

A Stakeholder Analysis: Stakeholders' perceptions of chronic pain management in older adults  
who reside in a long-term care facility.

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### Abstract

Chronic pain remains a major public health concern throughout the United States, but its high prevalence among older adults who reside in long-term care facilities (LTCF) emphasizes the need to focus research efforts on chronic pain management. Chronic pain in older adults who live in LTCFs is consistently undertreated and unrecognized by staff. The literature identifies the following four challenges to recognizing and managing chronic pain in older adults who live in LTCFs: generational differences; cognitive impairment; non-standardization of pain protocols and guidelines; and non-uniform pain assessment tools and pain scales. This honors project is part of a project funded by the North Carolina AHEC Innovation Grant in order to conduct a Quality Improvement Project on the quality issue of chronic pain management. The purpose of my project was to conduct a stakeholder analysis exploring the stakeholders' perceptions of chronic pain management in older adults who reside in the LTCF. The analysis revealed nine themes that were presented to the School of Nursing team. We discussed and examined several potential areas of intervention to suggest to the leadership team at Happy Meadows. This Quality Improvement Project will not only aid the leadership team at Happy Meadows in developing a new pain management protocol, but also it will inform future quality improvement efforts to improve chronic pain management in LTCFs.

*Keywords:* Chronic pain, long-term care facility, older adult, stakeholder, stakeholder analysis

A Stakeholder Analysis: Stakeholders' perceptions of chronic pain management in older adults who reside in a long-term care facility

Geriatric researchers are becoming increasingly aware that chronic pain in older adults who reside in long-term care facilities (LTCFs) is consistently undertreated and poorly managed (Leone et al., 2009). This, in turn, is leading to a decreased quality of life and decreased survival rate of older adults (Leone et al., 2009). Despite current studies that suggest the need for the standardization of pain assessment protocols and pain scales, the collaborative effort to develop and implement proper guidelines in LTCFs still remains a problem (Gibson & Bol, 2001).

In this paper, I aim to describe the literature on chronic pain in older adults residing in LTCFs, provide an overview of the Quality Improvement Project developed by the University of North Carolina at Chapel Hill School of Nursing, and discuss the results of a stakeholder analysis exploring chronic pain management. I also aim to offer recommendations for future changes to pain management practices that were presented to the nursing care leadership and administration of the LTCF. For the purposes of this paper, and to protect the anonymity of the project participants, I will call this facility "Happy Meadows".

I will begin my paper by defining five key terms that are essential to the project. Then, I will present a review of the literature related to the problem of chronic pain management in older adults who reside in LTCFs. Next, I will describe the setting and structure of the LTCF, whose six leadership members partnered with the School of Nursing team. Then, I will describe the School of Nursing's Quality Improvement Project that is funded by North Carolina Area Health Center (AHEC), in addition to my individual role in the project. I will then describe the methods that the School of Nursing team used to collect the stakeholder interview data and the methods that I used to conduct the stakeholder analysis. Then, I will present the results of the thematic

analysis. Lastly, I will discuss the overall results of my project and the implications for the findings, including limitations and recommendations for chronic pain management at the LTCF.

### **Definition of Terms**

*Chronic pain*: “Ongoing or recurrent pain, lasting beyond the usual course of acute illness or injury, or more than 3 to 6 months; adversely affects the individual’s well-being.” (American Chronic Pain Association, 2017, n.p.)

*Long-term care facility (LTCF)*: “Provides a variety of services, both medical and personal care, to people who are unable to manage independently in the community”; consists of nursing homes, skilled nursing facilities, and assisted living facilities.” (U.S. Department of Health and Human Services, 2015, n.p.)

*Needs Assessment*: “A study in which data are collected for estimating the needs of a group, community or organization.” (Jacobsen & O’Connor, 2006, p. 3)

*Older adult*: An individual who is 65 years or older.

*Stakeholder*: “A person or group with an interest, involvement, or investment in something.” (Griffiths, Maggs, & George, 2008, p. 9)

### **Review of the Literature**

The need for developing consistent and effective protocols for chronic pain management in older adults in LTCFs is an emerging priority among healthcare professionals and geriatric researchers. Researchers have become increasingly aware that pain in older adults is consistently undertreated and unrecognized by staff in LTCFs (Leone et al., 2009). And, older adults are likely to under-report their pain to health clinicians (Evers, Meier, & Morrison, 2002). When older adults’ chronic pain is not managed or treated properly, it can create many complications for their health and overall quality of life. For example, chronic pain that is poorly managed can

lead to a loss of mobility, increased dependence, anxiety, and agitation (Evers et al., 2002, Liu & Lai, 2012).

The literature identifies four current challenges to recognizing and managing chronic pain in older adults who reside in LTCFs. First, the older adults belong to a generation whose culture reflects stoicism and self-reliance. These once highly valued attitudes can contribute to the underreporting of pain (Crowe, Gillon, Jordan, & McCall, 2016). Many older adults accept their health problems and adapt to living with the pain (Crowe et al., 2016). They also are very private, and have a “strong desire to remain independent and in control” (Crowe et al., 2016, p. 48).

Second, assessing and managing chronic pain in older adults who have cognitive impairment is difficult. As older adults’ cognition deteriorates, their ability to report their pain and alert caregivers or staff declines (Evers et al., 2002). Therefore, older adults with cognitive impairment are at an increased risk for experiencing undertreated and poorly managed pain (Liu & Lai, 2014).

Third, standardization of pain protocols and guidelines is lacking in many LTCFs (Liu & Lai, 2014). Appropriate management of pain in older adults requires the development of “comprehensive, individualized plans that incorporate goals, specify treatments, and address strategies to minimize the pain and its consequences” (Evers et al., 2002, n.p.). Given the individuality of each older adult and his or her comorbidities, preferences, and backgrounds, it is difficult to develop standardized pain protocols and guidelines that can be effectively and consistently used to manage each older adult’s pain.

Fourth, application of uniform pain assessment tools and interpretation of pain scales are difficult to standardize and implement into a daily routine (Liu & Lai, 2014). Some examples of

current assessment tools that have been developed to assess pain in non-verbal or cognitively impaired older adults are the Abbey Pain Scale, the Checklist of Nonverbal Pain Indicators (CNPI), the FLACC behavioral pain scale, and the Pain Assessment In Advanced Dementia (PAINAD) Scale (Leone et al., 2009). Some examples of current assessment tools that have been developed to assess pain in verbal older adults are the Visual Analog Scale (0-10), Wong-Baker Pain Scale, and the faces pain scale (Leone et al., 2009). The effectiveness of these pain assessment tools and scales is still called into question by many pain experts who have identified various problems with the tools and scales. For example, staff members inconsistently carry out the pain tools and scales (Ersek & Polomano, 2011). Also, the behavioral indicators such as grimacing, crying, and shouting are not unique to pain; they might reflect other health or psychosocial problems (Liu & Lai, 2014). Since behavioral observation is subjective, staff members might misinterpret residents' behavior, which can lead to the implementation of incorrect pain interventions (Liu & Lai, 2014).

The quality issue of chronic pain management in older adults who reside in LTCFs is an important area on which to focus research efforts because of the high prevalence of pain in older adults, in addition to the abundance of challenges that staff members face when assessing residents' pain. Leone et al. reports that 45-80% of older adults in the United States experience pain, but the prevalence is as high as 83% in older adults who reside in LTCFs (Leone et al., 2009). As in any other LTCF, while Happy Meadows provides high quality care, the leadership thought it was important to conduct a Quality Improvement Project on this topic in order to gain insight from stakeholders of a LTCF and collaborate with them in order to develop a more standardized approach to pain assessment. This will in turn lead to an improvement in the

recognition and assessment of pain in older adults - both the cognitively intact and cognitively impaired - and the implementation of appropriate pain interventions (Leone et al., 2009).

### **Description of Setting**

Happy Meadows is a not-for-profit continuing care retirement community located in the southeastern United States. It is considered to be a LTCF that consists of apartments, cottages, and townhomes. These residences are classified as independent living, assisted living, or skilled nursing/nursing homes. Happy Meadows provides health services for over 500 residents, in addition to older adults living in the surrounding community. For the purposes of the Quality Improvement Project on chronic pain management, the team only focused on the problem in the skilled nursing component of the community.

### **Description of AHEC Project and BSN Honors Project**

The research project titled, “Intraprofessional Development of Nurse Leaders: Working Together Toward Quality Improvement in Long-term Care”, is led by Dr. Anna Song Beeber, PhD, RN of the University of North Carolina at Chapel Hill School of Nursing. The project received funding from the North Carolina AHEC Innovation Grant in order to conduct a Quality Improvement Project on the quality issue of chronic pain management.

Through the partnership between the School of Nursing and Happy Meadows, Dr. Beeber aimed to improve the quality of care that older adults receive in LTCFs by developing a protocol that will improve pain assessments and management. In addition, Dr. Beeber aimed to create an innovative intraprofessional opportunity for nursing students of all levels that will promote teamwork, collaboration, and respect among nursing professionals. Students of each level - Bachelor of Science in Nursing (BSN), Bachelor of Science in Nursing Honors (BSN Honors), Master of Science in Nursing (MSN), Doctor of Nursing Practice (DNP), and Doctor of

Philosophy (PhD) - who are interested in geriatric nursing and healthcare systems are members of the School of Nursing team. The students worked independently on an assignment within Dr. Beeber's project, while simultaneously collaborating as a team and learning from each other. Each of the student's assignments fits into an existing School of Nursing course, and will conclude with a final scholarly product. Appendix A graphically demonstrates how my role as a BSN Honors student fits into the intraprofessional AHEC project. As a BSN Honors student, the purpose of my project was to conduct a stakeholder analysis exploring the stakeholders' perceptions of chronic pain management in older adults who reside in Happy Meadows. My project sought to answer the following research questions: "What are the stakeholders' perceptions on the current chronic pain management practices in Happy Meadows?", "What are the identified strengths and barriers to carrying out chronic pain management practices?", and "How can Happy Meadows capitalize on its strengths and overcome its barriers?"

### **Methods: Stakeholder Interview Data Collection**

Dr. Beeber established a relationship with the leadership of Happy Meadows and they created a team with six leaders who were eager to provide any insight or support that they could. They collaborated with the School of Nursing team over an eight-month period in order to identify and gain access to other stakeholders at Happy Meadows. They also assisted with the creation of a flyer to inform staff about the AHEC project which is shown in Appendix B. In no particular order, the stakeholders of Happy Meadows were identified as follows: Physician; Nurse Practitioner; Registered Nurse; Licensed Practical Nurse; Certified Nursing Assistant; Medical Technician/Aide; Family Caregiver; Physical Therapist; Occupational Therapist; Healing Touch and Masseuse; Speech Language Pathologist; Fitness Coach; Social Worker; Supervisors of Staff; Dining staff; and Security staff.



The leadership of Happy Meadows and the School of Nursing team were also able to work together using a Dartmouth Organization Needs Assessment in order to create and develop interview questions to ask the stakeholders (Jacobsen & O'Connor, 2006). The goal of the interviews was to identify the stakeholders' perceptions on chronic pain management at Happy Meadows, and to determine whether or not they believed Happy Meadows' current pain management practices were meeting the needs of the residents.

Once the DNP student drafted the interview questions, the six leaders of Happy Meadows participated in pilot interviews in December of 2016. These pilot interviews allowed the leadership of Happy Meadows and the School of Nursing team to jointly examine each interview question in order to determine which questions needed to be changed, added, or removed. The finalized interview guide can be found in Appendix C.

Then, from January 2017 until February 2017, the leadership of Happy Meadows and School of Nursing team worked to recruit more stakeholders to participate in the interviews. Seven additional stakeholders were identified and interviewed. By the end of February 2017, 13 stakeholders had participated in the interviews (this total includes the six leadership members who participated in December 2016) and included the following professions, in no particular order: Administrator; Nurse Practitioner; Nursing Supervisors; Director of Clinical Services; Director of Nursing; Occupational Therapist; Physical Therapist; Social Work Coordinator; Nursing Assistant Supervisor; Certified Nursing Assistants; Volunteer Coordinator; and Rehabilitation Director.

The School of Nursing students (BSN, BSN Honors, MSN, DNP, and PhD) conducted each of the 13 stakeholder interviews in conference rooms and offices at Happy Meadows. The

students interviewed the stakeholders either with another student or individually. Each interview was voluntary and lasted 15-30 minutes.

### **Methods: Stakeholder Analysis**

The stakeholder analysis was conducted in the following seven phases:

- 1) Conducting and compiling of stakeholder interview data
- 2) Creation of Microsoft Excel Table, categorized by stakeholder and interview question
- 3) Insertion of data into Microsoft Excel Table
- 4) Analysis of each stakeholder's response to each question
- 5) Conducting of thematic analysis
- 6) Discussion of thematic analysis with the School of Nursing team
- 7) Presentation of thematic analysis to the leadership of Happy Meadows

Phase 1 consisted of School of Nursing students conducting interviews with stakeholders and typing the stakeholder interview responses into a Microsoft Word document, organized by interview question. Then, they uploaded the document onto Sakai under "Resources".

For Phase 2, I developed a Microsoft Excel Table that was categorized by stakeholder (vertical y-axis) and interview question (horizontal x-axis). Appendix D illustrates this table. As each interviewer continued to upload the stakeholder interview data, I enacted Phase 3 and inserted this information into my Excel table.

After receiving all 13 interviews, I enacted Phase 4 and printed out the Excel table. In a Microsoft Word document, Dr. Beeber and I categorized the stakeholders' responses to each question into common themes and analyzed them. We also made note if there were contradicting responses for each question. To protect the anonymity of the stakeholders, I will not display the

table or document in my paper. In Phase 5, Dr. Beeber and I conducted a qualitative thematic analysis. In the following section, I will discuss the thematic analysis in more detail. For Phase 6, I presented my findings of the qualitative thematic analysis to the School of Nursing team. The team was able to provide me with additional knowledge and insight into the interviews. This allowed me to further refine the themes. In Phase 7, the final thematic analysis was presented to the leadership of Happy Meadows. The goal of this meeting was to begin prioritizing the needs of the facility, to brainstorm ways to capitalize on its strengths, and to develop interventions to break down its barriers.

### **Qualitative Thematic Analysis**

In order to analyze the stakeholder interview data, Dr. Beeber and I conducted a qualitative thematic analysis. We looked at each stakeholder's responses and identified similarities and differences among these responses. From this we identified nine common themes. Then, we created a table in Microsoft Word in order to organize and define the themes, and to reference each stakeholder's response, shown in Appendix E. Lastly, in order to present the results to the leadership of Happy Meadows, we created an outline that clearly displayed the themes and definitions, which is shown in Appendix F. In order to protect the anonymity of the stakeholders, this outline did not include references to individual interviews. In the following paragraphs, I will present and define each of the nine themes.

### **Results**

The thematic analysis of the stakeholder interview exploring management of chronic pain in Happy Meadows resulted in nine themes. The themes include the following: the strengths and challenges with communication about chronic pain; perceptions about narcotics as a pharmacological intervention; the Electronic Medical Record; first-line treatment for pain;

standardized pain assessment protocol; standing order set that can be activated; pain management flow sheet communicating resident-specific needs; and interdisciplinary pain meeting.

**Communication.** The first theme identified from the data was defined as communication. This includes intraprofessional (within a given profession) and interprofessional (among professions) communication; communication between staff members and residents; and residents who have impaired communication due to cognitive impairment. The stakeholders identified two strengths and four challenges with communication at Happy Meadows.

**Strong interprofessional team collaboration.** The professions effectively work together, listen to, and respect each other. This good communication, in turn, positively affects the residents' pain management.

**Good communication between the residents and staff members.** This includes stakeholders' views that Happy Meadows utilizes a resident-centered approach when planning pain management interventions. Stakeholders reported that the staff members respect the residents' pain goals and choices. They believe that they effectively promote the residents to become integral members of their own healthcare team. The staff members spend a lot of time getting to know the residents and are able to notice changes in a resident's pain level.

**Challenges with intraprofessional communication.** This includes poor communication among staff members within the same discipline at shift report and patient handoff. Stakeholders reported that sometimes information is left out of shift report and patient handoff, and sometimes there is miscommunication among staff members within the same discipline. These challenges can hinder the management of residents' chronic pain.

**Challenges with interprofessional communication.** Stakeholders identified challenges with interprofessional communication. This includes poor communication among staff members

of different disciplines. Staff members often have contrasting opinions on pain interventions, which does not always ensure that the intervention will be consistently carried out. Staff members from each discipline are trained to conduct differing pain assessments according to their scope of practice. This includes poor communication with the pharmacy and with outside or on-call providers, especially on the weekends.

**Challenge of residents communicating pain to staff members.** Stakeholders reported on the difficulty of communicating with some older adults because of generational differences. The residents who do not effectively communicate their pain are members of the “stoic generation”. They are very private and have a tendency to withhold their complaints of pain and stress.

**Challenge of assessing pain in the resident who has cognitive impairment.** Stakeholders stated that it was difficult to assess pain in residents who are cognitively impaired. The process of pain management is “trial and error” because some residents have difficulty communicating their pain to the staff members. In addition, some residents forget to alert the staff members if they are in pain, and therefore they might not receive their PRN pain medications.

**Family dynamics.** This is a subgroup of the theme “Communication” that pertains to the communication among family members; communication between family members and staff members; and communication by family members on behalf of the resident. Stakeholders identified two strengths and three challenges of family dynamics at Happy Meadows.

***Good communication between family members and residents.*** Stakeholders reported on the positive communication that occurred between the residents and their family members. They

stated that family members are partners in the residents' pain management plans, and often take the resident to outpatient appointments.

***Good communication by family members on behalf of the resident who is cognitively impaired.*** Stakeholders reported on positive communication that occurred by family members for the resident who is cognitively impaired. They stated that family members effectively communicate the resident's needs and wishes when the resident is unable to do so. They also reported that family members are involved in the care plan meetings so they can make suggestions on behalf of the resident to the healthcare team.

***Lack of communication by family members to the staff members.*** Stakeholders reported on the ineffective communication by family members to staff members. They stated that some family members do not know to whom to report about the resident's pain. They also reported that family members are sometimes unclear of their role in the resident's pain management plan.

***Poor communication among family members.*** Stakeholders reported on the conflict within families that prevents effective management of residents' pain. They stated that some family members differ in opinion about how the resident should manage his or her pain. They also reported that some family members have their own ideas that contrast with the resident's wishes. This family conflict makes it difficult to carry out the pain interventions.

***Lack of communication by family members on behalf of the resident who is cognitively impaired.*** Stakeholders reported that some family members poorly communicate on behalf of the resident who is cognitively impaired. They stated that some family members have different wishes than the resident, and therefore communicate these to the healthcare team.

### **Challenges and Areas in Need of Improvement**

**Perceptions about narcotics as a pharmacological intervention.** Providers, residents, family members, and staff members delve into their negative views about narcotics. Stakeholders stated that providers are hesitant to prescribe narcotics to the residents, and that residents are reluctant to take the narcotics for fear of becoming addicted or feeling “fuzzy”. Stakeholders reported that family members have difficulty determining the benefits and risks of narcotics and are afraid that the resident will become addicted. Stakeholders also reported that some staff members are against the use of narcotics, but they support them if the residents wish to take the narcotics. In addition, some staff members believe that the effects of narcotics cause the residents to become less active, independent, and alert.

**The Electronic Medical Record (EMR).** This theme includes four categories that stakeholders identified as in need of improvement. Stakeholders reported that there are several areas of the EMR that need improvement. After documentation of a pain intervention, the EMR does not prompt the staff members to assess and re-assess the residents’ pain. The EMR does not have a pain assessment tool, and does not provide a defined location to document the pain scale rating. An additional problem that stakeholders reported on was the inconsistent use of pain scales. Each discipline uses a different pain scale, and not all practitioners use pain scales consistently.

### **Ways to Approach and Improve Pain Practices in Happy Meadows**

**First-line treatment for pain.** When stakeholders were asked about the first-line treatment for pain, each discipline identified a different “first line” treatment.

*Pharmacological interventions.* Stakeholders reported that some staff members view that pharmacological interventions are the first-line treatment. These interventions include medications that relieve pain, such as narcotics and NSAIDS. Staff and / or residents view pain medicine as the initial step in pain management.

*Alternative therapies.* Stakeholders reported that some staff members view alternative therapies as the first-line treatment. These include breathing, exercise, imagery, acupuncture, hand massage, distraction, and healing touch. Happy Meadows provides a multitude of non-pharmacological interventions that are utilized as the initial steps in pain management.

*Multimodal approach.* Stakeholders reported that Happy Meadows effectively manages residents' pain by using a balance between pharmacological and non-pharmacological interventions in the initial steps of pain management.

**Standardized pain assessment protocol.** When stakeholders were asked if the implementation of a “standardized pain assessment protocol” would help the healthcare team manage chronic pain, the majority of stakeholders agreed. Some stakeholders disagreed because they were concerned that a standardized pain assessment protocol would not effectively work for residents who are cognitively impaired. When stakeholders were asked if they thought additional training was needed on pain assessments, their responses revealed that all disciplines needed some training.

**Standing order set that can be activated.** When stakeholders were asked if the implementation of a “standing order set that can be activated” would help the healthcare team manage chronic pain, the majority of stakeholders agreed.

**Pain management flow sheet communicating resident-specific needs.** When stakeholders were asked if the implementation of a “pain management flow sheet communicating resident-specific needs” would help the healthcare team manage chronic pain, the majority of stakeholders agreed.

**Interdisciplinary pain meeting.** When stakeholders were asked if the implementation of “interdisciplinary pain meetings ” would help the healthcare team manage chronic pain, the



majority of stakeholders disagreed. They reported that they already discuss pain in their meetings. Since the majority reported that they did not want an additional meeting to be scheduled, an intervention for this would not be necessary.

### **Discussion**

After presenting the thematic analysis to the School of Nursing team, potential areas of intervention were discussed and examined. These interventions were presented and suggested to the leadership of Happy Meadows. The first suggested intervention is the implementation of standardized pain assessment protocol. The majority of stakeholders reported that they believed this would help the healthcare team manage residents' chronic pain. The literature suggests using a comprehensive pain management protocol that encompasses the following five components: a standardized pain assessment tool; a self-reporting pain scale; an observational pain score by staff member for residents with dementia; an investigation into the history of the residents' pain; and recommended pain interventions (Liu & Lai, 2014). The stakeholders mentioned that the standardized pain assessment protocol would truly be effective if it acknowledged residents who are cognitively impaired. They also recommended that the protocol require staff members to reassess pain.

The second suggested intervention is the implementation of a standing order set that can be activated. The majority of stakeholders believed this would help the healthcare team manage residents' chronic pain. Stakeholders suggested that the standing order set should have a clear, stepwise approach. This will empower nurses to be proactive and take the first steps to treat and manage residents' pain in a timely and effective manner.

The third suggested intervention is the implementation of a pain management flow sheet that communicates resident-specific needs. The majority of stakeholders believed this would help

the healthcare team manage residents' chronic pain. Stakeholders suggested that staff members could use this flow sheet as a report tool to the providers. This flow sheet can be added to the Electronic Medical Record so that all staff members can have access to it.

The fourth suggested intervention is to incorporate pain management discussions into already scheduled interprofessional meetings. Stakeholders preferred not to create a new meeting that isolates a clinical topic because it does not align with their resident-centered approach philosophy. During this pain management discussion, staff members can highlight what they think is working well and raise any concerns.

The fifth suggested intervention is "benchmarking". The leadership of Happy Meadows can research other LTCFs that are managing residents' chronic pain well and arrange a meeting with them. Happy Meadows can investigate how they structure their care and how they overcome their challenges, and then bring back this report to Happy Meadows.

The sixth suggested intervention is educating staff members about residents' pain. All stakeholders reported a need for additional training in all disciplines. Even stakeholders who do not have clinical backgrounds requested that they receive more education on pain. Suggested educational topics include the following: the types of pain; pain assessment; narcotics; pain communication; non-verbal signs and symptoms of pain; and pharmacological non-pharmacological interventions that Happy Meadows provides (Jones, Fink, Pepper, Hutt, Vojir, Scott, Clark, & Mellis, 2004). It is imperative that staff members be knowledgeable about pain topics so that they can educate residents and family members, and address misconceptions about narcotic addiction, dependence, and tolerance (Jones et al, 2004).

The seventh suggested intervention is the implementation of communication skills training. The thematic analysis revealed that communication was a challenge for various

relationships in Happy Meadows, including intraprofessional and interprofessional communication; communication between staff members and residents; communication by residents who are cognitively impaired; communication among family members; communication between family members and staff members; and communication by family members on behalf of the resident. There is a vast body of literature that discusses the prevalence of communication issues in LTCFs. Researchers note the importance of strong communication among staff members, family members, and patients in order to deliver optimal care to patients. An example of a communication skills training program that was implemented in a nursing home focused on three topics: “Active/empathetic listening skills”; “Feedback”; and “I-messages” (Pillemer, Sutor, Henderson, Meador, Schultz, Robison, & Hegeman, 2003). The ultimate goal of communication skills training is to “[foster] partnerships and [resolve] conflict and hostility” (Pillemer et al., 2003, n.p.).

One lesson learned was the importance of protecting the relationships among staff members at Happy Meadows, including the need to protect the anonymity. In some interviews, stakeholders directly addressed other disciplines’ faults. In order to prevent the development of conflict among staff members, this specific information was shared only with the head leadership at Happy Meadows. Another lesson learned was significance of the “lived experience”. Even though this project focused on the perceptions of a small number of stakeholders, each stakeholder’s view was important. Thus, it was necessary to include each perspective, even if it belonged to just one stakeholder.

The results from my project echoed the literature’s demand for the development of pain assessment tools and protocols. I think there were two outstanding conclusions from the stakeholder analysis. The first was the need to develop a protocol that addresses older adults with

cognitive impairment. The second was the need for additional education on pain management for the staff members, family members, and residents.

The main limitation of this project was that some problems were identified as a “systems issues”, which can often be challenging to address with a Quality Improvement Project. The first systems issue that the stakeholders identified was the process of obtaining medications from the pharmacy on the weekends. This seemed to complicate the management of residents’ chronic pain. Even though we were not able to provide a suggested intervention for this, we were able to shed light onto the problem and bring it to the attention of the leadership of Happy Meadows.

The second “systems issue” that the stakeholders identified was the Electronic Medical Record. We were able to highlight specific areas that are in need of improvement, so that the leadership of Happy Meadows can choose a new system that incorporates these changes.

The next steps for this Quality Improvement Project include collaborating with the leadership at Happy Meadows to develop and implement a pain management assessment tool and protocol that will improve management of residents’ chronic pain.

### **Conclusion**

Ineffective management of chronic pain in older adults who reside in LTCFs remains a major concern among researchers and geriatricians in the United States. The high prevalence of chronic pain emphasizes the need for more research in order to develop consistent and effective pain management assessment tools. By collaborating with the leadership team at Happy Meadows to develop a protocol, the School of Nursing team will be able to inform future quality improvement efforts to improve chronic pain management in other LTCFs in the United States.

### References

- American Chronic Pain Association. (2017). *Chronic Pain*. Retrieved February 10, 2017, from <https://theacpa.org/condition/chronic-pain>
- Crowe, M., Gillon, D., Jordan, J., & McCall, C. (2016). Older peoples' strategies for coping with chronic non-malignant pain: A qualitative meta-synthesis. *International Journal of Nursing Studies*, 68 (2017), 40-50. Retrieved from [http://ac.els-cdn.com/S0020748916302462/1-s2.0-S0020748916302462-main.pdf?\\_tid=18755252-17c3-11e7-b89c-00000aab0f6b&acdnat=1491151415\\_c66d30caae13bff3b7ee87f79b399ba6](http://ac.els-cdn.com/S0020748916302462/1-s2.0-S0020748916302462-main.pdf?_tid=18755252-17c3-11e7-b89c-00000aab0f6b&acdnat=1491151415_c66d30caae13bff3b7ee87f79b399ba6)
- Evers, M.M., Meier, D.E., & Morrison, R.S. (2002). Assessing differences in care needs and service utilization in geriatric palliative care patients. *Journal of Pain and Symptom Management*, 23 (5), 424-32. Retrieved from <https://consultgeri.org/geriatric-topics/palliative-care>.
- Ersek, M., Polomano, R.A. (2011). Nursing management of pain. In Lewis, S.L., Dirksen, S.R., Heitkemper, M.M., Bucher, L., Camera, I.M (Eds.), *Medical-Surgical Nursing: Assessment and Management of Clinical Problems*. (8<sup>th</sup> ed, pp. 127-152). Philadelphia: Elsevier.
- Gibson, M.C. & Bol, N. (2001). Changing practice: improving pain management for older adults in long-term care. *Topics in Geriatric Rehabilitation*, 16(3), 56-65.
- Griffiths, J., Maggs, H., & George, E. (2008). Stakeholder Involvement. World Health Organization. Retrieved February 10, 2017 from <http://www.who.int/dietphysicalactivity/griffiths-stakeholder-involvement.pdf>
- Jacobsen, M.J. & O'Connor, A.O. (2006). *Population Needs Assessment: A workbook for*

assessing patients' and practitioners' decision making models.

Jones, K., Fink, R., Pepper, G., Hutt, E., Vojir, C. P., Scott, J., Clark, L., & Mellis, K. (2004).

Improving nursing home staff knowledge and attitudes about pain. *The Gerontologist*, 44(4), 469-478. doi: <https://doi.org/10.1093/geront/44.4.469>

Lai, C & Liu, J.Y.W. (2014). Implementation of observational pain management protocol to

improve pain management for long-term institutionalized older care residents with

dementia: study protocol for a cluster-randomized controlled trial. *Trials Journal*, 15(78), p. 1-12.

Leone, A., Standoli, F., & Hirth, V. (2009). Implementing a pain management program in long

term care facilities using a quality improvement approach. *Clinical Practice in Long-*

*Term Care*. doi: 10.1016/j.jamda.2008.08.003

Pillemer, K., Suiitor, J. J., Henderson, C. R., Meador, R., Schultz, L., Robison, J., & Hegeman,

C. (2003). A cooperative communication intervention for nursing home staff and family

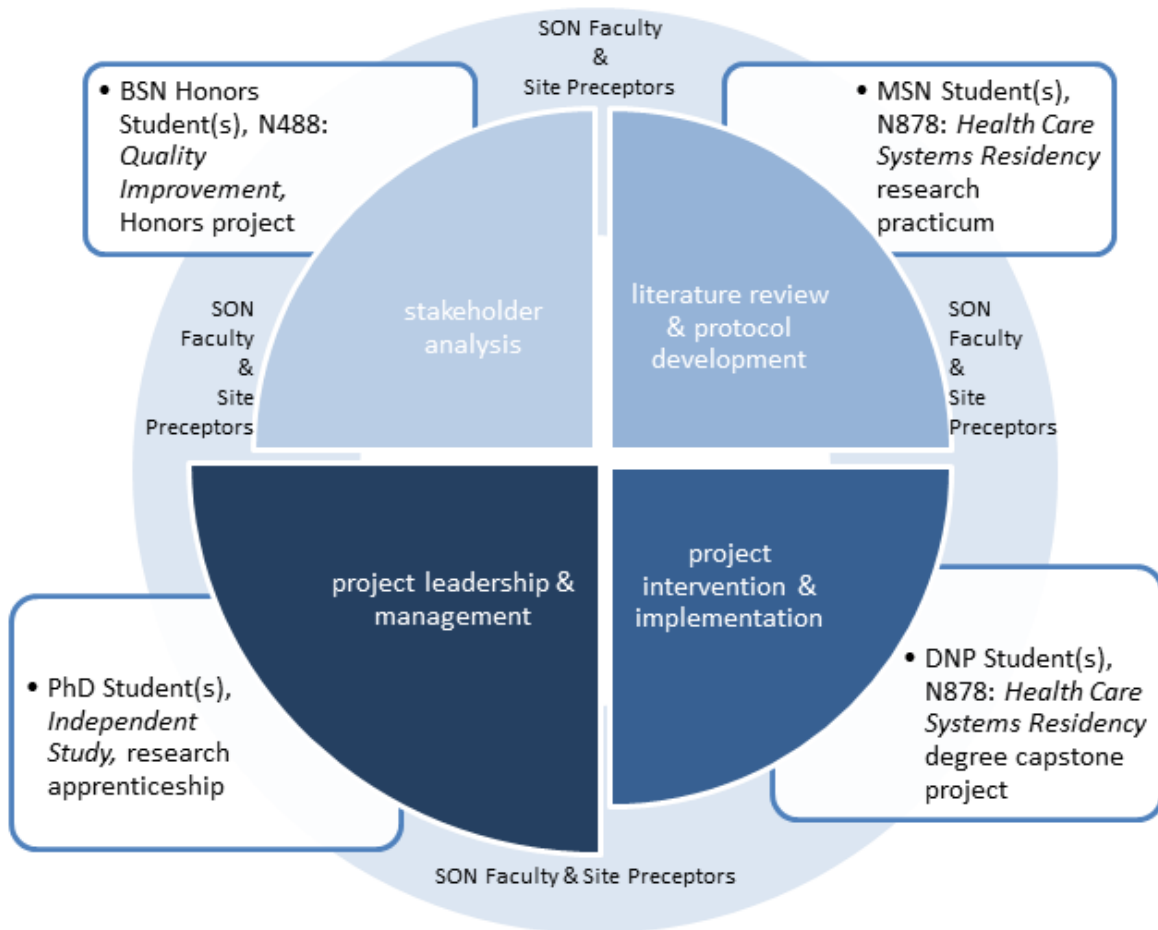
members of residents. *The Gerontologist*, 43, 96-106. doi: [https://doi.org/10.1093/geront/43.suppl\\_2.96](https://doi.org/10.1093/geront/43.suppl_2.96)

U.S. Department of Health and Human Services. (2015, September). Center for Disease

Control: Nursing Homes and Assisted Living (Long Term Care Facilities). Retrieved

from CDC database: <https://www.cdc.gov/longtermcare/>

Appendix A. Diagram illustrating how each nursing student's assignment fits into the AHEC Project



## Appendix B. Flyer to recruit stakeholders at Happy Meadows

**Improving Chronic Pain Management Project****Can you help us?**

We need your help to improve chronic pain management in Happy Meadows. We'd like your **honest and confidential** perspective about this problem.

The UNC team will ask residents' family members:

- To participate in **voluntary** interviews (15-30 minutes) about current pain management practices, current challenges, and provide insight into what are the best next steps
- What's next? We will contact you regarding participation in interviews.

**Background**

Pain is prevalent in residential care facilities and is associated with declines in physical and cognitive function, behavioral and sleep disturbances, poor quality of life, and increased healthcare costs. Pain management can be challenging for the care team because it's not a one-size fits all approach. Each resident's pain varies in type and severity, requiring individualized treatment plans. **The aim of this collaboration between the UNC School of Nursing and Happy Meadows is to develop a protocol to help staff work with residents and their families on the management of chronic pain. We will start working with residents living permanently in Buildings 4, 6, and 7 at the nursing level.**



Appendix C. Interview guide created by DNP student to use during stakeholder interviews

Good morning/afternoon/evening. My name is \_\_\_\_\_ and I am a nursing/masters/doctoral student at the UNC School of Nursing. UNC and Happy Meadows are partnering together to tackle the problem of chronic pain in the health center residents here, and we want to talk with key team members to learn more about their roles in pain management, as well as any resources or barriers that may be present.

This information will contribute to a better understanding of the current pain management practices at Happy Meadows. We hope to use this information to develop a more effective system for the team and residents. The information collected in this interview will be kept confidential. We would appreciate your help, and it will take about 15 to 30 minutes.

First, I have a few questions about you. This is just to get an idea of the team you are working with. Please feel free to tell me if you are not comfortable answering these questions:

Informant Characteristics

Discipline/Role:

How long have you worked at Happy Meadows?

How long have you been a [insert discipline/role]\_\_\_\_\_?

What shifts do you usually work?

To give you some background, the definition of chronic pain is not standardized, but it is generally understood to be pain that has persisted beyond the normal healing time, usually around 3 months. In the resident population here, arthritis pain would be a good example of chronic pain. Pain from a fall or from a surgical site would be considered acute pain. The questions I ask you today will focus on chronic pain.

1. The next set of questions is about how pain is managed in Happy Meadows.

<p>2. What is your usual role in chronic pain management?</p>	<p>Do you usually:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Complete pain assessments</li> <li><input type="checkbox"/> Report pain to another team member</li> <li><input type="checkbox"/> Make recommendations to another team member</li> <li><input type="checkbox"/> Provide therapies</li> <li><input type="checkbox"/> Prescribe medications</li> <li><input type="checkbox"/> Order other non-pharmacologic pain management strategies (not medication)</li> </ul> <p>Do you usually:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Make pain management decisions for the residents</li> <li><input type="checkbox"/> Share the decision with the residents</li> <li><input type="checkbox"/> Provide support or advice for residents to make the decision on their own</li> <li><input type="checkbox"/> Provide support or advice for another team member to make decisions</li> <li><input type="checkbox"/> Other, specify</li> </ul>
<p>3. Who else besides yourself and the resident is usually involved in making pain management decisions?</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> spouse</li> <li><input type="checkbox"/> family</li> <li><input type="checkbox"/> friend</li> <li><input type="checkbox"/> another team member</li> <li><input type="checkbox"/> outside health care provider</li> <li><input type="checkbox"/> other, specify</li> </ul>

<p>4. (If #3 was spouse, family, friend) What is their usual role in chronic pain management?</p>	<p>Do they usually:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Communicate on behalf of the resident</li> <li><input type="checkbox"/> Aid the resident in therapy</li> <li><input type="checkbox"/> Provide comfort to the resident</li> <li><input type="checkbox"/> Attend appointments with the resident</li> </ul> <p>Do they usually:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Make pain management decisions for the residents</li> <li><input type="checkbox"/> Share the decision with the residents</li> <li><input type="checkbox"/> Provide support or advice for the residents to make the decision on their own</li> <li><input type="checkbox"/> Provide support or advice for another team member to make decisions</li> <li><input type="checkbox"/> Other, specify</li> </ul>
<p>5. (If #3 was another team member or an outside provider) What is their usual role in chronic pain management?</p>	<p>Do they usually:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Complete pain assessments</li> <li><input type="checkbox"/> Report pain to another team member</li> <li><input type="checkbox"/> Make recommendations to another team member</li> <li><input type="checkbox"/> Provide therapies</li> <li><input type="checkbox"/> Prescribe pharmacologic</li> <li><input type="checkbox"/> Order non-pharmacologic</li> </ul> <p>Do they usually:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Make pain management decisions for the residents</li> <li><input type="checkbox"/> Share the decision with the residents</li> <li><input type="checkbox"/> Provide support or advice for the residents to make the decision on their own</li> <li><input type="checkbox"/> Provide support or advice for another team member to make decisions</li> <li><input type="checkbox"/> Other, specify</li> </ul>
<p>6. Think about a time when a resident reported chronic pain to you or you found out that a resident had pain. Please describe what you did about this.</p>	<p>Probes:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Did you experience any challenges with the process?</li> <li><input type="checkbox"/> How long did it take for something to be done?</li> </ul>
<p>7. What are some ways in which Happy Meadows manages chronic pain well?</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> What strengths and supports are present?</li> </ul>
<p>8. What barriers/difficulties are experienced?</p>	
<p>9. What are difficulties patients/families/representatives encounter when making decisions about pain management?</p>	<p>Do they feel</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> unsure about what to do?</li> <li><input type="checkbox"/> worried what could go wrong</li> <li><input type="checkbox"/> distressed or upset</li> <li><input type="checkbox"/> constantly thinking about decisions</li> <li><input type="checkbox"/> wavering between choices</li> <li><input type="checkbox"/> delaying the decisions</li> <li><input type="checkbox"/> questioning what is important to residents/ families</li> <li><input type="checkbox"/> physically stressed</li> </ul>
<p>10. What factors make pain</p>	<p>Is the team:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Lacking proper assessment/screening tools</li> </ul>

<p>management difficult for the team?</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Lacking proper charting systems</li> <li><input type="checkbox"/> Lacking proper handoffs/communications (i.e. shift report, other handoffs)</li> <li><input type="checkbox"/> Lacking information about effective treatment options</li> <li><input type="checkbox"/> Unclear about what is important to the residents/ families</li> <li><input type="checkbox"/> Feeling unsupported in decisions/ prescribing/suggestions for therapies</li> <li><input type="checkbox"/> Feeling pressure from others</li> <li><input type="checkbox"/> Lacking motivation or not feeling ready to make a decision</li> <li><input type="checkbox"/> Lacking the ability, training, or skill to perform tasks or make decisions</li> </ul>
<p>11. What do you/ other staff view as the main option for chronic pain management? What do you think residents view as the main option for chronic pain management?</p>	<p>(Ex. pharmacological, non-pharmacological)</p>
<p>12. What are the advantages and disadvantages/risks of <u>these</u> options?</p>	
<p>13. What factors make it difficult/easier for you to support/adhere to the pain management plans that have been created for the residents?</p>	
<p>14. I will list some ways that could potentially help the healthcare team with pain management. Which ones do you think might be useful to you and the healthcare team?</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Standardized pain assessment protocol</li> <li><input type="checkbox"/> Standing order set that can be activated</li> <li><input type="checkbox"/> Pain management flow sheet communicating resident-specific needs</li> <li><input type="checkbox"/> Interdisciplinary pain meetings (Is pain discussed in current care plan meetings? How are these meetings developed?)</li> <li><input type="checkbox"/> Additional training for your discipline (specify what)</li> <li><input type="checkbox"/> Additional training for another discipline (specify what)</li> <li><input type="checkbox"/> Are there any other strategies that might help?</li> </ul>
<p>15. Do you have any additional insights on the issue?</p>	



Appendix E. Microsoft Word Table depicting how the themes and subthemes were organized

Pink	Issue with intraprofessional and interprofessional communication / presence of conflict that the leadership of Happy Meadows might need to address	
Green	Issue with the pain assessment scale/tool, or issue with determining presence of pain in resident	
Yellow	Weekend issue	
Blue	Family dynamics	
<b>Theme</b>	<b>Description/definition</b>	<b>Example</b>
<b>Communication</b>	This includes intraprofessional and interprofessional communication; communication between staff members and residents; and residents who have impaired communication due to cognitive impairment.	
Strong multidisciplinary team collaboration and communication	Healthcare professionals of multiple disciplines work well together on the team and communicate effectively	The different professions are able to effectively collaborate, work together, listen to, and respect each other. This good collaboration, in turn, positively affects the resident's pain management.
Poor intraprofessional communication	Communication among staff within the same discipline.	There is a communication barrier among staff members during shift report and patient handoff. How to intervene? Incorporate Team STEPPS.
Poor interprofessional communication	Communication among staff of different disciplines	There is a communication barrier when determining the pain interventions. Differing opinions during pain management meetings- specifically on pain interventions, which doesn't ensure that the intervention will be consistently carried out.. Staff members from each discipline are trained to conduct differing pain assessments according to their scope of practice. Feedback and documentation on the success of the intervention is sometimes omitted. How to intervene? Incorporate Team STEPPS and shared governance principles
Good communication between the resident and staff members: a resident-centered approach	The healthcare team utilizes a resident-centered approach when planning pain management interventions	Stakeholders reported that the healthcare team respects the residents' pain goals and choices. They believe that they effectively promote the residents to become integral members of their own healthcare team. Staff members listen to the resident in order to create and adhere to the pain management plan. They support and respect the choices of the resident. They also use the resident's pain goals in order to enhance the care plan.
Good communication between the resident and staff members: Tight relationships	The staff and residents spend a large amount of time together over the years.	Stakeholders commented that they know the residents very well and can notice changes in their pain level easily and alert entire healthcare team. They spend lots of time with them and join them in community activities.
Communication by	Residents do not effectively	Stakeholders described poor communication by the

resident to staff members	communicate pain symptoms to staff members; therefore, the staff do not know if the resident has pain, or their pain level	residents to the staff members because they belong to the “stoic” generation. These residents have a tendency to withhold their complaints of pain and stress. Residents have accepted that pain has become a normal part of their lives, and that it just something they have to live with. Residents are sometimes very private and wait until the pain is so bad to let staff know.
Residents who are cognitively impaired	It is difficult to assess pain in the adult with cognitive impairment, such as dementia; therefore, the staff do not know if the resident is in pain, or their pain level.	Stakeholders described how difficult it is to assess pain in the adult with cognitive impairment, such as dementia. They also described the process of pain management for these adults as “trial and error”, because the residents are unable to verbalize their reaction the pain in response to certain pharmacological or nonpharmacological interventions. Adults with mild cognitive impairment often forget to alert the staff they are in pain; therefore, they might not receive PRN pain medications. How to intervene? Take into account the cognitively impaired adult when implementing a standardized the pain assessment protocol.
Weekend communication with pharmacy- Omnicare	The process of requesting a medication order and administering it to the resident takes a very long time, especially when the pain medication is requested on the weekend.	Obtaining medications, especially on weekends, in a timely manner from pharmacy makes it difficult to appropriately manage the residents’ pain.
Weekend communication with outside or on-call providers	Outside or on-call providers are used on the weekends when the in-house providers are not there.	On nights and weekends, the in-house providers aren’t at Happy Meadows. There are on-call and off-site providers who are assigned to the residents who don't know the resident well, so it is a struggle to get them to prescribe something. Stakeholders stated that they have developed a workaround to avoid calling these providers. How to intervene? Implement a medicine box on the unit.
<b>Sub-theme of Communication (1a): Communication and Family Dynamics</b>		
Poor communication by family members to staff members	Lack of communication by family members to staff	Some family members do not know to whom to report about the resident’s pain. They are also sometimes unclear of their role in the resident’s pain management plan. How to intervene? Ensure that upon arrival, each family member knows to whom to report.
Poor communication among family members	Family conflict makes care difficult	Some family members differ in opinion about how the resident should manage his or her pain Some family members have their own ideas compared to the residents’ wishes. How to intervene? Investigate Advanced Care Plans; team staff to begin crucial conversations early on if an Advanced Care Plan is not yet in place.
Good communication between family and resident	Family members are partners in the residents’ pain management plan	Stakeholders mentioned that family members help the residents by reminding them to do their exercises and take care of the residents’ needs. They take residents to appointments.
Good communication by family member on behalf of resident, who is	Good communication when the resident is unable to do so	Family members communicate resident needs when resident is unable to do so; they provide comfort to resident; they are also involved in care plan meetings..

cognitively impaired		Family members join in on the care plan meetings so they are on the same page and can make suggestions to the healthcare team.
Communication by family members on behalf of the resident, who is cognitively impaired	Poor communication when the resident is unable to do so	Residents who are cognitively impaired sometimes have family members who have different wishes than the residents, and therefore communicate these suggestions to the healthcare team.
<b>First-line treatment for pain</b>	There are three various responses that the stakeholders view as the first-line, or “go-to”, intervention for residents’ pain. Each discipline identified a different first line intervention.	
Pharmacological interventions	These include medications that relieve pain, such as narcotics and NSAIDS	Staff and / or residents view pain medicine as the initial step in chronic pain management. Stakeholders believe that medications are better for intense pain and coping with exhaustion
Alternative Therapy interventions	These include breathing, exercise, imagery, acupuncture, hand massage, distraction, healing touch	Stakeholders reported on the abundance of non-pharm interventions. Some stakeholders prefer this approach first because they do not agree with using medications- this is related to their discipline
Multimodal approach	Many stakeholders reported that Happy Meadows effectively manages residents’ pain by using a multimodal approach.	Resident has different levels of pain, which can be healed by different modalities. Happy Meadows uses a balance between pharmacological and nonpharmacological interventions in the first steps, simultaneously
<b>Perceptions about narcotics as a pharmacological intervention</b>	Providers, residents, family members, and staff members delve into their negative views of narcotics.	
Narcotic perceptions- Providers	Providers prescribing narcotics as the primary intervention for pain relief.	Providers are hesitant to prescribe narcotics to the residents. How to intervene? Provide in-house education on the benefits and risks of narcotics.
Narcotic perceptions- Residents	Residents’ negative perceptions about the effects of narcotics	Residents are reluctant to take narcotics for fear of becoming addicted or feeling “fuzzy”. Resident has fear of taking narcotics and then wondering what life would be like without it if they become addicted. How to intervene? Provide patient education on narcotics.
Narcotics perceptions- Family members	Family members are uneasy about the resident taking narcotics	Family members have difficulty determining the benefits and risks of narcotics and are afraid of the resident becoming addicted. How to intervene? Provide family education on narcotics.
Narcotic perceptions- staff members	Staff members’ negative views on narcotics.	Some stakeholders are “against” using medications, but acknowledge that it is “whatever the patient wants”. Responses are discipline-dependent. Stakeholders do not think narcotics are always helpful because they can make the resident give up certain activities, alertness, and independence. How to intervene? Provide in-house education on the benefits and risks of narcotics.
<b>Electric Medical Record</b>	This theme includes four categories that stakeholders identified as in need of improvement	
Lack of pain re-assessment prompts		After documentation of a pain intervention, stakeholders reported that the EMR does not prompt the staff member

		to assess and re-assess the pain after “x” amount of time. Therefore, it is often omitted
Lack of proper pain assessment and pain screening tools		Stakeholders reported that Happy Meadows lacks proper pain assessment tools and proper pain screening tools.
Lack of proper location to document the pain scale		Stakeholders reported that the EMR does not provide a distinguished location to document the pain rating
Inconsistent pain scale used among disciplines		Stakeholders reported that the pain scales that the staff uses are inconsistently utilized and ineffective
<b>Additional training is needed</b>	Stakeholders were asked if they though additional training was needed on pain assessments.	
Agreed		Stakeholders’ answers revealed that all disciplines need some additional training
<b>Standardized pain assessment protocol</b>	Stakeholders were asked if the implementation of a “standardized pain assessment protocol” would help the healthcare team to manage chronic pain.	
Agreed		The majority of stakeholders agreed that this factor would improve the management of chronic pain.
Disagreed		Stakeholders disagreed because it would not effectively work well for residents who are cognitively impaired. How to intervene? When developing and implementing a standardized pain assessment protocol, should consider the cognitively impaired adult.
<b>Standing order set that can be activated</b>	Stakeholders were asked if the implementation of a “standing order set that can be activated” would help the healthcare team manage chronic pain	
Agreed		The majority of stakeholders agreed that this would improve the management of chronic pain.
Disagreed		Stakeholders disagreed.
<b>Pain management flow sheet communicating resident-specific needs</b>	Stakeholders were asked if the implementation of a “pain management flow sheet communicating resident-specific needs” would help the healthcare team manage chronic pain	
Agreed		The majority of stakeholders agreed that this would improve the management of chronic pain.
Disagreed		Stakeholders disagreed.
<b>Implementation of Interdisciplinary Pain meetings</b>	Stakeholders were asked if the implementation of “interdisciplinary pain meetings” would help the healthcare team manage chronic pain	
Agreed		Stakeholders agreed.
Disagreed		The majority of stakeholders disagreed.



Appendix F. Microsoft Word Outline of the themes and subthemes that were presented to the leadership of Happy Meadows

**Communication-** This includes intraprofessional and interprofessional communication; communication between staff members and residents; and residents who have impaired communication due to cognitive impairment.

- a. Strengths
    - i. Strong multidisciplinary team collaboration
    - ii. Good communication between resident and staff members
      1. Resident centered approach
      2. Spend lots of time getting to know resident
  - b. Challenges
    - i. Intraprofessional communication
    - ii. Interprofessional communication
    - iii. Communication with pharmacy
    - iv. Communication with outside or on-call providers
    - v. Residents communicating pain to staff members (stoic generation)
    - vi. Residents with cognitive impairment have difficulty communicating pain
  - c. **1a- Family Dynamics-** This is a subgroup of “Communication” that pertains to communication among family members; communication between family members and staff members; and communication by family members on behalf of the resident.
    - i. Strengths
      1. Good communication between family members and resident
      2. Good communication by family members on behalf of resident, who is cognitively impaired
    - ii. Challenges
      1. Lack of communication by family members to staff members
      2. Communication among family members (family conflict)
      3. Communication by family members on behalf of resident, who is cognitively impaired
- 2- First line treatment for pain-** There are three various responses that the stakeholders view as the first-line, or “go to”, intervention for resident’s pain. Each discipline identified a different first-line treatment.
- a. Pharmacological interventions
  - b. Alternative therapy interventions
  - c. Multimodal approach
- 3- Perceptions about narcotics as a pharmacological intervention-** providers, residents, family members, and staff members delve into their negative views of narcotics.
- a. Provider’s perceptions about narcotics
  - b. Resident’s perceptions about narcotics
  - c. Family member’s perceptions about narcotics
  - d. Staff member’s perceptions about narcotics
- 4- Electronic Medical Record -** This group includes four categories that stakeholders identified as in need of improvement.
- a. Lack of pain re-assessment prompts

- b. Lack of proper pain assessments and pain screening tools
  - c. Lack of proper location to document the pain scale
  - d. Inconsistent pain scale used among disciplines
- 5- **Additional training is needed**-When stakeholders were asked if they thought additional training was needed on pain assessments, the interviews revealed that all disciplines needed some training.
  - 6- **Standardized pain assessment protocol**- When stakeholders were asked if the implementation of a “standardized pain assessment protocol’ would help the healthcare team manage chronic pain, the majority of stakeholders agreed.
  - 7- **Standing order set that can be activated**- When stakeholders were asked if the implementation of a “standing order set that can be activated would help the healthcare team manage chronic pain, the majority of stakeholders agreed.
  - 8- **Pain management flow sheet communicating resident-specific needs**- When stakeholders were asked if the implementation of a “Pain management flow sheet communicating resident-specific needs” would help the healthcare team manage chronic pain, the majority stakeholders agreed.
  - 9- **Implementation of interdisciplinary pain meetings**- When stakeholders were asked if the implementation of “interdisciplinary pain meetings” would help the healthcare team to manage chronic pain, the majority of stakeholders disagreed.