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Nurses' Perception of Pain Assessment in Cognitively Impaired Older Residents in Long-Term Care

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This is to certify that the doctoral dissertation by

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Abstract

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MSN, Grand Canyon University, 2016

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Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Nursing Education

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Abstract

Pain has been a significant problem in old age and is more problematic in cognitively impaired older residents (CIOR) because of their inability to express themselves. The goal of pain assessment in CIOR is to treat pain before it escalates to behavioral problems. The purpose of this descriptive qualitative study was to explore nurses' perceptions of pain assessment in CIOR in long-term care facilities. Watson's theory of human caring was used to frame the study. A purposive sample of eight nurses was recruited from two long-term care facilities for interviews conducted using the telephone and continued until saturation was reached. Data was manually transcribed after collection. Results indicated three themes; difficulty, pain assessment tools, and pain management. Findings showed that nurses have different perceptions of pain assessment and manage pain differently depending on the residents. Further study is recommended on pain in CIOR to explore the lived experiences of other health care professionals. Findings may affect positive social change in long-term care facilities by increasing nurses' awareness and understanding of the consistency and accuracy of pain assessment in CIOR. Positive social change may occur in long-term care facilities through improved CIOR care and relationships with families and the community.

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Dedication

This study is dedicated to Almighty God for his mercy upon me throughout this course; my sons, Godwin Bolaji and Olukorede Isaac Owolabi; my daughters, Rolanda Ayomide and Comfort Damilola Owolabi; my mother, Esther Omolayo Ajayi; and my brother, Adewuyi Olorunfemi.

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Chapter 1: Introduction to the Study

Pain is a general term that describes the uncomfortable sensations of the body, which stem from the nervous system's activation (Reyes et al., 2019). Pain is an uncomfortable feeling that can be acute or chronic. Pain assessment in cognitively impaired older residents (CIOR) is vital for their care. The pain they experience can be acute or chronic, and because of the cognitive impairment, the residents cannot express themselves; therefore, they suffer through their pain most of the time. The residents in long-term care often complain of chronic pains. However, cognitively impaired residents cannot complain of pain due to their inability to express themselves, which results in misdiagnosis and undertreatment. Gimenez-Llort et al. (2020) found that underdiagnosed and undertreated pain in a cognitively impaired patient with diminished verbal communication leads to poor quality of life.

I explored nurses' perception of pain assessment among older cognitively impaired residents in long-term care facilities. Pain in older residents can be due to diseases such as arthritis or injuries such as falls. When the resident is cognitively impaired, it makes the pain assessment difficult for nurses, resulting in misdiagnosis or undertreatment. Pain ranges from annoying to debilitating, such as cancer pain, which can feel sharp and stabbing, or like a dull ache. Pain can also be localized (minor injury or headache) or generalized (the whole body), and pain is an uncomfortable feeling Gimenez-Llort et al. (2020). Aging inclines individuals toward various comorbidities, especially pain, unrelated to their vulnerability (Atee et al., 2018). The residents cannot express themselves when in pain, leading to their pain being ignored and undertreated.

Nurses often underassess their pain, resulting in behavioral problems such as anxiety, agitation, and loud outbursts. Adequate pain assessment will enable the nurses to recognize the residents are in pain. Nurses can administer treatment before the pain worsens to prevent behavioral problems such as anxiety, fidgeting, loud outbursts, agitation, fighting, kicking, throwing punches at others, and disrupting the environment. Such behavior can also lead to injuries and sometimes death; these can be prevented by adequate assessment and proper management. According to Center for Social Change (2022) at Walden University, positive social change is a deliberate process of creating and applying ideas, strategies, and actions to promote the worth, dignity, and development of individuals, communities, organizations, institutions, cultures, and societies. The current study may effect social change by enabling the nurses caring for CIOR to recognize when they are in pain and act promptly to manage their pain to 0promote comfort and self-dignity. The study may also promote pain assessment and management knowledge to prevent behavioral problems leading to injury. Chapter 1 includes a detailed description of the background of the study, problem statement, purpose, research questions, conceptual framework, nature of the study, definitions, assumptions, scope of delimitations, limitations, and significance of the study.

Background

CIOR experiencing pain may exhibit behavioral symptoms such as grimacing, restlessness, crying, moaning and groaning, inability to eat, avoiding contact with others, problems falling asleep, anxiety, and loud outbursts (Felman & Bell, 2020). These signs may indicate pain or symptoms of other illnesses, making it difficult for nurses to identify when CIOR are experiencing pain. Venable and Cruz-Oliver (2018) described pain in a person with cognitive impairment as challenging to assess because of their inaccurate self-report of pain. Overall, pain in CIOR poses difficulties for nurses to assess because of residents' inability to express themselves and their behavioral outbursts, interpreted as agitation.

Pain assessment is an essential aspect of the care of CIOR. Adequate assessment will enable the nurses to diagnose and administer the proper treatment for pain experienced by individual residents. Nurses need to be conversant with the resident's moods to know when they deviate from the standard, suggesting pain and discomfort. Rababa and Al-Rawashdeh (2019) found that the association of pain assessment scope, nurses' certainty, and cognitive and verbal characteristics of nursing home residents are essential to patient outcomes. Therefore, the nurses' understanding of pain assessment in nursing home residents is crucial to their treatment.

Nursing home residents often suffer through pain due to their inability to express themselves. Pain intensifies when there is no adequate treatment; most of the time, the residents can suffer through it. The nurses often neglect pain in the cognitively impaired because they cannot complain or ask for pain medication. When the pain becomes unbearable, residents tend to result to violence to get the attention they need, and when this happens, the nurses will medicate them for agitation, which will mask the pain symptoms. Ogidan et al. (2018) identified pain assessment as the first step in pain management and relief, and a crucial element of patient care. Ogidan et al. also described meager pain management as a burden on the patient, health care systems, and society.

Nurses can use several methods of assessing pain in CIOR to make a proper diagnosis and treatment. Navatio et al. (2020) studied the reliability of the Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC) and Pain Assessment in Advanced Dementia Scale (PAINAD) in assessing pain in patients with advanced dementia after surgery. Navatio et al. assessed nurses' preference for either instrument and found that nurses prefer the PACSLAC even though it is a time-intensive tool. Navatio et al. applied Snow's conceptual model of pain assessment for nonverbal people with dementia for practitioner pain rating through a combination of demography, pain history, pain knowledge, and relationship with patients. The results suggested that more thorough PACSLAC may improve pain assessment and treatment. Nurses in long-term care need to be knowledgeable of pain assessment in residents; this will enable them to apply other pain remedies and administer medication. Nurses must also be knowledgeable of all pain assessment tools and know how to use them at any time to avoid mismanagement, which may result in deprivation of adequate care resulting in low morale and self-esteem among residents.

Currently, pain assessment tools are used for cognitively impaired residents (Navatio et al., 2020). A literature review specified that studies had been carried out on pain assessment strategies for people with cognitive impairment in the nursing home (Bobo, 2019). However, no study has been found that addressed nurses' perception of pain in long-term care facilities, enabling nurses to assess pain in residents and know how to manage it. The gap that the current study intended to fill related to the absence of nurses' perception of pain management in cognitively impaired long-term care residents.

This understanding is essential to prepare nurses to effectively manage the pain in cognitively impaired residents for their comfort, their family's peace of mind, the nursing home staff's safety and job satisfaction, and the provision of a peaceful nursing home environment.

Problem Statement

The assessment of pain in CIOR in long-term care facilities has been a problem for nurses working with these residents related to their inability to verbalize their pain. Most older residents in long-term care facilities have one form of cognition impairment or another; it may be mild or severe (Centers for Disease Control and Prevention, 2020). Davis and Tucker (2018) suggested that pain may be camouflaged in patients with cognitive impairment who cannot dependably express and describe their pain experience. Cognitive impairment makes it difficult for nursing home residents to complain about pain because they cannot differentiate their symptoms. Nevertheless, pain assessment in nursing home residents is vital for their care (Meldrum, 2020). Hale and Marshall (2017) highlighted that proper pain management is essential for older adults with cognitive impairment, vulnerability, and unrelieved pain due to the inability to articulate pain. However, some health care providers have specious beliefs regarding pain and may not recognize its severity when the patient cannot verbalize it effectively (Hale & Marshall, 2017).

Goebel et al. (2019) found that nurses must rely on behavioral observation tools to assess and manage pain in patients with cognitive impairments who cannot self-report pain. Evidence supporting the PAINAD psychometric efficacy for pain screening in older adults is lacking in medical-surgical units. The Critical Care Pain Observation Tool has also been used, but the PAINAD is a reliable and valid tool for pain screening for older adults with cognitive impairment in medical-surgical settings. Goebel et al. described behavioral tools for pain screening in cognitively impaired patients as relevant to their pain assessment and treatment. Also, understanding the pain experiences of delirium-positive patients remains challenging, and nurses should consider frequent screening for pain in medical-surgical units.

Binnekade et al. (2018) assessed pain occurrence, intensity, and pain medication use in older patients with a diagnosed subtype of dementia (mild cognitive or subjective cognitive impairment). The research was conducted on patients recruited from three outpatient memory clinics. Binnekade et al. excluded primarily mentally disabled patients from the study and assessed pain in patients age 60 and over by asking them if they were experiencing a different type of pain than usual. Patients who complained of pain were treated with analgesics, and further research was recommended. After analyzing these research articles, I identified a gap that my study addressed, which was nurses' perception of pain management related to pain assessment in cognitively impaired residents in long-term care facilities.

With no appropriate assessments and treatments, CIOR experiencing pain may degenerate with increased depression and additional comorbidities. In this case, nurses should use their knowledge and skills to treat these patients' pain (Harmon et al., 2019). Inadequate assessment and undertreatment or untreated pain can lead to the CIOR not responding well to treatment. When there is pain, it affects the whole system and makes the individual uncomfortable, restless, anxious, and agitated. Prompt pain assessment and management will facilitate recovery in these populations. Ludvigsson et al. (2020) indicated that the lack of systemic use of pain assessment among people with cognitive impairment and their difficulties expressing pain might lead to undertreatment of pain. Inadequate pain assessment tools can result in inadequate pain management and relief, prolonging the disease process among CIOR in health care facilities. The research problem was the gap in nurses' knowledge and perception of pain assessment in CIOR in long-term care. Pain assessment in this population is a vital component of their care; nurses need to be proficient in assessing pain among CIOR and knowledgeable about pain management.

Purpose of the Study

The purpose of this descriptive qualitative study was to explore nurses' perception of pain assessment in CIOR in long-term care facilities. I explored the lived experience of the nurses' perception of pain assessment in CIOR in long-term care facilities. My research aimed to facilitate adequate pain management among the cognitively impaired nursing home population. Managing pain in CIOR can be challenging for nurses because of residents' inability to express themselves (Docking et al., 2018). Nurses are closer to patients than other health care providers; nurses observe the patients and know when things are not right with them, but there is a difference between knowing when things are not right and knowing what is wrong or what to do. Most of the time, the nurses are confused about what is wrong with the residents because they cannot express themselves; therefore, nurses misinterpret their pain symptoms as agitation (Docking et al. 2018).

Knowing what is wrong with the residents, the nurses will tend to the problem by making an adequate pain assessment and administering treatment to alleviate the pain. The method of inquiry in the current study included a descriptive qualitative design. The nurse participants described their experience with CIOR during pain assessment and management. This approach enabled me to collect raw data on the nurses' experience of pain assessment in CIOR.

Research Questions

The main question was the following: What are nurses' perceptions of pain in an older cognitively impaired resident? The subquestions were the following:

1. What are the manifestations of pain recognized by nurses in cognitively impaired residents?
2. What are the barriers to pain assessment encountered by nurses in older cognitively impaired residents?

Conceptual Framework

My conceptual framework was used to address the issue of assessing and caring for CIOR with pain. Watson's (2006) theory of human caring is a human science of person and health-illness experiences mediated by professional, personal, scientific, artistic, and ethical personal care transactions. I used Watson's (2006) theory of human caring because caring science aids in embracing the positive energy that flows from an integrated mind, body, and spirit. This approach is equally rewarding to the patient and the nurse. The theory states that "there are unity and harmony within the minds, body, and soul" (McEwen & Wills, 2014, p. 43). According to Watson (n.d.), "the emerging philosophy and theory of human caring sought to balance the cure orientation of medicine, giving nursing its unique disciplinary, scientific, and professional standing with itself and its public" (p. 6). Watson (n.d.) stated that caring can be adequately demonstrated and practiced interpersonally. Caring satisfies human needs and facilitates health promotion for individuals, families, and the community (Watson, 2006). Watson (2006) also emphasized the nursing process (assessment, planning, intervention, and evaluation); this is in line with managing pain in CIOR. The assessment results can determine the treatment, giving the patients relief, comfort, and self-dignity. Pain assessment and CIOR were the two central concepts in the current study. The concepts aligned with the phenomenon of interest and the research questions.

My conceptual framework was based on the theory of human caring by Watson (n.d.). I explored how nurses perceive pain assessment in CIOR using the framework. Nurses often misdiagnose pain in these residents because they cannot verbalize their pain symptoms; they exhibit signs that make them anxious and agitated (Ford, 2017).

Nature of the Study

I study used a heuristic inquiry method of descriptive qualitative research. This method was used to explore the lived experience of individual nurses' and their perception of pain assessment in CIOR in long-term care facilities (see Moustakas, n.d.). The method was used to answer the qualitative research questions. Moustakas (n.d.) stated that "heuristic research methods are open-ended, meaning that any form of creative expression or channel of exploration is an appropriate method for scientific investigation" (p. 3). Heuristic qualitative research places human experience above numbers, emphasizing quality, meanings, and essence instead of quantity and appearances (Patton, 2015). Data were collected from in-depth interviews with RNs and LPNs with 2 or more years of experience caring for CIOR. The data were analyzed with a hands-on coding method and Quirkos.

Definitions

Assessment: The act of making a judgment about something. In the case of nurses, assessment is the act of making a judgment about their patients and their environments and taking appropriate action to prevent complications (Khan, 2019). Assessment is done on admission as part of initial care and continues until the patient is discharged.

Cognitive impairment: A neurological problem associated with the inability to remember, learn new things, concentrate, and make decisions (Jansen et al., 2018). Cognitive impairment can be mild, moderate, or severe. It is caused by aging, disease conditions such as Alzheimer's, thyroid issues, dehydration, and recurrent depression. A recent study showed that cognitive impairment could occur due to COVID-19 in the older population (Liu & Lai, 2017). Severe acute respiratory syndrome associated with coronavirus 2 (SARS-Cov-2) infection causes damage to the immune and nervous systems, which can increase the risk of long-term cognitive decline in the older population (Liu & Lai, 2021). The cognitively impaired patients experiencing pain are often unable to report their pain to their caregivers; therefore, the residents in long-term care are often misdiagnosed, and nurses misconstrue their pain for behavioral problems.

Long-term care: A variety of services designed to meet a person's health or personal care needs during an extended period, which enable people to live independently and safely when they can no longer care for themselves or tend to their activities of daily living (National Institutes of Health, 2017). People go to long-term care after severe disease, ongoing health issues, and disabilities that do not allow them to do things themselves.

Pain: An unpleasant sensation that may be acute or chronic, resulting from illness or injuries (Felman & Bell, 2020). According to the International Association for the Study of Pain (2021), "pain is unpleasant sensory and emotional experience associated with actual or potential tissue damage which cannot be inferred solely from activity in sensory neurons" (p. 4). Acute pain is generally intense and starts and stops frequently; it lasts about 6 months and goes away when the underlying cause is gone. It may occur under some conditions such as headache, toothache, sore throat, muscle cramps, stomach ache, bruises, burns, sprains, labor and childbirth, menstrual pain, and fractures. Chronic pain can result from chronic illnesses such as cancer, arthritis, gout, chronic migraine, and fibromyalgia (Weatherspoon, 2021). Pain by any means poses a threat to human dignity, and in the case of those who cannot express themselves, the risk of agony increases throughout life (Gimenez-LLort et al., 2020).

Assumptions

Assumptions are necessary because assumptions are the foundation of any credible and valid research work. Assumptions describe what the researcher believes is accurate but cannot demonstrate (Grove et al., 2013). For my study, I assumed that nurses would honestly express their perception of pain assessment in CIOR. Another assumption was that nurses would answer the questions honestly.

Scope and Delimitations

Exploring what pain assessment in CIOR means to nurses was the goal of this study. Even though pain is considered the fifth vital sign, some nurses do not take time to assess the residents for pain, which delays their recovery progress. This can also result in violence, which may be detrimental to residents' health. The study was conducted in a long-term care facility among nurses with 2 or more years of experience caring for CIOR. Nurses with fewer than 2 years of experience working with CIOR were not considered because they may have lacked the knowledge and skills involved in taking care of these residents. Other health care professionals such as physicians, nurse practitioners, social workers, and certified nursing assistants were not included because the main subjects were nurses taking care of CIOR.

I considered using Newman's (1990) theory of expanding consciousness. According to Newman, time is conceptualized as either subjective or objective and is viewed in a holographic sense; time is considered an index of consciousness. Furthermore, a person must be fully present at the moment, knowing that all experiences are the manifestation of evolution to higher consciousness. Time is essential in recognizing that time frame helps nurses and patients recognize patterns and reorganize activities. Newman argued that time management might help nurses and patients regain consciousness. In cognitively impaired patients, poor assessment or underassessment can cause the patient to become agitated and may lead to death if time is wasted. I decided to use Watson's theory of care because the basic rule to relieve pain and promote comfort is through adequate care, which involves assessing pain and proper management, promoting a calm demeanor and environment. Even though nurses are responsible for assessing pain in CIOR, the management is not limited to nurses; it also involves physicians who prescribe pain relief medication and therapists who massage the affected area.

I used a descriptive qualitative design, a method that enables individuals to describe their experience about the phenomenon under study because it aids in prompting individual participants to describe their lived experiences. I used the interview as the mode of data collection. I would have also used a focus group, but it is challenging to gather nurses in one room to discuss their experience because of shift differences and the care of the patients. Also, a focus group was not advisable during the COVID-19 pandemic to avoid cross-infection and maintain social distancing.

I demonstrated that my study could apply to practice. I provided a thick description of the data collected during my study so that readers could compare the context to others and transfer the findings of my study to another context as applicable. I also ensured the data collected were dependable in answering my research questions using the qualitative research method and in-depth interviews as my data collection (see Ravitch & Carl, 2016).

Limitations

The challenge I anticipated with this study was collecting data and reaching the nurses for the interview. Because the interviews were in-depth, nurses may not have been willing to spend that much time expressing themselves in the interview. Another challenge was nurses’ work schedule; a nurse working on night duty may have been sleeping during the day, which would have prevented me from interviewing the nurse. I could not interview nurses while at work to prevent resident neglect. Another barrier was the issue of social distancing due to the COVID-19 pandemic. Face-to-face interviews may have been a problem because most of the time people want to know whom they are dealing with to develop trust. The limitations of my study were obtaining access to long-term care facilities, time constraints, and recruiting nurses for the interviews.

I planned to address the limitations by getting permission and approval to interview nurses from the facility’s leadership. After approval, I interacted with the participants to determine what method was best for them and gave them reasons why specific methods were not suitable at that particular time. I worked with them and made myself available to suit their schedule. If any participant agreed to a night interview while on break, I set my alarm to get the interview done at the participant’s convenience.

Significance

The study was intended to fill the gap in understanding nurses’ perceptions of pain assessment in CIOR in long-term care facilities. Findings may encourage nurses caring for these patients to recognize when they are in pain through assessment and assessment, caring for them, and managing their pain on time before it results in behavioral problems. My phenomenon of interest and the result of my study may impact social change, per Walden University’s mission for social change, by enabling nurses to recognize the signs of pain in CIOR in nursing homes or long-term psychiatric units. The residents may experience pain relief because the nurses will quickly assess and intervene by administering prompt treatment. My study may also enable the family members to manage their loved ones by recognizing they are in pain before behavioral problems occur. Long-term care and nursing homes may change their perspectives of assessing CIOR and promptly managing their pain before it results in behavioral problem. The presence of pain affects the entire body and can make the individual uncomfortable, restless, anxious, and agitated. Prompt pain assessment and management may facilitate recovery and improve the quality of life in these populations. Ludvigsson et al. (2020) stated that the lack of systemic use of pain assessment among people with cognitive impairment and their difficulties expressing pain verbally might lead to undertreatment of pain.

Inadequate pain assessment can result in inadequate pain management and poor quality of life, prolonging the disease process among the CIOR in long-term care facilities (Ludvidsson et al., 2020). Nurses are closer to residents than other health care providers; nurses observe the residents and know when things are not right with them, but there is a difference between knowing when things are not right and knowing what is wrong or what to do. Most of the time, the nurses are confused about the resident's prognosis; therefore, nurses misinterpret residents' symptoms for agitation. Findings from the current study may enable nurses to assess the patients and know what is wrong with them, and tend to the problem by administering treatment to alleviate the pain.

Significance to Practice

My study revealed nurses' perception of pain assessment among CIOR and how to manage pain on time to avoid misdiagnosis and mismanagement, which may delay the healing process and be detrimental to the residents. Findings may help in modifying or updating nurses' standards of practice. Findings may also promote job satisfaction for the nurses.

Significance to Theory

According to Watson (2006), the philosophy and science of caring have four central concepts: human beings, health, environment, and nursing. Watson proposed that caring and love are widespread and enigmatic, encompassing primal and general cognitive liveliness0. Adequate assessment and diagnosis of pain may enable nurses to administer treatment on time to prevent behavioral problems. The nurses may be conversant with the assessment, make the correct diagnosis, and administer treatment to prevent behavioral problems. Timely treatment may relieve the residents of their pain, provide comfort, improve their health status, and promote their self-dignity. Pajnkihar et al. (2017) stated that caring is the core concept of nursing, and caring includes caring for and caring about clients. Pajnkihar et al. also noted that caring is central to the patients' experience by implementing Watson's theory of human caring as the guide for nursing practice. Nurses can contribute to the well-being of patients through their behaviors and attitude toward the care provided. According to Watson (1999, as cited in Pajnkihar et al., 2017), "caring is the moral ideal of nursing whereby the end is protection, enhancement, and preservation of human dignity" (p. 5).

Significance to Social Change

My findings may affect positive social change in long-term care facilities by increasing nurses' awareness and understanding of the consistency and accuracy of pain assessment in the cognitively impaired. Nurses may perceive pain differently in this population. Chronic pain is a problem for the older population, and it is difficult for them to express themselves or complain of pain when they have a cognitive impairment. The inability of these residents to express their pain makes it difficult for the nurses to determine whether they are in pain, anxious, or agitated. My study may aid the nurses in differentiating the signs presented by the residents; nurses may be able to distinguish pain from behavioral problems and manage the pain before it becomes intense and poses a problem for residents and nurses. Findings may also indicate whether more training is needed depending on the nurses' perceptions.

Summary and Transition

Pain is aggravating, and it can become unbearable to an individual affected. Pain assessment among CIOR is an integral part of their treatment and wellness, and when pain is not adequately assessed and managed, it can be detrimental to their recovery. Pain assessment is paramount for nurses caring for CIOR because of their inability to express themselves. Verbal description is one of several behaviors to express pain, and the inability to communicate does not negate the possibility that the CIOR are not experiencing pain. Pain assessments in the older population have been implemented in emergency rooms, hospital units, and nursing homes; however, an exploration of nurses' implementation of pain assessments among CIOR in long-term care facilities had not been done. Therefore, I used a descriptive qualitative approach to obtain rich data on nurses' perception of assessing pain in CIOR. Findings may help generate positive social change. A review of the literature is presented in Chapter 2.

Chapter 2: Literature Review

Pain is a general term that describes the uncomfortable sensations of the body, which stem from the nervous system's activation (Reyes et al., 2019). Pain is an uncomfortable feeling that can be acute or chronic. Pain assessment in cognitively impaired residents is a vital component of their care. The pain they experience can be acute or chronic, and because of the cognitive impairment, the residents cannot express themselves; therefore, they suffer through their pain most of the time. The residents in long-term care often complain of chronic pains. However, cognitively impaired residents cannot complain of pain due to their inability to express themselves, which results in misdiagnosis and undertreatment. Gimenez-Llort et al. (2020) noted that pain is underdiagnosed and undertreated in a cognitively impaired patient with diminished verbal communication, leading to poor quality of life.

I explored nurses' perception of pain assessment among older cognitively impaired residents in long-term care facilities. Pain in older residents can be due to cancer or injuries such as falls. When the resident is cognitively impaired, it makes the pain assessment difficult for nurses, resulting in misdiagnosis or undertreatment. Pain ranges from annoying to debilitating, such as cancer pain, which can feel sharp and stabbing, or like a dull ache. Pain can also be localized (minor injury or headache) or generalized (the whole body), and pain is an uncomfortable feeling (Wilner & Arnold, 2020). Aging inclines individuals toward various comorbidities, especially pain, unrelated to their vulnerability (Atee et al., 2018). The residents cannot express themselves when in pain, leading to their pain being ignored and undertreated. Nurses often underassess residents’ pain, resulting in behavioral problems such as anxiety, agitation, and loud outbursts. Adequate pain assessment may enable the nurses to recognize when the residents are in pain. Nurses can administer treatment before pain gets worse to prevent behavioral problems such as anxiety, fidgeting, loud outbursts, agitation, fighting, kicking, throwing punches at others, and disturbing the environment. Such behavior can also lead to injuries and sometimes death; these outcomes can be prevented by adequate assessment and proper management. In this chapter, I describe my literature search strategy and theoretical framework and provide a literature review and summary.

Literature Search Strategy

I used the Walden University Library, which has numerous databases, to search for my study’s literature, and I sought the help of a librarian to gather my sources. The key concept was pain assessment in cognitively impaired residents in long-term care. The search phrases included *pain assessment* + *cognitive impairment* + *elderly* + *long-term*. I used the following databases: MEDLINE with Full Text/PubMed, CINAHL, PsycInfo, SocIndex, ScienceDirect, Academic Search, Education Source, OVID Nursing Journals, ProQuest, Nursing and Allied Health Sources, Google Scholar, and several others. When I used pain assessment, I received 20,166 results and retained 110 of them; with cognitive impairment, I received 1,280 hits and retained 80 of them. My literature search articles were within 5 years of the study completion date and were relevant to my study. I was able gather enough articles for my literature review with the resources in the Walden University Library. The articles used for the framework were older than 5 years.

Theoretical Foundation

The main component of care for older residents in a nursing home is pain management; to manage their pain effectively, the nurses taking care of them need to assess their pain. In CIOR, the nurses need to be more attentive to their signs of pain because they cannot express themselves. Watson's (2006) care theory was used as a framework to explore nurses' perceptions of providing adequate care to residents to relieve their pain and improve their health status. Watson developed the theory in 1979. Watson (2006) described nursing as a human science and human care, and stated that the care theory was the only theory that incorporated the spiritual dimension of nursing.

The philosophy and science of caring have four central concepts: human beings, health, environment, and nursing. Watson (2006) defined humans as holistic, interactive beings and as an energy field, and explained health and illness as a manifestation of the human pattern. Watson proposed that caring and love are widespread and enigmatic, encompassing primal and general cognitive liveliness. Watson noted that health professionals make social, moral, and scientific contributions to humankind. Nurses' caring ideal can affect human development related to caring for CIOR. Watson defined the caring concept as a human being, health, nursing, science of human caring, and caring need that are precise to human understanding that nurses should address with their clients in the caring role. Watson described a significant concept of the science of human caring as a human being (a valued person to be cared for, respected, nurtured, understood, and assisted), which was applicable to CIOR in long-term care. Health is the unity and harmony within the mind, body, and soul. Nursing is a human science of people and human health-illness experiences mediated by professional, personal, scientific, aesthetic, and ethical human care transactions.

Explicit assumptions of Watson's (2006) theory of caring are (a) an ontological assumption of cohesion, totality, harmony, understanding, and connectedness; (b) a caring science model that makes the diverse perception unambiguous and direct; and (c) a caring science that emerges and makes a clear, increasingly unitary, energetic worldview with interpersonal human caring ethics and ontology. Watson also integrated the 10 creative factors: (a) the formation of a humanistic system of values; (b) the installation of faith and hope; (c) sensitivity to self and others; (d) emerging helping-trusting, caring rapport; (e) articulating constructive and adverse feelings and emotions; (f) original, personalized, problem-solving caring method; (g) transpersonal instruction and erudition; (h) supportive and educative mental, physical, societal, and spiritual environment; (i) anthropological needs support; and (j) empirical descriptive and psychic forces. Watson also proposed that the transpersonal caring relationship connotes a spirit-to-spirit unitary connection within a caring moment, honoring practitioners' and patients' embodied spirit within a unitary field of consciousness. Practical caring also promotes health and individual or family growth. If the CIOR are cared for by nurses to relieve their pain, their health continuum will improve, and there will be physical and emotional healing, leading to positive social change.

A caring environment offers potential development while allowing the patient to choose the best action for themself at a given time. The CIOR depend on their caregivers to make that decision because they cannot express themselves due to diminished cognition. Watson’s (2006) philosophy and science of caring are concerned with how nurses express care to their patients, and the theory stresses humanistic nursing interwoven with scientific knowledge and nursing practices. According to Gonzalo (2021), Watson’s theory of caring can be demonstrated and practiced by nurses by caring for patients and promoting health. Also, a caring atmosphere that accepts patients as they are and looks to what they may become after regaining their health and wellness at whatever level is possible for the resident. Watson’s theory of caring was applied in my study by assessing the CIOR’s degree of pain and giving prompt treatment to alleviate the pain. I also explored how nurses reassessed the CIOR to determine whether their pain had been relieved and to ensure they are comfortable.

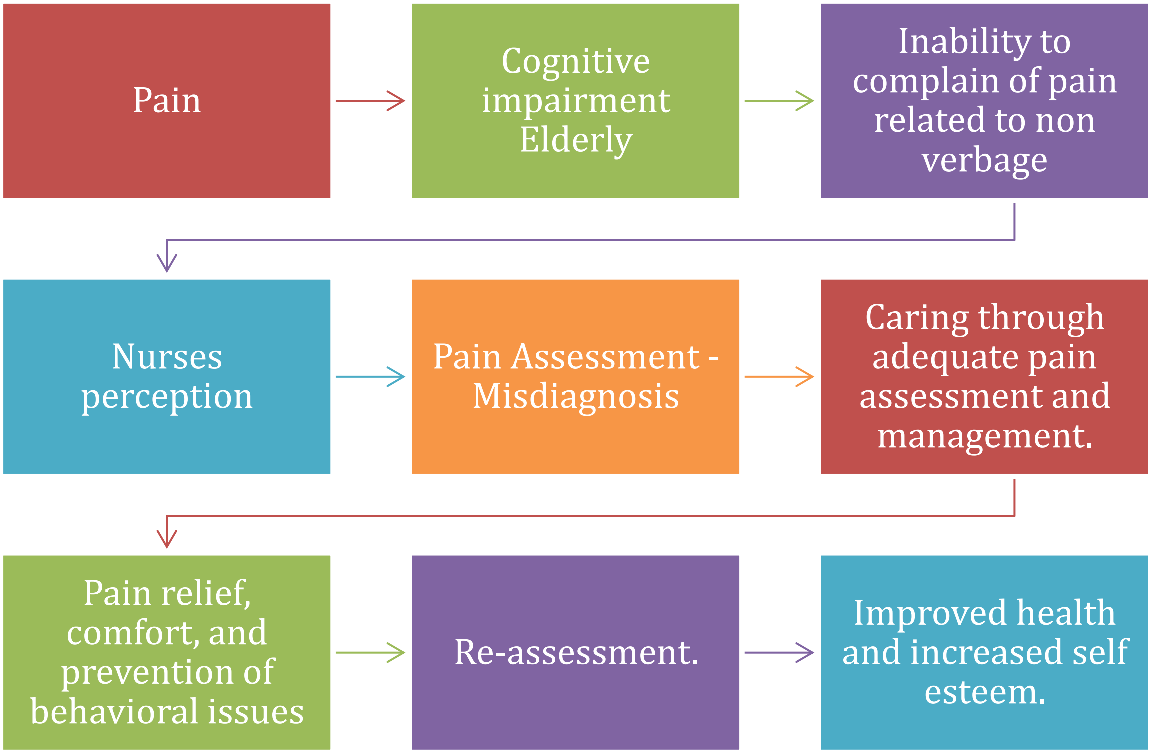
The assessment of pain is paramount to the care of the residents in long-term care; pain assessment enables nurses to manage residents’ pain, thereby relieving them of the discomfort from pain and promoting their health and well-being. Nurses are encouraged to engage realistically and psychologically with their patients and families to promote healthy recovery. Wei and Watson (2019) stated that Watson’s theory of human caring is widely used to guide nursing practice and research internationally, and the promotion of health care requires collaboration among interprofessional teams, thereby relieving pain and promoting comfort and patients’ well-being.

Carpenter et al. (2017) used Watson’s theory of human caring to focus on transpersonal caring, healing, and wholeness rather than disease, illness, and pathology. Carpenter et al. noted that the current and accepted treatment for pain management is the use of pharmaceuticals, but Watson’s theory guides nurses to consider alternative views and apply evidence-based practice to treat patients' pain. Goral Turkcu and Ozkan (2021) used Watson's theory of human caring as an intervention to relieve pain in cancer patients through reflexology. Goral Turkcu and Ozkan noted that Watson's theory of human caring effectively reduces anxiety and pain. Goral Turkcu and Ozkan used Watson's theory to examine pain relief and found that the theory effectively relieved patients' pain, promoted comfort, and reduced anxiety.

Figure 1 illustrates how nurses could misperceive the pain in CIOR through inadequate assessment resulting in misdiagnosis and undertreatment. Figure 1 illustrates the inability of the residents to express themselves and the nurses' knowledge of pain management in this population. Adequate assessment and diagnosis may enable the nurses to administer treatment promptly to prevent behavioral problems. The nurses must be conversant with the assessment and make the correct diagnosis and adequate treatment to prevent behavioral problems. Adequate treatment may also relieve the residents of their pain, giving them comfort and improving their health status, promoting their self-dignity.

Figure 1

Pain Assessment in the Older Cognitively Impaired Resident



My research question was informed by Watson’s (2006) theory by demonstrating that nurses care about the residents and want to manage their pain effectively. I selected Watson’s theory of human caring because it addresses human caring and caring for CIOR by assessing their pain and managing it. The theory was selected after I reviewed the following theories I initially considered using: Kolcaba’s comfort theory and Neuman’s theory of health as expanding consciousness.

Literature Review

Pain

Pain is an unpleasant sensation associated with sensory and emotional experiences that can cause potential or actual tissue damage. Pain is an uncomfortable feeling, which can be steady or temporary, throbbing, stabbing, aching, pinching, or described in many other ways (John Hopkins Medicine, n.d.). Pain is an unpleasant sensation that may be acute or chronic, resulting from illness or injuries (Felman & Bell, 2020). Acute pain is generally intense and starts and stops frequently; it lasts about 6 months and goes away when the underlying cause is gone (Felman & Bell, 2020). Pain may occur under conditions such as headache, toothache, sore throat, muscle cramps, stomach ache, bruises, burns, sprains, labor and childbirth, menstrual pain, and fractures. Chronic pain can result from chronic illnesses such as cancer, arthritis, gout, chronic migraine, and fibromyalgia (Weatherspoon, 2021).

Ho (2019) defined chronic pain as a process in which attitudes and beliefs can change daily life and activities. Pain is described as twinging, exasperating, annoying, foreboding, tender, and hostile (Ashkenazy & Ganz, 2017). Ashkenazy and Ganz (2017) also defined pain as discomfort, a lack of ease, trivial pain, mental uneasiness, and lack of comfort made perturbed. Chronic pain can occur due to illnesses and injuries such as cancer, arthritis, back pain, migraine headache, fracture, peptic ulcer, and tendinitis. Pain is a personal experience influenced by varying degrees of biological, psychological, and social factors (Vader et al., 2021).

Pain is subjective, and only the individual experiencing pain can describe the feelings; pain is unpleasant and, therefore, can be an emotional turmoil for the individual in pain. Sommerborn and Williams (2020) stated that the meaning of pain can be changed from an unpleasant, sensory, and emotional experience associated with actual or potential tissue damage to an unpleasant sensory and emotional experience resembling that connected with actual or potential tissue damage. Sommerborn and Williams also stated that pain can be reported without tissue damage or likely pathological causes. According to Malik (2020), pain is derived from Anglo-French *peine,* meaning pain or suffering. Pain cannot be measured physically, and only the person in pain can describe their feelings. In older people, pain is inevitable due to aging and disease conditions, resulting in depression and cognitive disorders. According to Zis et al. (2017), pain can be classified into seven groups: chronic cancer pain, neuropathic pain, posttraumatic and postsurgical pain, chronic musculoskeletal pain, visceral pain, chronic headache, and orofacial pain. Zis et al. also stated that chronic pain increases the risk of depression, and people suffering from depression are susceptible to nonneuropathic and neuropathic pains. Older patients can present with several different types of pain related to illnesses and injuries.

Pain is considered the fifth vital to improving pain care and relief (Scher et al., 2018). Pain is a prevalent ongoing health care challenge in the United States; pain can impair an individual’s mental and physical health. Pain in cognitively impaired residents is challenging for nurses to assess, diagnose, and manage. Tolman and Harrison (2018) described pain in dementia due to comorbidity, and it is evident that the pain is untreated.

The cognitively impaired population has inequitable assess to practical pain assessment and management because of their inability to express themselves. Pain management is a fundamental human right that should be routinely assessed and recorded to promote comfort (Montoro-Lorite et al., 2020). Montoro-Lorite et al. (2020) stated that describing pain emphasizes that it is an unpleasant sensation that interferes with the person's well-being and ability to work their daily lives.

Cognitive Impairment

Cognitive impairment is a term used for a reduction in mental functioning. It occurs when a person has trouble remembering things, learning new things, and finding it challenging to make everyday decisions that affect their lives. It progressively leads to a decline in cognition and the ability to carry out activities of daily living (Agit et al., 2018). According to Montoro-Lorite et al. (2020), cognitive impairment involves memory loss, deceased intellect, and the inability to carry out daily activities. It affects the cognitively impaired elderly to understand and describe their pain resulting in undertreatment. It is characterized by forgetfulness, intellectual disabilities, and difficulties concentrating, especially during learning; it may occur at birth or due to injuries ranging from mild to severe (Lloyd III, 2021). The common signs of cognitive impairment are memory loss, inability to recognize familiar people and environments, inability to remember short-term events, impaired judgment, mood swings, vision problems, and difficulty taking care of oneself (Lloyd III, 2021). Mild Cognitive Impairment (MCI), according to He et al. (2021), is a prodromal stage of Alzheimer's disease that shows cognitive declines while they can still carry out their daily activities.

MCI is an intermediate state between normal aging and the early stage of neurodegenerative disease (Rouge et al., 2021).

Cognitive impairment often combines behavioral and psychological symptoms such as disturbed perception, mood changes, loud outbursts, and inability to express themselves (Nowark et al., 2019). According to Kutschar et al. (2019), one of the causes of cognitive decline in nursing homes is dementia, and two-thirds of the residents of nursing homes are thought to be affected. Cognitive impairment makes it difficult for caregivers to recognize or identify when something is wrong with cognitively impaired older people. In summary, the researchers concluded that cognitive impairment reduces mental function, preventing residents from caring for themselves. They cannot function normally and require assistance from their caregivers because they depend on them for their activities of daily living.

Pain in Cognitively Impaired Older People

Many older people frequently experience pain, which is primarily chronic; such pains occur from depression, cardiovascular disease, cancer, arthritis, and osteoporosis (Canton-Habas et al., 2019). Older people are prone to falls and cognitive impairment, making them vulnerable patients in pain assessment. Pain and cognitive impairment are two health problems associated with aging and two of the vital cause of a decrease in the quality of life in older persons (Minaya-Freire et al., 2021). Pain in older people is chronic and may be primarily osteoarthritic. Pain is a common problem in older adults, and it has imperative significance in the increased prevalence of cognitive decline in nursing home residents. It is stated that pain in the cognitively impaired elderly is often neglected because of their inability to verbalize their feelings. The pain in this population is under-reported, underestimated, misdiagnosed, and undertreated; this strongly impacts their health and healing process (Cravello et al., 2019). Advanced age correlates with increased cognitive impairment and leads to pain due to comorbidities; when not properly managed, it can lead to behavioral problems (Nowark et al., 2019). According to Bentur et al. (2021), the pain experience is intensified among the elderly with cognitive impairment. Their pain is often underdiagnosed or untreated related to their decreased ability to verbalize their feelings. It may lead to discomfort resulting in agitation, aggression, apathy, depression in some cases, sleep deprivation, and psychosis; when these occur, it is difficult to manage. When the pain is not well managed and results in behavioral problems, it is difficult for nurses to manage the behavioral problems. Nurses will often assume agitation and sedate the resident to minimize their combative, loud behavior (Bentul et al., 2021). It is nerve-racking for family members to deal with. Pain management is of utmost importance for nursing home residents to improve their quality of life. In summary, the researchers concluded that many older adults experience pain, and when it involves cognitive defects, it prevents the cognitively impaired elderly from complaining about their pain. They often suffer because the nurses misdiagnose their pain related to their inability to report pain; hence, they are undertreated or mistreated.

Pain Assessment in Cognitively Impaired Older People

Pain assessment is very particular and practical pain management and can be challenging in older people, especially cognitively impaired nursing home residents. Self-reporting of pain is essential in pain management. Still, when a resident cannot report pain and the individual is suffering, it prolongs the healing process and reduces self-dignity. According to Yoon-Sook et al. (2017), elderly cognitively impaired patients cannot verbally report their pain; hence they are regularly unrecognized or ineffectively treated. Pain is the fifth vital sign, which signifies that it is essential for nurses and other healthcare professionals to ask patients if they are in pain. The cognitively impaired elderly cannot verbally communicate their pain, which prevents adequate treatment or management.

Research has shown numerous pain assessment tools to diagnose pain in cognitively impaired elderly patients. These are Abbey Pain Scale, Pain Assessment in Advanced Dementia (PAINAD), Pain Assessment for the Dementia Elderly (PADE), Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC), Checklist for Nonverbal Pain Indicator (CNPI), Visual Analog Scale (VAS), DOLOPLUS-2, and Mahoney Pain Scale (MPS) (Jones et al. 2017). The tools are used in assessing pain in the elderly cognitively impaired elderly to measure the level of their pain, which will enable the nurses to recognize that the resident is in pain, and they will treat it accordingly. The most commonly used pain assessment tools in a long-term care setting are Abbey Pain Scale and PAINAD.

Pain assessment in the elderly cognitively impaired is an essential aspect of their treatment; when a resident is experiencing pain, it can delay their healing and worsen their prognosis. Nurses taking care of this patient need to be conversant with their pain assessment to differentiate pain from other health problems. According to Jonsdotir & Gunnarsson (2020), nurses are ambiguous about assessing and managing pain in older people with dementia. It is paramount that nurses assess cognitively impaired residents to manage their pain effectively.

Pain assessment and management in the cognitively impaired can be tremendously challenging for nurses and other caregivers because of their nonverbal and frailty, which prevents them from describing the frequency, intensity, and area affected. According to Tinnirello et al. (2021), pain assessment in the elderly can be highly thought-provoking for several reasons: inability to locate the areas affected, inability to describe the intensity, and multiple medications. The inability makes it difficult for nurses to assess and manage pain in the CIOR properly. To summarize the literature related to my research, pain is an uncomfortable, resource-draining condition that affects the lives of residents with cognitive decline and dementia, especially since they cannot tell the staff or their family where or how they hurt.

The studies, specifically related to my topic, demonstrated that pain is problematic in cognitively impaired residents; nurses are unequipped to recognize pain in these residents. That pain interferes with the resident's quality of life and the resident's family's satisfaction. By capturing and understanding the nurse's perspective on pain management in cognitively impaired residents, we can create and apply ideas, strategies, and actions that will result in positive social change for these individuals (Center for Social Change, 2022).

Summary and Conclusions

Pain assessment remains the center of care for all patients in emergency units, inpatient units, and nursing homes. There is no unique way of pain assessment and relief among patients because pain is subjective, and the individual affected can describe the intensity and the degree. Unlike the CIOR, patients are asked for their pain level in clinics and hospital settings and can express the level of pain and the area affected. The nurses need to pay special attention to the resident's moods to discover when they are in pain because CIOR cannot verbalize their pain's degree and intensity.

In the literature reviewed, the following areas were suggested where additional research needed to occur. They represent our lack of understanding of effectively managing pain in CIOR. My study will fill the gap in the literature by providing an understanding of how the nurse sees the management of pain in CIOR, including the challenges and barriers to pain management, as well as the facilitators

Pain relief can promote the CIOR's emotional states, psychosocial wellness, and self-dignity, resulting in health recovery. This information about the resident needs to be communicated to all staff. However, to achieve pain relief and comfort of CIOR in long-term care, it is essential to understand the nurses' perception of pain assessment. The descriptive qualitative study approach will utilize interviews to collect pertinent information to understand nurses' worldviews about pain assessment in CIOR. The understanding will assist nurses in playing an essential role in assessing and managing pain in individual CIORs in long-term care facilities. In chapter 3, the detailed method of data collection, the research design and rationale, participants' recruitment, interview methods, the analysis approach, and the process of trustworthiness.

Chapter 3: Research Method

The purpose of this descriptive qualitative study was to explore nurses' perception of pain assessment in CIOR in long-term care facilities. I also explored nurses' perception of adequate pain management in this population. Managing pain in CIOR can be challenging for nurses because of residents' inability to express themselves (Docking et al., 2018). Nurses are closer to patients than other health care providers; nurses observe the patients and know when things are not right with them, but there is a difference between knowing when things are not right and knowing what is wrong or what to do. Most of the time, the nurses are confused about what is wrong with the residents because they cannot express themselves; therefore, nurses misinterpret residents' pain symptoms as agitation. By knowing what is wrong with the patients, nurses can tend to the problem, make an adequate pain assessment, and administer treatment to alleviate the pain. In Chapter 3, I provide details about the research method, role of the researcher, recruitment procedure, sampling design, data analysis, issues of trustworthiness, and ethical procedures.

Research Design and Rationale

Research Questions

The following research questions and subquestions were used to align my research topic, problem statement, and purpose: What are nurses' perceptions of pain in an older cognitively impaired resident? The subquestions were the following:

1. What are the manifestations of pain recognized by nurses in cognitively impaired residents?

2. What are the barriers to pain assessment encountered by nurses in the older cognitively impaired residents?

Central Concepts and Phenomenon

This descriptive qualitative study's central concept was pain experienced by cognitively impaired long-term care residents, and my main research question addressed how nurses perceive and recognize pain in the population. National Institutes of Health (2017) defined pain as an unpleasant sensation that links to tissue damage, causing physical symptoms such as nausea, dizziness, weakness, or drowsiness. Pain also causes emotional experiences such as anger, depression, mood swings, or irritability. Understanding what pain assessment means to nurses caring for CIOR may promote nursing care in a holistic view. The positive pain relief results measured through residents' mood, behavior, and nonverbal behaviors. The assessment result facilitated adequate management, promoting comfort and healing.

Rationale for the Selected Tradition

I used a descriptive qualitative approach to explore nurses' experiences who strive to assess CIOR and provide desired relief for them. The best way to understand a phenomenon is to learn how people view the world around them (Burkholder et al. 2016). The meaning of a phenomenon is dictated by how people interpret what they encounter and how values are assigned to the phenomenon. According to Burkholder et al. (2016), perception is a lived experience of how people relate to a phenomenon and understand and give meaning to it. A descriptive qualitative study is an approach that aims to provide detailed examinations of personal lived experience (Smith & Osborne, 2015). A descriptive qualitative study addresses a situation, problem, phenomenon, or attitude toward an issue. The descriptive qualitative approach was appropriate for the current study.

I used a descriptive qualitative approach to explore how nurses describe their experiences when assessing the pain of CIOR in the long-term care setting. Using interviewing techniques with open-ended questions enabled me to obtain information-rich data from nurses about their perceptions of pain assessment among CIOR. The results of this study have the potential for positive social change by helping nurses better understand pain assessment while caring for CIOR.

Role of the Researcher

An in-depth interview is a choice for exploring participants' worldviews on the unique and intricate phenomenon. To attain in-depth participant information, a researcher plays different roles in the descriptive qualitative research method, such as a recorder and interviewer. Researchers can also observe participants performing an everyday activity. The researcher keeps memos and journals of the activity and later analyzes the behavior and action pattern (Rubin & Rubin, 2012). The researcher must have the trust and confidence of the participants, must speak their language, and must understand their world. The researcher must also avoid being biased by the type of information received from the participants due to differences in how individuals communicate and present their words (Roger et al., 2018).

As the researcher in the current study, my role was interviewer, listener, observer, and recorder as the participants shared their experiences. I interviewed nurses to understand their perceptions of pain assessment in CIOR. I was diligent in asking questions while observing participants' tone of voice as the interview was conducted by telephone because face-to-face and Zoom options were not feasible. I took notes while recording the interview. Creating a good rapport with the participants enabled them to share their stories with me and elicited better data collection. Each interview was tape-recorded to focus my full attention on the participants. Jacob and Furguson (2012) suggested using open-ended questions because this approach will help elicit information from participants.

To ensure that participants felt free to express their perceptions of pain assessment in CIOR, I assured them that the information shared would be confidential. Also, I assured them that participating in this study would not negatively impact their employment and personal life. I informed them that participation in this study was voluntary and the interview questions would be open-ended; therefore, there would be no right or wrong answers. The information obtained would not be used against the participants in any form and would not be shared with anyone without the participant's consent. It is ethical to obtain informed consent from participants before the interviews. The informed consent process will alleviate any fear the participants may have and promote confidentiality (Jacob & Ferguson, 2012). During the interviews, I treated participants respectfully and honored my promises by avoiding pressuring them to provide information while diligently seeking to elicit helpful information for the study. To avoid ethical issues, I did not conduct this study within my place of work. I used other long-term care facilities and did not use incentives to recruit participants for interviews.

Methodology

My research addressed adequate pain management in the CIOR nursing home population. In-depth interviews were used to collect data from participants. The interview questions were open-ended, and interviews were conducted via telephone because Zoom, Skype, and face-to-face options were not feasible. I chose this method because of my subject: nurses; in this case, observations or focus groups were not feasible because of patients' privacy and nurses' schedules. Researchers must resist the temptation to analyze the meanings of an observation prematurely; once the basic observation from the participants has been recorded, the data may be reduced, reconstructed, and analyzed (Rudestam & Newton, 2015).

Participant Selection Logic

The target population of this study were RNs and LPNs who had worked with CIOR for at least 2 years in the long-term facility and had assessed their pain regularly. I extended my selection to nurses who had worked with residents for more than 2 years. The reason for selecting these nurses was due to their knowledge of the care of the residents about this phenomenon. I selected the nurses for interviews by asking the administration to suggest nurses based on their work experience. I asked the leadership to make potential participants aware of my study and to allow me to post my flyers in strategic places where the nurses could see them, such as the notice board and the nurse's stations. My study was a descriptive qualitative study, so I recruited 20 nurses and received responses and consent from eight nurses who participated in the interview. The inclusion criteria were RNs and LPNs with 2 or more years of experience managing

CIOR and their pain. The exclusion criteria were nurses who had worked fewer than 2 years in the facilities.

I used a purposeful sampling technique to select a sample of nurses who had worked with CIOR. Purposeful sampling ensures that participant selection aligns with the research purpose, research questions, and data collection (Patton, 2015). Participants knowledgeable about the phenomenon will be selected (Patton, 2015). Nurses working with CIOR were information-rich about their experiences assessing pain and providing care as necessary in this environment. My choice of sampling method was information-rich purposeful sampling to select participants with knowledge of the phenomenon who were able to address the phenomenon being studied. My goal was to use a minimum of eight and a maximum of 10 participants based on the concept of data saturation. My interviews took 30 to 60 minutes. I needed participants' in-depth knowledge of the phenomenon, which may have required another attempt of the interview session to follow up and clarify issues from participants who agreed to a follow-up interview. However, there were no reasons for this because participants all provided the information needed.

There are no set rules that stipulate a certain number of participants in qualitative research. However, the participants should provide a multiperspectival understanding of the studied phenomenon to enable the researcher to answer the research questions (Ravitch & Carl, 2016). A small number of participants can be valuable in a qualitative research study because it is an in-depth information-seeking process. Meaningfulness is rooted in the participants' information richness instead of a larger sample size (Patton, 2015).

I interviewed eight participants; data saturation determined the number. Data saturation has attained widespread acceptance as a methodological principle in qualitative research whereby no further data collection is necessary because the interviewer receives the same responses (Saunders et al., 2018). I selected the long-term care facilities close to my neighborhood to facilitate easy access. Most long-term care facilities do were not accepting visitors due to the COVID-19 pandemic to prevent the spread of infection to their residents and staff. This posed a barrier to sample recruitment, so I spoke to some of them on the phone and sent emails.

Instrumentation

The descriptive qualitative approach includes interviewing techniques, especially a responsive interviewing model, which was appropriate for the current study. I used in-depth interviews to collect data from my participants (RNs and LPNs). The in-depth interviews enabled me to gather information about the nurses' perception of pain assessment in CIOR. The interview guide was developed using the literature review and Watson's (n.d.) theory of human caring. I used telephone interviews because face-to-face and Zoom options were not feasible. During the interview, I used an audiotape to record the conversations and used hands-on techniques to analyze my data. I intended to use Quirkos software for the analysis but did not need it. The interview was at the participant's discretion and choice of type and time with an assurance of confidentiality. I interviewed each participant and did not impose on them. Before the interview, I prepared a quiet and conducive space and dressed formally. I initiated and practiced social distancing because of the pandemic. I introduced myself and allowed my participant to introduce themselves; I reviewed the reason for our meeting. I respected my interviewee’s wishes and started the interview; the method was convenient to ask questions to gather the information in a quiet place with only the two of us. This approach avoided distractions and promoted the trust that no other person was around and listening to our conversation.

I ensured a quiet place with no distractions with a good working phone during telephone interviews. I also advised the interviewee to be in a quiet location, free from distractions. I introduced myself and allowed my participants to introduce themselves; I reviewed the reason for our meeting. I respected my interviewee’s wishes and started the interview. A telephone interview can occur anywhere the interviewee wants, and I felt this approach was conducive for interviewing. It did not require space preparation or talking in the same room. It was also the most convenient for the interviewee and me to maintain social distance per the Centers for Disease Control and Prevention guidance on preventing COVID-19 infection. Zoom interviews would have enabled me to engage my participants and prevent distraction because we could see each other. The participants and I could have looked at each other while we were talking, and we did not have to be in the same place. The method encouraged me to interview people from different places and see their body language. I also thought it was convenient to conduct the interview and was suitable for social distancing, but none of the interviewees had access to Zoom, making it impossible to use.

RNs and LPNs were the data source in this study; I collected qualitative data using responsive interviewing, eliciting in-depth responses to a phenomenon. I treated participants as experts, and the participants' responses were not right or wrong but revealed different perspectives on the phenomenon. I was attentive when listening to participants and obtained information-rich data that answered the research questions while keeping the participants within their comfort zone by asking questions in a nonconfrontational and nonjudgmental manner.

Procedures for Recruitment, Participation, and Data Collection

I used a descriptive qualitative approach to explore nurses' perceptions of pain assessment in CIOR. The heuristic qualitative research method places human experiences above numbers and is concerned with meanings, essence, quality, and not appearance, quantity, or behavior (Patton, 2015). I used purposive sampling to recruit nurses who were knowledgeable about assessing pain in the CIOR in their facilities. Purposive sampling occurs when the researcher relies on their discretion to choose the sample population. Purposive sampling allows the researcher to gather qualitative answers, which leads to better intuition and more accurate results (Patton, 2015). I also used snowball sampling because one of the participants introduced me to her colleague for the interview. Snowball or chain sampling is a strategy that allows the researcher to ask interviewees to suggest a colleague that might be interested in participating based on their interview (Patton, 2015). My interview subjects were RNs and LPNs, and I sought their consent by sending emails to ask them to participate in my study. In-depth interviews were used to collect data from participants. The aim was to obtain a detailed and rich understanding of nurses' perception of pain assessment in CIOR. The interview questions were open-ended, and the interviews were conducted via telephone.

The data were collected through an in-depth interview of the RNs and LPNs working in a long-term care facility. The information collected was not shared with anyone without their permission. I sought permission from the administrative officer and the facility's directors of nursing (DON) and made my intentions known. I also asked their approval to interview their nurses on their perception of their residents' pain assessment and ensure that the interview will be confidential. After getting the approval, I sent twenty nurses an email to seek their consent about interviewing them on their perception of the pain assessment of the CIORs under their care in their facility. I described the purpose of the study, the requirement for participation using a screening guide (Appendix B), and what they will be asked to do when they contact me. I emailed the institutional review board (IRB) approved consent form to those who meet the criteria and agree to participate in the study for them to review. I also distributed fliers to them, including my email address and telephone number, so those interested could contact me (Appendix A).

When I received the response that they were willing to participate in the interview, I emailed them to acknowledge that I received their willingness to participate and reassured them that the interview and their identity would be confidential. I sent a follow-up email to those who did not respond to my email and let them know the importance of the interview and the purpose of the study, inquiring if they were still interested in participating. After receiving enough responses, I sent the consent form to review their agreement to participate in the interview. After they had consented to participate, I scheduled an appointment to meet with them for the interview. I also scheduled an appointment for the interview, which was between 30 to 60 minutes long. When we met for the interview, I reminded them I would record it after asking for their permission. I informed them that I was the only interviewer and researcher with access to their data. I also reiterated that the interview would not be shared with anyone (except my doctoral committee chair), and their identity and response to the interview would be confidential.

I utilized the interview guide template from Walden University to develop my interview guide (Appendix C). During the meeting with the participant, I reviewed the introductory information as stated in an interview guide (Appendix C). I also stated the purpose of the study, that the interview would last between 30 to 60 minutes, and that our discussion would be tape-recorded, and I let them know I would share it only with the faculty involved in my study. I told them I would listen attentively and take a few notes while tape-recording our conversation to not rely on my memory. Immediately after the interview, I asked if they were willing to participate in the second interview if there was a need and made notes of the individuals who agreed to participate. They will be contacted, if needed, for further clarification of information. I thanked the participants at the end of the interview and reiterated the purpose of the interview and the potential for positive social change. I also shared the transcript with the participant to facilitate transparency.

Data Analysis Plan

Qualitative analysis transmutes data into findings. In-depth interviewing is the tool of choice for exploring participants’ worldviews in a unique and sensitive phenomenon. Patton (2015) stated that in-depth interviews strive to get the interviewee to talk about experiences, feelings, opinions, and knowledge. I avoided dichotomous response questions that could defeat my research questions' purpose. A researcher plays different roles in qualitative research, ranging from the recorder to the interviewer to obtaining in-depth data from research participants. Data analysis in a qualitative research study transforms the information-rich data obtained from the participants during the interview process into findings (Patton, 2015). I organized myself for the analysis and ensured that the field notes were complete, including additional data collection, before I began my analysis. Qualitative analysis requires immersion in the data, and it takes time. I created enough time for the analysis and gave it the dedicated time it deserved. After conducting the interview, I played the tape and listened to it before downloading it into transcripts. I read the transcript, edited it, and made grammatical error corrections. I reviewed the transcripts severally to ensure they were free from biases. I started using manual coding and did not use Qualitative Data Analysis software. Qualitative Data Analysis (QDA) software provides tools that help qualitative research, such as transcription analysis, coding, and text interpretation. According to Saldaña (2016), it is essential for any qualitative researcher who is enthusiastic about being an expert in qualitative data analysis (QDA) to study the coding system and incorporate the expertise for excellence in qualitative research. Saldana (2016) suggested that a novice researcher engages in manual coding before advancing to QDA software; it gives you control and ownership of the work. According to Saldana (2016), the specific personal qualities required of qualitative researchers, especially for coding, include being organized, determined, skilled in dealing with ambiguity, flexible, creative, and meticulously principled in applying extensive vocabulary. I would have used a combination of manual coding and qualitative data analysis (QDA) software, Quirkos, but I used manual coding.

As mentioned above, I downloaded the interview conversation into the transcript. I read and re-read it severally to understand the critical point of the conversations. As I re-read the transcripts, I looked for the themes, inserted them into a margin on the right side or in the text itself, and provided a name for the theme found in the transcript. Next, I looked for connections between the themes to group them, explore the connections within and between the conceptual groups, and generate an explanation (Saldana, 2016). As mentioned earlier, I only used hands-on and did not use QDA Quirkos software for the coding.

I mentioned using Quirkos as my second choice in my proposal because it helps sort, manage, and understand text data (Turner, 2017). I did not use Quirkos because the manual coding worked well for my data analysis. To avoid discrepancies, I ensured that the data collected were reliable, complete, and available for future updates. I also started and kept journals to document my process in the analysis. I ensured I had an ideal number of nurses for the interview. I also ensured no glitches in the recording and background noise that may cause discrepancies in analyzing the data collected. I protected the data from getting into the wrong hands and made backup copies to store in a safe place to avoid being lost, stolen, disturbed, or burnt (Patton, 2015).

Issues of Trustworthiness

Social change is defined as challenging trends of discernment, mistreatment, coercion, and suppression demonstrated by people who repute themselves as preferred and thus take rights for themselves and deny other people the right to a stately life leading to optimistic social change (Yob & Brewer n.d.). According to Shelton (2004), "The trustworthiness of qualitative research is often interrogated by positivists, possibly since their notions of validity and reliability cannot be addressed in the same way as a real effort" (p. 63). My study aims to explore the nurses' perception of pain assessment in cognitively impaired elderly residents in a long-term care facility. I used a descriptive qualitative approach that allows the nurses to express themselves about their pain assessment experiences, how they know the residents are in pain, and what type of pain remedy is appropriate for each resident. I also made sure I initially collected all my data.

The study result is anticipated to help nurses differentiate pain and anxiety or agitation in cognitively impaired elderly. It enabled the nurses to treat their pain, prevent misdiagnosis and mistreatment, and avoid name-calling. It will also prevent the stereotypical behavior of nurses by referring to some patients as sundowners. The nurses will discover that even though the resident cannot express themselves, there are many ways they can recognize pain in them. Also, the residents need to be on routine pain medicine to avoid pain leading to behavioral outbursts that may lead to agitation, injury, or death if not well managed.

Credibility

Credibility addresses how accurate the study's findings are, whether research methods were appropriate, how samples were selected, how familiar the researcher and the participants were, and what methods were used in data collection. All of these must be clearly described in the research, including a description of the researcher's qualification, use of peer scrutiny of the research project, and use of the iterative method of questioning to expose deliberate mendacities and clarify contradictions and falsehoods (Shenton, 2004). I engaged with the participants to get their trust and encouraged them to tell me the truth about their perception of pain assessment in CIORs. I shared the transcript with the participant to facilitate transparency and clarify what they said during the interview to avoid miscommunication.

Transferability

Transferability is how qualitative research can be transferred to other content or settings with other respondents. The researcher facilitates the transferability judgment by a probable user through a copious description. As a researcher, I demonstrated that my study could apply to practice. I provided a thick description of the data collected during my study so that the readers could compare the context to others and transfer the aspect of my study to another study as required. I ensured the data collected were dependable in answering my research questions using the descriptive qualitative research method and in-depth interviews as my data collection (Ravitch & Carl, 2016).

Dependability

The research study must be dependable and stable in findings over time. Dependability involves participants' evaluation of the study's findings, interpretation, and recommendations. Such that all are supported by the data received from the study participants. Cross-checking and cross-validating data sources during the interviewing process show dependability (Patton, 2015). I ensured data saturation, where the data collected are the same and the participants' no new information is collected or shared. I kept the audit in sequential order throughout the study process and kept a journal documenting additional information and events that may arise through the interview process.

Confirmability

According to Korstjens & Moser (2018), confirmability is the step by which other researchers can confirm the study's results. It is concerned with creating the original data and ensuring the results are not fabricating the interviewer's imagination but are derived from the data. The study must be as significant as possible; the coding must align with the interview. The researchers are concerned with establishing that the findings' data and interpretation are not figments of the inquirer's imagination but derived from the data. I implemented a method to manage my potential biases, impacting the analysis process (Rudestam & Newton, 2015).

Ethical Procedures

Considering the intrusive nature of research, participation in a research study must be voluntary. Participants reserve the right to know what the study is about, and pertinent questions must be answered; they also have the right to drop out of the study whenever they choose to. Informed consent must be obtained from the participants, detailing what to expect during the study. The right to anonymity and confidentiality, information, and other data obtained from participants must be kept confidential (Babbie, 2017).

I obtained a collaboration agreement from the long-term care facility I intended to use. I obtained IRB approval from Walden University (08-30-22-1020536). Informed consent was sent through an email to each participant, informing them that participation is voluntary and they can opt out whenever they want. I also assured them that the information collected would be kept confidential and not be shared with anyone other than my faculty involved in the study. I did not share the participant's identity with anyone; I assigned each individual a code to conceal their identity for the coding. Interview recordings and full transcripts were shared with the participants. Transcripts with personal identifying information will not be visible when shared with my university faculty and analysis. Data will be kept for at least five years as the university requires and disposed of following protocols established by the university.

Summary

In qualitative research, where participants' lived experiences and perceptions about a chosen phenomenon are anticipated, interviewing is one of the data collection methods to produce information-rich knowledge about the phenomenon under study. I organized an interview session for about 30 to 60 minutes with each participant. It enables them to elicit information-rich data about their experiences. I also ensured they were comfortable and did not fear the unknown related to their sharing information. Having a good rapport with people allows them to share their stories and elicit information-rich data (Jacob & Ferguson, 2012). This study was subject to approval by the IRB of Walden University because the study involves humans (Nurses) as the participants. Consent of participants was obtained after assurance of their safety and protection of identity and confidentiality. I interviewed without biases and made sure I did not exceed the stipulated time for the interview. I showed my gratitude for their participation and asked them if they would be willing to engage in a second interview if needed. In the next chapter, I demonstrated approval from IRB, collected data from my participants, organized my data, and analyzed the data collected by coding. I also report the findings of the data collected.

Chapter 4: Results

In this descriptive qualitative study, I explored nurses' perceptions of pain assessment for CIOR in long-term care facilities. To align my research topic, problem statement, and purpose of research study, I developed the main research question: What are nurses' perceptions of pain in an older cognitively impaired resident? Sub-questions were the following: What are the manifestations of pain recognized by nurses in cognitively impaired residents? What are the barriers to pain assessment encountered by nurses in the older cognitively impaired residents? In this chapter, I discuss the setting, demographics, data collection, data analysis, and evidence of trustworthiness including credibility, transferability, dependability, and confirmability. Also, I present the study results and a summary.

Setting

I visited nursing homes in the Southeast United States to see the DONs and their administrators and make my intentions known about my data collection. I obtained the DONs' email addresses and telephone numbers. I shared my dissertation topic with them and asked them to post my flier in their facilities to recruit RNs and LPNs to participate in the study. I emailed three DONs to request permission to post my fliers in each of the three facilities. I also sent a follow-up email to the DON when I received no response from the previous email and repeated phone calls were unsuccessful. I was successful in reaching two of the DONs when they responded to my email. I attempted to follow up with the third DON but did not receive an answer. The two DONs responded with the approval for me to post my fliers after I received IRB approval to proceed with data collection. Participants were recruited by the fliers posted in strategic places such as the nurses' station and notice boards where information is shared with staff at the facilities. Participation was strictly voluntary, and nurses could choose not to continue participating in the interview at any stage. The study did not require a change in any organizational budget or personnel management.

Demographics

The RN participants were four African American women, one African American man, and one White woman. The LPNs consisted of one White woman and one African American woman. The RNs had at least a bachelor's degree in nursing, at least 12 years of experience in nursing, and at least 2 years of long-term care experience. I used an audio recorder to record the interviews; I manually transcribed each interview and conducted manual coding.

Data Collection

I interviewed eight participants from two different facilities, and the average interview time was 25 minutes. Each interview was conducted at the participant's discretion and preferred location. I made multiple trips to two long-term care facilities to recruit nurses to participate in the study. I found some volunteers who were interested in participating in the study. I made follow-up phone calls to potential participants several times to remind them of their willingness to participate and the study's purpose and to schedule them for the interview at their convenience.

All interviews were conducted by telephone at the participant's discretion because most had no access to online meeting resources and face-to-face interviews were not feasible. I made sure the participants chose the time they wanted to participate in the interview. The data were recorded on a digital audio recorder. Consent forms were emailed to each participant, and a consent reply was received before scheduling the interview. A few of the interviews were difficult to arrange due to delays in participant responses; however, the interviews were arranged and conducted as planned. There were no variations in the data collection plan, as outlined in Chapter 3.

I reviewed the introductory information in the interview guide (see Appendix C) stating the purpose of the study, that the interview would be tape-recorded, and that the information provided would be shared only with the faculty involved in my research. I took notes of my initial reaction to the interview because I did not want to rely on my memory. I did not use any identifiable information.

Data Analysis

The first step in my data analysis was to manually transcribe the recorded interview into a Word document to make it easy for me to code. I applied preliminary coding; I started coding as I collected my data and formatted my data; I did not wait until the fieldwork had been completed (see Saldana, 2016). I wrote up my field notes, transcribed the recorded interviews, and jotted down the notes during the interview. I read and reread the transcript several times to get a sense of the data; as I read the transcripts, I looked for themes that I inserted into the margin on the right side with an appropriate name. I looked for the connections between the identified themes and clustered them together (see Saldana, 2016). The three themes I identified from the data collected were difficulty, pain assessment tools, and pain management. Seven participants indicated that pain assessment in CIOR is difficult because of their inability to express themselves.

Some participants described pain assessment in CIOR as being difficult to assess because of their impairments and inability to express themselves. P1stated “it is difficult to assess their pain in CIOR. They can be misinterpreted as an escalation in behavior”. You cannot differentiate it because they cannot express themselves. It can also be their facial expression. P2 stated “mostly, you have to have the experience to assess them because it is somewhat difficult. Some residents are not severely cognitively impaired and can still communicate with you and express their feelings. It just depends on what is going on with the patients”.

P3 also stated “pain assessment is subjective. It is a bit tasking because of the cognitively impaired patient, and it is tough to know when they are in pain, which makes it more difficult to assess.” The symptoms most participants perceived in the residents suggestive of pain were frowning their faces, refusal to participate in activities, and refusal to get out of bed and eat. P4. stated “sometimes they do not want to respond; they do not want to participate. They do not want to get out of bed, can be challenging to approach, and can be combative.” Table 1 includes subthemes of Theme 1.

Table 1

Theme 1: Difficulty

Subtheme	Participant
Pain assessment in CIER is difficult and tasking	1, 2, 3, 4, 5, 7, 8.
Pain assessment is interesting	6.

Using pain assessment tools was identified as the second theme. Pain assessment tools are used to assess pain in CIOR. Most participants mentioned they use numeric scales in mildly cognitively impaired residents that can indicate when they are hurting and where they are hurting. The tools used for severe impairment were the Wong-Baker facial charts in which are 0 = *no pain* and 10 = *severe pain that makes them cry*. P5 stated that "there are two different kinds, there is the numeric 0 to 10 with 0 being no pain and ten being the unbearable pain. We also have facial recognition with normal or frowning faces and teary eyes." Most facilities use the Wong-Baker faces chart; the nurses look at the resident's facial expressions to know their pain level, especially the severely cognitively impaired. P8 also stated "we have the pain scale of 0 to 10 for those that can verbalize their pain. We also have the face chart we use for those severely cognitively impaired. We have a certain way of checking the pain." Table 2 shows the subthemes for Theme 2.

Table 2

Theme 2: Pain Assessment Tools

Subtheme	Participant
Numeric tool (0-10)	3, 4, 5, 6, 8
Wong-Baker facial chart (smiling to crying)	1, 2, 3, 5, 6, 7, 8
Body language	1, 2,

Pain management, the third identified theme, is an integral part of the resident's management. When a resident is experiencing pain related to the assessment made by the nurses, the nurses will think about a method that will be suitable to relieve the pain. Most participants said they use therapies such as cold or warm compresses, repositioning, warm blankets, and distractions through imagery, soft music, and television. Participants also mentioned medication to relieve residents' pain. P8. stated "after pain medication has been administered. I can use distraction, I might use a warm blanket, I might reposition them, I might provide a pillow, even turn on the TV to distract them." P5. stated "repositioning, keeping their skin dry, you can also apply ice to their pain area, in case that did not work, then you go on to medication if they have PRN ordered you can administer it to relieve their pain." To differentiate pain and agitation in the residents, nurses have to know the residents to differentiate their moods. When a nurse knows the resident's facial expressions when they are their usual self, the nurse will be able to know when the resident is in pain or agitated. P1 stated

> knowing the residents, if you know the residents and their mood, you will be able to know when they are in pain or agitated. Sometimes they get agitated when their loved one leaves them. So, unless one knows the residents, you may be unable to differentiate their pain from agitation.

Table 3 shows subthemes for Theme 3.

Table 3

Theme 3: Pain Management

Subtheme	Participant
Therapies – cold compress, warm compress, and keeping their skin dry.	2, 3, 4, 5, 6, 7
Warm blankets, Massage, heating pads, and repositioning	2, 4, 5, 6, 7, 8
Distractions - Imagery, Television, Drawing, and music.	3, 7, 8
PRN Pain medications as prescribed	1, 2, 3, 4, 5, 6, 7, 8

Evidence of Trustworthiness

Positivists often interrogate the trustworthiness of qualitative research because their notions of validity and reliability cannot be addressed in the same way as real effort (Shenton, 2004). I explored nurses' perception of pain assessment in CIOR in a long-term care facility. I used a descriptive qualitative approach that allowed the nurses to express themselves about their pain assessment experiences. Participants said they could recognize the residents' pain through facial expressions, body language, and withdrawal from activities.

Credibility

I followed up with the participants to schedule them for the interview and restate the purpose of the study. I asked the participants probing questions to elicit information-rich data. I engaged the participants to obtain their trust and encouraged them to tell me the truth about their perception of pain assessment in CIOR. I shared the transcript with the participant to facilitate transparency and clarify what they said during the interview to avoid miscommunication. I scheduled appointments to meet with some participants to review their responses to the interview transcripts to ensure that nothing was missing and nothing was added that they did not share with me. For instance, P1. expressed that it is challenging to access pain in CIOR. Pain can be misinterpreted with the escalation of behavior, which is difficult to differentiate because of residents' inability to express themselves. I asked P1. how he could determine pain from agitation, even though the resident could not verbalize their feelings. P1. said he could differentiate the two by residents' facial expressions and unwillingness to participate in activities, contrary to the combativeness accompanying agitation. P1. also mentioned that pain management depends on the symptoms present. Sometimes symptoms can distract residents from activities, and when residents can point to where they are hurting, the nurse can apply an ice pack or warm compress. P1. mentioned Per Need (PRN) medication as the last resort after all therapies did not work.

Transferability

The interviews were information-rich data about participants' experiences with pain assessment in CIOR. I recruited nurses with at least 2 years of experience in long-term care facilities to participate in the study. I reiterated to them that participation was voluntary and that they could discontinue participation at any stage. They voluntarily participated in the interview. The interview was conducted among participants in two long-term care facilities across three shifts. The data enabled me to answer my research questions using the descriptive qualitative method.

Dependability

Data collected were cross-validated with the participants by allowing them to review the interview transcripts to ensure that information recorded was accurate. The transcripts represented the participants' experiences, and nothing was missing and nothing was added participants they did not share with me. I interviewed eight participants and experienced data saturation after interviewing six participants. More data did not provide me with more information, and as the study went on new data did not shed further light on the studied issue (see Patton, 2015). It seemed as if I was repeating the same concepts and hearing the same responses from the participants.

Confirmability

I implemented a self-reflection approach to illuminate my potential biases, which may have influenced the data analysis process (Rudestam & Newton, 2015). I took some notes during the interview that I combined as a memo to help me with decisions about coding during data analysis. However, the data analysis was based on the data collected from the participants' experiences that they shared with me. The study was significant, and the coding aligned with the interview. The findings and interpretation were not figments of my imagination but were derived from the data collected.

Results

I interviewed eight participants and reached saturation after the sixth interview. All participants had at least 12 years of experience in nursing and at least 2 years of experience in long-term care. To align my research topic, problem statement, and purpose of the study, I formulated the main research question and two sub-questions.

Main Question

What are nurses' perceptions of pain in an older cognitively impaired resident? Participants described their experiences as difficult and tasking, but that must be done. P4 stated "that is, it can be challenging, but it is something that can be overcome. We also use their condition to assess them; sometimes they will not participate in activities and are withdrawn." P4 added "let me elaborate; with cognitively impaired residents instead, one has to develop that intuition and ability to understand them."

Another participant, P7, stated, "Elderly patients or residents are part of the vulnerable group. With my experience, it can be hard to recognize pain in them if one does not know how to pitch in or if you are not skilled in treating the patient and do not know the patient well." Another participant, P3, stated, "Pain assessment is subjective. It is a little tasking because of the cognitive impairment, and it is challenging". Another participant, P1, stated, "It is difficult to assess pain in cognitively impaired residents. They can be misinterpreted as an escalation in behavior. You cannot differentiate it because they cannot express themselves. It can also be their facial expression."

Overall, 87.5% (N=7) expressed that pain assessment in CIOR is complex and tasking related to their inability to express themselves or report their pain, and 12.5%

(N=1) indicated that you have to have experience and have a rapport with them, and even though they are cognitively impaired, some of them can still communicate with you and express their feelings, it just depends on what is going on with the residents. One of the participants believed that pain assessment in CIOR is not difficult. She mentioned that pain assessment in CIOR required having a rapport with them to know what was going on with them. P2. stated “Mostly, you have to have experience and rapport with them. Some patients are cognitively impaired and can still communicate with you and express their feelings, and it just depends on what is going on with the residents.”

Subquestions

SQ1 was the following: What are the manifestations of pain in cognitively impaired residents recognized by nurses? Answering the questions, 100% of the participants described the image of pain in the elderly as facial grimacing, facial expression, withdrawal from activities of daily living, refusal to participate in the unit’s activities, refusal to eat or take medication, and sometimes refusal to get out of bed. P1 stated, “Sometimes they refuse to participate in activities, and they refuse to do regular things they used to do.” P3 said, “When they are not participating in their activities, it may suggest pain because they cannot express themselves.” P4 said, “Sometimes they do not want to respond; they do not want to participate. They do not want to get out of bed, and they can be difficult, they can be combative, sorry that was the word I was trying to use, combative”. P7 stated, “Their facial expression helps me to know if they are calm or frowning. If the patient is not smiling and squeezing their face, I can tell if they are in pain. Certain body parts can indicate that the resident is in pain, such as; slow walking and sluggish arm movement depending on the body part that is affected". P8 also stated, "I will say their facial expression, whether they are frowning. Also, they are groaning in pain, or they are crying. The patient may be in pain when they are frowning, groaning, or crying; even they may be restless".

SQ2 was the following: What are the barriers to pain assessment in the elderly cognitively impaired residents encountered by nurses? The majority of the participants identified the barriers as; the inability to adequately assess pain in the CIOR because it is difficult to know when they are in pain unless you know their mood. P1 noted that; the most challenging thing is knowing they are in pain as opposed to having pain. Most of the time, they do not participate in activities, and their facial expression may suggest they are in pain, but all of these are not definitive; they are all assumptions. Knowing residents, if you know the residents and their moods, you will be able to know when they are in pain. P3. also stated that assessing the pain, like the character, intensity, and length, is the most challenging. All these are considerable challenges to knowing their pain; most of them cannot tell you where and how it hurts. So, this poses a significant challenge to us, and it is challenging to differentiate if they are in pain or agitated. P4. indicated that responding appropriately to what is happening is challenging. Many of them are withdrawn; it takes some strategies to understand them and whatever is going on in their mind, which can be difficult. P5 stated, "It is most challenging, well they don't complain of pain, and if you are not assessing it regularly, it can get higher than what can be managed, leading to anxiety and agitation." Overall, the majority of the participant stated it is challenging to know when the residents are in pain because they cannot tell you where they are hurting and the intensity. 100% use the facial expression and the Wong-Baker pain scale to assess the residents' pain.

Summary

The information-rich responses from the participants aided in answering the research questions; the participants expressed their lived experiences, including difficulties in assessing pain in the CIOR because of their impairment. The participants said you must study their body language and facial expressions, such as grimacing, frowning, and sometimes shedding tears, to know they are in pain. The participants also expressed that they use numeric and facial pain scales to assess their pain because most of them can point to the chart and give you an idea of the Degree to which they are hurting. The participants also mentioned therapies such as applying ice packs, warm fomentation, warm blankets, and routine and PRN medication as the best pain management in the CIOR. Overall, you must know your resident when things are not going well with them. The study's findings will be discussed in the next chapter (Chapter 5).

Chapter 5: Discussion, Conclusions, and Recommendations

In this descriptive qualitative study, I explored nurses' perception of pain assessment in CIOR in long-term care facilities. I explored the lived experience of the nurses' perception of pain assessment in CIOR in long-term care facilities. I described nurses' lived experiences in assessing pain in CIOR and how they manage pain in this population. Most residents in long-term care facilities experience chronic pain daily, and they suffer through it because they cannot express themselves or complain about their pain.

Assessment and managing pain in CIOR can be challenging for nurses because of the inability of the residents to express themselves (Docking et al., 2018). The study was conducted to elicit information-rich data that could increase nurses' knowledge about pain assessment in CIOR, how nurses recognize residents are in pain, and how nurses manage the residents' pain. The information-rich data obtained from participants indicated that nurses have some knowledge about pain assessment and management in CIOR.

Interpretation of the Findings

The participants described pain assessment in CIOR as difficult and tasking; most residents suffer daily pain related to their multiple health issues, such as arthritis. Pain assessment in these populations is paramount to their well-being by caring for them through repositioning, keeping their skin dry, applying ice packs or warm fomentation, and administering medication. This makes them relaxed and relieved to participate in unit activities, resonating with Watson's (2006) theory of care that a healing environment is a caring atmosphere that allows patients to recover and develop to their full potential. According to Gonzalo (2021), Watson's theory of caring can be demonstrated and practiced by nurses by caring for patients and promoting health. When a resident is relieved of their pain, they will be able to get out of bed and engage in the activities of daily living, such as eating, drinking, taking routine medications, and participating in unit activities with no signs and symptoms of agitation. One of the participants (P3) stated that

> Majority of the time, we redirect them before using the pharmacological intervention. Instead of using pharmacological, we can apply an ice-cold pack on their necks or shoulders, depending on the area that is hurting, which can distract them from the pain. Some like listening to music or dance, and we offer these before pharmacological treatment.

The perception consistent with Watson is the description of nursing as a human science and human care; Watson stated that it was the only theory that incorporated the spiritual dimension of nursing. Watson's philosophy and science of caring concern how nurses express respect to their patients, and Watson's approach stresses humanistic nursing interwoven with scientific knowledge and nursing practices.

Pain is subjective, and pain in CIOR, as identified by the participants, is related to aging and chronic diseases such as cancer, arthritis, neuropathy, surgical pain, and musculoskeletal pain, which can lead to depression. The symptoms are in line with Canton-Habas et al. (2019), who stated that many older people frequently experience pain, and the pains are primarily chronic; such pains occur from depression, cardiovascular disease, cancer, arthritis, and osteoporosis. The current participants also mentioned that pain assessment is complex, challenging, and tasking and can be misinterpreted with escalating behavior due to residents' inability to verbalize their feelings and express themselves. This resonates with Yoon-Sook et al. (2017), who observed that CIOR cannot verbally report their pain. Hence, they are regularly unrecognized or ineffectively treated, as stated in Chapter 2. One current participant (P2) said that

> it is difficult to assess their pain in cognitively impaired residents. They can be misinterpreted as an escalation in behavior. You cannot differentiate it because they cannot express themselves. It can also be their facial expression. Pain assessment in these populations is subjective; it is a little tasking because most cognitively impaired patients cannot complain of pain.

The participants described the signs and symptoms of pain in CIOR as facial grimacing, frowning, groaning, restlessness, withdrawal from normal activities, refusal of food and drinks, inability to get out of bed, slow movement, sluggish movement of extremities, unusual body language or motion, acting out, and sometimes crying. The signs and symptoms resonate with Zis et al. (2017), who stated that pain can be classified as chronic cancer pain, neuropathic pain, posttraumatic pain, postsurgical pain, chronic musculoskeletal pain, visceral pain, chronic headache, and orofacial pain. Zis et al. also stated that chronic pain increases the risk of depression, and people suffering from depression are susceptible to nonneuropathic and neuropathic pain. Malik (2020) also described pain in older people as inevitable due to aging and disease conditions, resulting in depression and cognitive disorders. Vader et al. (2021) also noted that pain can be chronic due to illnesses such as cancer, arthritis, back pain, migraine headache, peptic ulcer, and tendinitis. P2 stated that “some of them may have facial grimacing, and others may not. Knowing your patient and what causes their pain such as surgery, arthritis, cancer, wound, and so on.”

As identified by the current participants, pain intervention includes watching residents’ mood and countenance to know what treatment they require. When a resident is hurting and can still move around and not cry, the nurses ask the resident to touch where they are hurting to observe the area and know what type of therapy is required. Such therapies are distractions, massages, warm blankets, ice-pack application, fomentation, calming music, watching television, telling stories, and PRN medications. According to the participants, when a resident is crying and unable to get out of bed, the nurses administer medication to relieve their pain; this resonates with Pajnkihar et al. (2017), who stated that caring is the core concept of nursing and includes caring for and carinh about clients. Pajnkihar et al. also noted that caring is central to the patients’ experience by implementing Watson’s theory of human caring as the guide for nursing practice. Nurses can contribute to the well-being of patients through their behaviors and attitude toward the care provided. P5. stated that “repositioning, keeping their skin dry, I can apply ice to their pain area. Then I go on to medication; if they have PRN ordered, I can administer it to relieve their pain, which is how I manage pain.”

Participants agreed that pain assessment is challenging and is being misdiagnosed because the residents cannot express themselves or complain about their pain.

Participants also reported that nurses must know their patient if they are in pain or agitated. This resonates with Gimenez-Llort et al. (2020), who noted that pain is underdiagnosed and undertreated in a cognitively impaired patient with diminished verbal communication leading to poor quality of life. One participant (P1) stated that

> knowing the residents, if you know the residents and their mood, you will be able to know when they are in pain or agitated. Sometimes they get agitated when their loved one leaves them. So, unless one knows the residents, you may be unable to differentiate their pain from agitation.

Another participant (P2) stated that

> knowing your patients and carrying out a head-to-toe assessment using the assessment tools like facial pain scales, and asking them but because they are impaired and cannot communicate, you will do the assessment when you touch the patient are they guarded, and use your nursing experience such as grimacing, facial assessment, are they are guarding and others, that is how we generally assess patients in a long-term patient.

It was evident from the participants’ shared experiences that pain in cognitively impaired residents can be due to old age and disease conditions such as arthritis, cancer, osteoporosis, headaches, gout, neuropathy, posttraumatic pain, postsurgical, and so on. The participants mentioned that pain assessment in CIOR is difficult, tasking, and challenging but must be done to know the type of pain management that will be administered to the residents. The pain intervention will give the residents some comfort and relief to participate in or perform daily activities. Also, when pain is well managed, it can hasten the recovery process and give CIOR a sense of dignity and belonging. Caring for them is consistent with the assumptions of Watson’s theory of caring, which states that a caring science emerges and makes a clear, increasingly unitary, energetic worldview with interpersonal human caring ethics and ontology. The use of the theory of human caring was well aligned with the current study because practical caring promotes health and individual or family growth; when the residents are free from pain, they will be able to live their lives as expected within their capability.

Limitations of the Study

One strength of this study was the organizations’ willingness to allow their nurses to work with me. I also reached data saturation after interviewing six participants. I did not find sample size to be an issue in my study because the participants were selected from two long-term care facilities. Morrison et al. (2020) stated that pain may be underreported among residents on admission, whereas my study focused on CIOR in long-term care. There was intrinsic bias in the choice of participants involving certain nurses working in long-term care facilities related to their work schedules. The resident’s care is paramount, making it impossible to reach the nurses during work hours. Some of them have young children they take care of after work, making it almost impossible to get their attention for participation. For instance, I called one of the participants as agreed, and she told me she was on her way to football practice with her son, and we had to reschedule. The challenge I encountered with data collection was reaching the DON and calling the nurses for interviews. I had to send emails and messages several times to the DON to get approval. After getting the support of the DON, I had to email some of the nurses several times after they consented to the interview to identify a time that would work for them. I did not include other valuable health care professionals such as nurse practitioners, physicians, social workers, administrators, nursing assistants, and others. The findings from this study may not represent the experiences of the excluded health care professionals. Therefore, the study findings' transferability to other long-term care facilities may be limited.

Recommendations

I discovered that pain management in CIOR is a multidisciplinary approach. It includes physical, pharmacological, and psychological rehabilitation, which means it involves multidisciplinary efforts to manage pain in CIOR. There are guidelines for managing pain in CIOR, including knowing the potential causes, observing and listing the patient's behavior that may indicate pain, and attempting analgesic trials. According to Hosseini et al. (2020), there are many nonpharmacological treatment modalities for pain management, including effective therapies for treating pain in older adults. However, they are not enough, which warrants the use of analgesics. However, there are numerous considerations when choosing an analgesic for older adults relating to their comorbidities. Even though the nurses treat pain in CIOR using ice packs, warm compresses, and PRN medications, further training would be needed to impart the required knowledge about the assessment of pain in CIOR to differentiate when they are in pain compared to when they are agitated.

Some participants start pain management with medication before therapeutic intervention. Further study is needed in long-term care facilities to explore the lived experiences of other valuable health care professionals. The practice recommendations include a care plan shared among all stakeholders in the resident's care, including the family, that indicates the best way to assess pain for each resident. Using pain assessment tools, whenever possible, is the standard of care for pain assessment. For mildly impaired residents, using this tool provides them control over their expression of pain in a way that respects their limited autonomy.

Implications

This study provides implications for researchers considering studying in this area of nursing care for pain management in CIOR. Qualitative approaches used with the nursing staff may reveal their perceptions and experiences in caring for the cognitively impaired resident. Most older patients have a variety of discomforts that require management. Understanding how nurses manage and process their assessment data to manage pain effectively fits well with a qualitative descriptive approach (see Patton, 2015).

Watson's (2006) theory of caring provided a useful framework for the current study. In seeing the nurse–patient relationship as a dyad that functions to make patient comfort a priority, the nursing staff facilitates patient comfort, dignity, and respect. Other elements of Watson's theory could be used to explore the well-being of long-term care residents to elevate their growth and development in their later stages of life. Research on nursing care of residents in long-term care is a neglected area related to the perspectives of nursing staff, residents, their families, leaders, and other providers. Exploring the perspectives of these people in the long-term care environment may contribute critical insights into what the residents experience and how care can be provided that honors their unique contribution to the world.

My findings may effect positive social change in long-term care facilities by increasing nurses’ awareness and understanding of the consistency and accuracy of pain assessments in the cognitively impaired. The resident’s improvement may help their family members to be satisfied with the care for their loved ones because the family can enjoy their interactions knowing their family member is not in pain. While in the community, residents can continue participating in activities that help their behaviors. Additional recipients of social change are other professionals because the resident’s pain will not be a barrier to the care rendered to them by these professionals. The findings may also effect positive social change for the long-term facilities because it may improve patient and family satisfaction scores as care control of pain is improved. The nursing organization may benefit from positive social change by updating the standard of practice and guidelines. Findings may make a difference in knowing how different cultures perceive and react to pain. Some cultures believe pain is a result of punishment for sins. Knowing this may help nurses and other health care professionals educate residents to alleviate their misconceptions about pain.

Nurses perceived pain differently in CIOR. Chronic pain is a problem for the older population, and it is difficult for them to express themselves or complain of pain when they have cognitive impairment. The inability of these residents to express their pain makes it difficult for the nurses to determine whether they are in pain or agitated. The findings from the current study may be used to distinguish signs and symptoms of pain from those of agitation. Nurses may assess pain regularly in CIOR and intervene before it gets worse. The residents may have self-dignity when they are relieved from pain, and they may be able to participate in daily activities, which may increase their family's satisfaction. Findings may also help organizations and their leadership attain higher scores in resident satisfaction.

Conclusion

Pain in CIOR is inevitable because of their age and multiple disease conditions associated with pain. Pain assessment in these residents is difficult, tasking, and challenging. Nurses apply their experiences with the residents' knowledge to assess and diagnose their pain. Findings indicated that most nurses used the Wong-Baker facial chart to assess pain in the residents. Knowing the resident and differentiating their pain from agitation may help the nurses manage residents' pain effectively. Pain relief may aid the residents in recovering from their diseases and make them comfortable. Overall, pain assessment is paramount in CIOR for health management and health promotion.

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