5) suggested that nurses' decisions about when to request a referral for a multidisciplinary pain specialist should be based on the documentation of a need for comprehensive, multidisciplinary assessment, particularly when pain management progress is not achieving the desired results. This referral is regarded as the strength of the multidisciplinary team approach to pain management that all nurses need to incorporate into the day to day nursing activities to manage pain effectively (Webster 2016:6).

4.4 SUMMARY

This chapter presented the data analysis and descriptions of the study findings. The findings were discussed in relation to the nurses' perception of pain, nurses' responses to pain expression, pain management challenges and measures to improve pain management. All the themes, subthemes and categories were supported by verbatim quotations from the participants to address the objectives of the study. Chapter 5 will present the research interpretations, a discussion of research findings, recommendations and conclusions drawn from the study.

CHAPTER 5
INTERPRETATIONS, DISCUSSIONS OF RESEARCH FINDINGS, RECOMMENDATIONS AND CONCLUSION

5.1 INTRODUCTION

This qualitative, descriptive and explorative study was conducted to answer the following questions: how do nurses interpret and respond to pain expression by aged people at a long-term care home facility; what are nurses' beliefs and attitudes about pain management in a long-term care home facility; and what are the factors related to the effective management of pain among aged people at a long-term care home facility. This chapter presents the interpretation and discussion of findings generated from Chapter 4 of this study. Themes generated during the data analysis were used to support the interpretation and recommendations on how to improve nurses' pain management practices. This chapter also presents the limitation of the study, recommendations, contribution of the study and conclusion.

5.2 INTERPRETATION OF FINDINGS

According to the findings presented in Chapter 4, this study explored nurses' pain management practices, as well as their beliefs and attitudes regarding pain management practices. The barriers to effective pain management were identified, and nurses' interpretation of elderly people's pain expression and measures to improve pain management were reviewed. Through improvements in the control of pain, the quality of life of residents with pain will be improved, and the rate at which residents go to hospitals for pain control will be reduced.

5.2.1 Nurses' perception of pain

Nurses' perception of residents' pain is the ability to identify information from the individual's pain expression. Such information is collected using five human senses, including sight, hearing, taste, smell, and touch (Johnson et al. 2015:258). When nurses identified pain in a resident, they used their knowledge of pain, understanding

of pain etiology, and experience. Nurses seemed to have relied mostly on their nursing background and knowledge to recognise pain in the residents. They used visual and non-visual indicators of the pain, such as facial expressions like a grimace or frown, clenched jaw, quivering chin, or acting disinterested, to diagnose pain (Johnson et al. 2015:256). Data also showed that nurses managed pain through assessment using various tools, although it seemed like there was a preference for one way of doing things.

Nurses' interpretation of pain was key to the effective management of pain. Participants stated that residents with dementia who have poor communication skills could not express their pain. In addition, nurses were aware that residents who were cognitively impaired were not able to express pain appropriately. Proper pain interpretation is thus a critical factor among these groups of people. Furthermore, the findings also showed that, in some instances, cultural influences played a role in the way nurses responded to the residents' expression of pain. Nurses working in the long-term care home were from different parts of the globe, the same as their residents. They could thus have different belief systems on how to express pain (RNAO 2013:45). Nurses' perception of pain is described as challenging (Goransson, Heilborn & Djarv 2016:2246) and the working environment may also hinder the nurses' ability to demonstrate understanding and caring when residents are in pain (Bergman 2012:218).

The findings of this study showed that employers need to provide adequate guidelines on pain management measures in Canada. Nurses are obliged to practice within this scope that provides the legislative framework for pain management (RNAO 2013:45). The data showed that the meaning of pain to nurses also affected their perception of pain. The biomedical interpretation of pain, such as body malfunctioning and pathological processes associated with diseases, largely influenced the nurses. It appeared that nurses had better knowledge of the biomedical dimension in pain management than the behavioural dimension. This distinction was stronger among nurses with many years' experience than among newly skilled nurses (Prem, Karvannan, Chakravarthy, Binukumar, Jaykumar & Kumar 2017:232).

The study findings also indicated that nurses lack cultural assessment tools to perform a cultural assessment of pain. Participants stated that different nurses from different cultures perceived pain differently due to their previous knowledge of pain. According to Yennurajalingam (2018:6), nurses must be aware that in many cultures, it is considered inappropriate and culturally insensitive to discuss pain as an act of bad lifestyle engaged by the resident. Many cultures also have distinct cultural beliefs regarding the meaning, origin, and role of pain which can affect how residents interpret and perceive pain. The net effect of cultural differences in pain response often results in the over- or underestimation of the severity of pain in some residents, which could affect pain management (Yennurajalingam 2018:8). Nurses should also be aware of the cultural beliefs, values, and behaviours that influence their own responses to residents' pain.

5.2.2 Nurses' responses to pain

Findings from this study indicated that nurses responded to the pain expression of an elderly person through pain assessment. The participants recognised that residents with cognitive, sensory or motor deficits were not able to give adequate pain expression through verbal communication. Therefore, they mostly relied on pain indicators, such as facial expressions, vocal signs, enhanced confusion and withdrawal. They used a customised pain assessment tool in addition to behavioural observations. The standardised pain assessment tools, such as numeric rating, verbal descriptor, faces pain scale and VAS to respond to pain were regarded as reliable but were not uniformly used by all nurses (Lee-Meyer 2016:104).

The assessment of pain included the usual nursing assessment procedures such as inspection and palpation, including a comprehensive physical examination and health history. The focus of assessment seemed to be on neuromuscular and musculoskeletal systems. Hogan (2014:202) agrees that pain etiology helps to obtain information that would lead to a nursing diagnosis and an effective plan of intervention. Selecting pain assessment tools should be a collaborative decision between residents and nurses (Laranjeira & Quintao 2014:1). Therefore, nurses and care providers need to consistently use valid, reliable, and practical pain assessment tools that are appropriate for the residents (Booker & Haedtke 2016:69).

Other methods by which nurses responded to pain included the implementation of pharmacological and non-pharmacological methods, such as diversional therapy. These appeared to have been prescribed by physicians; the study could not find any unique nursing intervention developed by these nurses. There was mention of resident-centred care approaches, however, only a few seemed to practice such methods. According to RNAO (2013:20), effective pain management is reliant on an accurate pain assessment and the implementation of an all-inclusive approach to pain that includes non-pharmacological and pharmacological methods.

5.2.3 Pain management challenges

The study showed that nurses had some challenges in managing residents' pain effectively. Some of those barriers were listed as being resident-related, organisational and nurse-related challenges. However, the findings from this study supported the fact that verbal communication between residents and nurses is an important component of pain assessment. This is problematic with residents who are non-English speaking, as a lack of proficiency in the language of communication becomes an obstacle to identifying pain location and intensity. The language barrier also appeared to have affected the conversation on pain between nurses who are English speakers, but who do not originate from Canada. The lack of effective verbal exchange strategies with residents and nurses can, consequently, prevent the effective management of pain (Pasero & McCaffery 2014:37; Berben et al. 2013:21).

Cultural differences between nurses and residents were also indicated as a challenge. Cognitive barriers pose a severe problem to effective pain management. The alteration in mental status affects the self-report ability and has a direct positive correlation with pain severity ratings. Nurses need to learn individuals' unique responses to pain, underlying reasons for pain, responses to treatments, and the best pain management strategies to be implemented to meet the outcome of pain control (Veal, Williams, Bereznicki, Cummings, Thompson, Peterson et al. 2018:182). Low nurse-to-resident ratios were identified as the main reason for nurses' work overload, and this factor was among the most frequently mentioned barriers by all participants.

All participants also identified nurses' lack of training on pain management as barriers to pain management. Nurses were hindered by their failure to use pain rating scales to assess residents' pain intensity. Misconceptions by nurses and the unavailability of cultural pain guidelines delayed effective pain management practices. In addition, residents were afraid of the side effects of analgesics. According to Veal et al. (2018:182), many would prefer not to take any drugs because of concerns about developing dependence or other side effects. Some residents and family view pain medications as comprising many complications and side effects; they believe it is therefore better to recover without the help of medications.

Findings from the study moreover showed that lack of physician retention challenged continuity of care. Earlier studies have continuously produced comparable outcomes as the present research in terms of the adverse effects of insufficient physician collaboration and insufficient pain relief medication prescription (Kaasalainen et al. 2013:665; Berragan 2013:254).

5.2.4 Measures to improve pain management

The goal for the treatment of pain is to restore the residents' functional capacity and improve the overall quality of life. The participants recommended some measures, such as organisational and interprofessional initiatives, to improve pain management in long-term care homes. Results showed that nurses were eager to improve the quality of life of the residents. They made several recommendations to improve their practices, such as enhanced communication, ongoing training for nurses and increased family involvement in pain management initiatives. They also suggested that providing resources for optimal pain assessment, implementing a reasonable workload for nurses and introducing an incentive for nurses are other strategies to improve pain management. The barriers to optimal pain management included difficulty identifying and assessing pain, residents' resistance to reporting pain and taking medications, and communication barriers between nurses and residents (Veal et al. 2018:180).

Pasero and McCaffery (2014:38), who reported on the benefits of training on pain management practice, support the findings on the importance of training in general,

and on cultural pain assessment and management in particular. Participants recommended facility administrators to develop culturally congruent pain guidelines. This was indicative of their awareness of cultural diversity and the need to be culturally competent. They recognised the impact of high workload on them and suggested the use of the self-scheduling system and the introduction of incentives to reduce nurses' turnover rate. Findings from the study showed that the enhancement of an existing multidisciplinary team and strengthened referrals to other health professionals could also improve pain management.

5.3 LIMITATIONS OF THE STUDY

The findings of a qualitative study cannot be generalised; instead, its purpose is to provide a deep understanding of a situation through research. This study focused on nurses' pain management practices, and was conducted in only one long-term care home facility in Ontario, Canada. Therefore, the findings cannot be generalised to the rest of the facilities. Generalisation would require a more extensive study of a representative sample of long-term care home facilities in the province. Another limitation of this study is that the scope did not include residents' perceptive regarding pain management.

5.4 RECOMMENDATIONS

The core concept of optimising effective pain management practices is that of creating a relationship-oriented environment supportive of optimal pain management practices. To accomplish this objective, the following recommendations should be implemented:

- Provision of ongoing training in pain management for staff.
- Enhancement of communication lines among healthcare professionals, residents and family members.
- Creation and implementation of standard operating procedures for detecting, assessing and managing pain.
- Strengthening the multidisciplinary team approach.

- Improved implementation of policies with regards to nurses' pain management practices.
- Implementation of a reasonable workload and self-scheduling for nurses.
- Provision of resources to identify pain in cognitively impaired residents.

5.4.1 Recommendations with regards to resident care

To improve the quality of pain management practices rendered to elderly people, it is recommended:

- Increase family involvement in pain management initiatives.

5.4.2 Recommendations with regards to nursing education

To improve the knowledge and skills of nurses in rendering quality pain management practices, nursing education should include:

- Basic and evidence-based pain management practices incorporated into the pain management of elderly people.
- Practical pain assessment tools to assist nurses in detecting pain problems among elderly people.
- Continuous professional training on pain management practices must be improved.

5.4.3 Future research

The researcher recommends that further research should be conducted in the following areas:

- The importance of the resident-centred approach and creating an environment supportive of effective pain management practices.
- Residents' perceptions of pain management practices.

5.5 CONTRIBUTION OF THE STUDY

This study elaborated and highlighted nurses' beliefs and practices of pain management in a long-term care home facility. Some barriers to pain management were recognised to alert decisionmakers, nursing directors and nurses to implement changes that will enhance pain management practices. It was shown from the data that pain assessment is an essential part of the pain management process and, as such, nurses ought to be competent in that skill. The study identified the need for a unique assessment tool for residents with some form of cognitive impairment. Studies also show that nurses have an obligation to routinely screen all residents for pain because disease, treatment, and other factors may inflict new pain during treatment and follow-up (Long, Morgan, Alonso, Mitchell, Bonnell & Beardsley, 2010:154; Li & Osborne 2018:6).

It is presumed that the findings will increase nurses' awareness of the barriers to effective pain management among the elderly. This will enable nurses to make informed decisions when caring for the elderly in long-term care homes. The researcher believes that insights from this study would inform policy regarding the cultural assessment of pain as well as referral protocols and team approaches. The study provides a strong basis for concluding that addressing pain management through interdisciplinary care models holds some promise, especially among the institutionalised geriatric population (Tse & Ho 2014:9; Jones & Sharpe 2014:1576; Kaasalainen et al. 2013:667).

5.6 CONCLUSION

Managing pain in a long-term care home presents unique considerations. Nurses need special skills to provide effective pain management to the elderly, who at times may not be able to communicate their pain. In such settings, the study found that the family becomes a critical factor in liaising with nurses and providing some cues regarding the elderly individual's behaviours associated with pain, especially upon admission. The setting seems to be multicultural in terms of nurses as well as residents; this requires nurses to be culturally aware of different forms of pain expression. This can only happen if there are guidelines on the cultural assessment of pain.

Effective pain management practices can be a complex phenomenon in a long-term care home. Nurses play an important role in providing continuity of care, and ongoing assessment of pain intensity is needed on admission and continuously. Nurses recognised that they could not rely on traditional methods of pain assessment in residents with dementia; instead, they must consider pain indicators such as changes in mood and behaviour to provide an accurate assessment.

Uncontrolled pain can impact residents physically, mentally, and socially in many respects, including causing a problem with activities of daily living, sleep, and mobility. Based on the results of this study, the nurses' responses reflected a relative understanding of pain management practices. The barriers to effective pain management were highlighted, and a shortage of nurses and nurses' workload are persistent challenges in all healthcare facilities. A readily available comprehensive pain assessment protocol would be beneficial.

The population serving in long-term care requires increased awareness of pain expression and management, and improved practices to make a sound nursing diagnosis. Interdisciplinary support is also necessary; this could include physiotherapists, psychologists, nurses, physicians and occupational therapists. Continuous in-service training would benefit residents and nurses. It is evident from findings that pharmacological interventions alone might not be adequate, and non-pharmacological interventions need to be refined. As such, physiotherapists should support nurses and provide appropriate training programmes. Non-pharmacological methods of pain management should also be discussed and initiated in a team setting.

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ANNEXURE A: INFORMED CONSENT TO PARTICIPATE IN THE STUDY

What is the study about?

This is a study being conducted by Justin Oluwasegun Rojaye as part of Master of Nursing Science at the University of South Africa. You are invited to participate in this study in your capacity as Registered Nurses working at one of the long-term care homes located in Ontario, Canada. The purpose of this study is to explore nurses' pain management practices in Ontario long-term care homes. The ultimate aim is to recommend measures for the effective pain management in a long-term care home and to explore the nurses' perceived barriers that hinder the delivery of effective pain management to an aged person living in long-term care homes.

What will I be asked to do if I agree to participate?

You will be requested to answer questions related to the study that will be asked by the researcher. The questions will not take more than one hour. The answers will be based on your experience or views. They do not require any prior preparation.

Would my participation in this study be kept confidential?

The information you will share with the researcher will be kept confidential as much as possible. Your name or address is not required. The documented interview responses will be locked away by the researcher. No individual names or identity will be used in the report. Should an article be written about this study, your identity will be protected to the maximum extent possible.

What are the risks of this study?

There are no known risks associated with your participation in this study. However, you have the right to refuse to answer any question that makes you feel uncomfortable.

What are the benefits of this study?

This study will not have any monetary benefit to you as a participant. However, your experiences will assist the researcher to make a recommendation for nurses' pain management practices in Ontario long-term care homes. Your participation will contribute to the learning process of the researcher.

Do I have to be in this study, and may I stop participating at any time?

Your participation in this study is entirely voluntary. You may choose not to take part in the study. You may decide to withdraw your participation at any time should you

decide to participate in the study, and you will not be penalised or lose any benefits which you otherwise qualify for.

What if I have questions?

If you have any questions about the study itself, please contact me (Justin Oluwasegun Rojaye) on Telephone: 416 302 3071 or on Email: 60825588@mylife.unisa.ac.sa or justinroe2020@yahoo.com

This study has been approved by the Department of Health Studies' Ethics Committees, University of South Africa. Should you wish to report any problems you have experienced in relation to the study, please contact Dr. Margaret Ramukumba, the study Supervisor on Tel number: +27 726302504 or E-mail: ramukmm@unisa.ac.sa or Prof J Marits, the Head of the Department of Health Studies' Ethics Committees on Tel number: +27-827888703 or E-mail: maritje@unisa.ac.sa

Declaration by the participant

I .... voluntarily consent to participate in the study mentioned above project. The background, purpose, risks and benefits of the study have been explained to me. I also understand that I may withdraw from the study at any time without consequences. I know that my participation in the study will be acknowledged, although my identity and the identity of the health facility will be withheld.

I understand that my participation in the study is voluntary.

……………………….	……………………..
Participants' signature	Date
....	....
Witness	Date

Declaration by investigator

I, **Justin Oluwasegun Rojaye** declare that:

- I explained the information in this document.
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understand all aspects of the study, as discussed above.
- I did/did not use an interpreter.

________________________ ___________

Signature of investigator **Date**

ANNEXURE B: LETTER SEEKING PERMISSION FROM TALL PINES LONG-TERM CARE HOME

Tall Pines Long-term Care Home
1001 Peter Robertson Boulevard
Brampton, Ontario L6R 2Y3
Canada

REF: REQUEST FOR PERMISSION TO COLLECT INFORMATION FROM NURSES

Dear,

The above matter refers. I am enrolled with the University of South Africa (UNISA) as Master of Nursing Science student. In partial fulfillment of the requirements to complete my studies, I have to carry out a study, and it is entitled: **NURSES' PAIN MANAGEMENT PRACTICES IN ONTARIO LONG-TERM CARE HOMES.**

The purpose of this study is to explore nurses' pain management practices in Ontario long-term care homes. The ultimate aim is to recommend measures for the effective pain management in aged people and to explore the nurses' perceived barriers that hinder the delivery of effective pain management to an aged person living in long-term care homes.

The study is to be done in the Department of Health of the University of South Africa (UNISA), with the assistance of a supervisor who is allocated to me. This request is introduced to the Tall Pines Long-term Care Home to obtain approval to collect information from registered nurses working at one of the nursing homes located in Ontario, Canada for the study.

My supervisor and the chairperson of the Ethics Committee can be accessed through the following details:

Supervisor: Dr. Margaret Ramukumba
Tel: +27726302504
Email:ramukmm@unisa.ac.sa

Ethics committee chair: Prof JE Marits
Tel: +2712 429 6534
Email: maritje@unisa.ac.sa

I hope to hear from you.

Regards,

Mr. Justin Oluwasegun Rojaye
ID Number: 60825588
22 Baby Pointe Trail
Brampton, Ontario L7A 0W3
Cell Number: +1 416 302 3071
Email: 60825588@mylife.unisa.ac.sa

ANNEXURE C: LETTER OF APPROVAL FROM TALL PINES LONG-TERM CARE HOME TO CONDUCT THE STUDY

Health Services

Long Term Care
Tall Pines

1001 Peter
Robertson Blvd.
Brampton, ON
L6R 2Y3
tel: 905-791-2449

peelregion.ca

Justin Oluwasegun Rojaye
ID Number: 60825588
22 Baby Pointe Trail
Brampton, Ontario L7A 0W3

August 28, 2017

Re: Permission to conduct study at Tall Pines Long Term Care facility

The Administrative section of the Peel Region Long Term Care reviewed your application to conduct a study at one of our long term care homes. This is to inform you that your request to conduct the study on NURSES' PAIN MANAGEMENT PRACTICE IN ONTARIO LONG TERM CARE HOMES in Tall Pines Long Term Care Home for partial fulfillment to your Master of Nursing at University of South Africa has been approved.

Kindly be informed that:

- In the course of your study there should be no action that disrupts the nursing services of the home.
- After completion of the study a copy of your final report should be submitted to the Nursing Department to serve as a resource.
- The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
- You are requested to respect the confidentiality of the study participants and the long term care home.
- The above approval is valid for a 2 year period.
- If the proposal has been amended, a new approval should be sought from the home.
- All findings from the research must receive appropriate approval by Tall Pines Long Term Care home Director/designate prior to their release.
- Your cooperation will be highly appreciated.

I wish you much success in your study, and look forward to receiving a report of your findings.

Sincerely

Valrie Lewin
Acting Administrator

ANNEXURE D: DEPARTMENT OF HEALTH STUDIES, HIGHER DEGREES COMMITTEE, UNISA: ETHICAL CLEARANCE CERTIFICATE

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES
REC-012714-039 (NHERC)

1 November 2017

Dear Justin Oluwasegun Rojaye

HSHDC/739/2017
Justin Oluwasegun Rojaye
Student No:60825588

Supervisor: Dr MM Ramukumba
Qualification: PhD
Joint Supervisor: -

Decision: Ethics Approval

Name: Justin Oluwasegun Rojaye

Proposal Nurses pain management practices in Ontario long care homes

Qualification: **MPCHS94**

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted from 1 November 2017 to 1 November 2019.

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 2 August 2017.

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*

2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *[Stipulate any reporting requirements if applicable].*

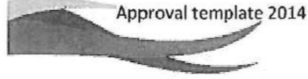
Note:
The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,

Prof JE Maritz
CHAIRPERSON
maritje@unisa.ac.za

Prof MM Moleki
ACADEMIC CHAIRPERSON
molekmm@unisa.ac.za

Prof A Phillips
DEAN COLLEGE OF HUMAN SCIENCES



ANNEXURE E: INTERVIEW GUIDE

BIOGRAPHIC DATA

1. What is your highest nursing qualification? ______________________
2. How many years of nursing experience do you have? ___________
3. How long have you been working at a long-term care home? __________
4. How old are you? ________________
5. Employment status (Permanent or Fixed term) __________________
6. Gender___________________

INTERVIEW QUESTIONS

1. What is your understanding of effective pain management for an aged person?
2. What guides your pain management practices at a long-term care home?
3. What do you think about the way an aged person' express their pain at the long-term care home?
4. How do you respond to their expression?
5. What are the challenges to effective pain management you have encountered at a long-term care home?
6. How can these challenges be overcome?

Thanks for your feedback!

ANNEXURE F: LANGUAGE EDITING CERTIFICATE

Leatitia Romero
Professional Copy-Editor, Translator and Proofreader
(BA HONS)

Cell: 083 236 4536
leatitiaromero@gmail.com
www.betweenthelinesediting.co.za

1 November 2019

To whom it may concern:

I hereby confirm that I have edited the dissertation entitled: "NURSES' PAIN MANAGEMENT PRACTICES IN ONTARIO LONG-TERM CARE HOMES". Any amendments introduced by the author hereafter are not covered by this confirmation. The author ultimately decided whether to accept or decline any recommendations made by the editor, and it remains the author's responsibility at all times to confirm the accuracy and originality of the completed work.

Leatitia Romero
(Electronically sent – no signature)

Affiliations

PEG: Professional Editors Group (ROM001)
EASA: English Academy of South Africa
SATI: South African Translators' Institute (1003002)
SfEP: Society for Editors and Proofreaders (15687)
REASA: Research Ethics Committee Association of Southern Africa (104)