



ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

An appreciative inquiry into older adults' pain experience in long term care facilities: a pain education initiative

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Abstract

Background: The prevalence of pain in older adults living in long-term care homes is as high as 80% in developed countries. A Pain Initiative was implemented to improve the pain experience of older adults in two care homes in Vancouver, Canada. This initiative consisted of education and coaching to strengthen the staff teams' competence and confidence in pain management, although it was not evaluated for effectiveness.

Aim: A clinical research team explored the lived experiences of older adults and professional caregivers participating in the Pain Initiative. The two research questions were: what were the experiences of participating in the Pain Initiative of older adults, professional caregivers and nurse supervisors? and what are enabling factors for positive changes in older adults' pain experiences?

Methods: We used appreciative inquiry to identify enabling factors for effective pain management, staying consistent with the tradition of this method to focus on the strengths within an organisation. Older adults and nurse supervisors participated in one-to-one interviews, and professional caregivers participated in focus groups. Inductive thematic analysis was used to analyse the data.

Findings: Enhanced awareness of older adults' pain led to increased empathy in professional caregivers. Ongoing coaching, education and resources were enabling factors for effective pain management. The findings illustrate that person-centred practices for pain management in long-term care homes were enhanced through getting to know the older adult, teamwork, non-pharmacological solutions and effective clinical and team processes.

Conclusions and implications for practice:

- Pain management is enhanced with ongoing multidisciplinary education, and coaching
- Older adults' life stories affect their experiences of pain. Care teams should seek personal knowledge about the older adults as a priority of care
- Increased frequency of pain discussions results in changing assumptions about pain as a normal part of ageing and encourages empathic practice

Keywords: Pain, appreciative inquiry, care homes, communication, person-centred care, teamwork

Introduction

In 2015-16, 14.8% of older adults living in long-term care in the Vancouver Coastal Health (VCH) regional health authority in the Canadian province of British Columbia experienced 'moderate daily' or 'severe' pain according to the Experienced Pain Quality Indicator – higher than the Canadian average of 8.5% (Canadian Institute of Health Information, 2019). To better understand the complex issues around older adults' pain, the VCH Residential Care Quality Practice Council formed a pain steering group with the objective of developing a pain-management improvement programme – the Pain Initiative. The vision of the steering group was to reduce the pain experienced by older adults, to increase professional caregivers' competency and confidence in assessing and managing pain, to improve communication among team members, and to sustain best practice (Lean Enterprise Institute, 2019). This report describes the findings from an appreciative inquiry study conducted by a multidisciplinary clinical research team to explore the influence of the Pain Initiative.

Background

Older adults living in long-term care have a pain prevalence that ranges from 49% to 83% in developed countries (Fox et al., 1999; Tsai et al., 2004; Boerlage et al., 2008; dos Reis et al., 2008). Fox et al. (1999) found a significant incongruence between older adults' pain prevalence and the provision of analgaesics, suggesting that pain is often overlooked in long-term care settings. Studies have identified a paucity of research on effective pain management interventions for older adults living in long-term care (Corbett et al., 2012; Knopp-Sihota et al., 2016).

Unresolved pain can have a devastating impact on quality of life (Zanocchi et al., 2008). For example, pain causes sleep disturbance, loss of function and higher rates of disability, reduced mobility, weaker cognitive performance and depleted independence (Asghari et al., 2006; Blay et al., 2007; Boerlage et al., 2008; Patel et al., 2013). Furthermore, unrelieved pain contributes to anxiety and depression (Asghari et al., 2006; Boerlage et al., 2008) and can negatively impact on behaviours in older adults with dementia, for example, increasing displays of aggression and agitation (Cipher and Clifford, 2004; Ahn and Horgas, 2013).

A systematic review conducted by Knopp-Sihota et al. (2016) demonstrates that professional caregivers have inadequate knowledge about effective implementation of pain management for persons living in long-term care. Professional caregivers are impacted by older adults' experience of pain, often feeling powerless, frustrated, and morally distressed when efforts to relieve suffering are unsuccessful (Bernhofer and Sorrell, 2015; Knopp-Sihota et al., 2016).

Barriers to effective pain management are multifactorial. A meta-synthesis, conducted by Vaismoradi et al. (2016), suggests the beliefs and attitudes of older adults and professional caregivers influence their acceptance of pain as a normal part of ageing, leading to some older adults suffering in silence. Others report barriers include a lack of confidence in assessing and managing pain, poor interprofessional communication, and a disconnect between knowledge of best evidence and clinical practice (Bernhofer and Sorrell, 2015). Moreover, challenges in pain management are compounded when cognitive impairment limits older adults' ability to express their pain (Feldt, 2000). In these instances, researchers have noted variable use of pain-management interventions (Monroe et al., 2014; Sacoco and Ishikawa, 2014).

Current recommendations for addressing these barriers propose implementing regular pain assessment training and relevant management training for all professional caregivers (Tse and Ho, 2014; Torvik et al., 2015). A synthesis by Swafford et al. (2009) makes multiple recommendations, including: a systematic approach to organisational change; decision-making algorithms; ongoing evaluation of outcomes; increasing interdisciplinary teamwork and collaborative decision-making; and access to support resources onsite.

Projects to improve pain management could include engagement in generative conversations and inquiry into possible actions for change from the point of view of both caregivers and older adults.

Unresolved pain in older adults living in long-term care can be attributed to a lack of knowledge and misconceptions about the pain-management process among caregivers and older adults (Vaismoradi et al., 2016). Appreciative inquiry is an effective research method to promote action for change from participant engagement in the co-production of knowledge (Hung et al., 2018). Attributes of patient empowerment are enabling processes, personal change and self-determination, which have the potential to improve quality of life (Castro et al., 2016). Therefore, researchers and clinicians should consider promoting engagement in quality improvement and research processes among older adults and caregivers.

The purpose of this appreciative inquiry study was to explore the lived experiences of older adults and professional caregivers following their participation in the above-described Pain Initiative. The research questions were:

- What were the experiences of participating in the Pain Initiative of older adults, professional caregivers and nurse supervisors?
- What are enabling factors for positive changes in older adults' pain experiences?

Research design

Research team

The research team comprised eight health professionals, five of whom have a masters-level degree, and one research mentor with a doctorate. The team members brought perspectives from occupational therapy, physiotherapy, nursing, and informatics. A clinician scientist from the University of British Columbia nursing science department mentored the research team. Four research team members were also members of the pain steering group, and the team consolidated the work of the steering group and incorporated this study's findings into the continuing work of the Pain Initiative.

Sample

This study took place at the two VCH care homes that participated in the Pain Initiative. Participants included older adults, professional caregivers and nurse supervisors who had participated in the Pain Initiative between August 2017 and January 2018. For the purposes of this article, the term caregivers is used to describe healthcare personnel, which include members from various health professions and healthcare aides (See Table 1). Caregivers and nurse supervisors were included in the study if they had participated in the Pain Initiative and were employed at one of the two participating care homes. Purposeful sampling was used to recruit older adults for one-to-one interviews, optionally including their family; this method intentionally includes representatives from a specific group to provide information about a specific phenomenon or event (Thorne, 2008). Nurse supervisors were invited to attend one-to-one interviews and caregivers were invited to attend focus group sessions. The inclusion criteria for older adults were that they resided in a long-term care home during the Pain Initiative training, and having communication difficulties and a diagnosis of dementia was acceptable. Individuals with dementia would only be excluded if they were unable to engage in conversation due to severe cognitive decline. Older adults with a range of pain experiences were included. Our study team aimed to use appreciative inquiry technique of gathering positive examples for fostering change (Bushe and Kassam, 2005) by asking for recommendations from nurses on which older adults had experienced positive changes in their pain scores, as identified by assessment records. However, at the time of interviews a difference between pain scores and older adults' pain experiences was noted, and older adults were given the opportunity to discuss the ineffective pain treatments they were receiving. Four older adults expressed interest and joined the research study.

The older adults participated in one-to-one interviews with two research team members. They were two males aged between 60 and 70 years and two females over the age of 70. Three had lived at the care home for more than six years and one for less than a year. All were cognitively intact, although Cognitive Performance Scale (CPS) scores were only available for two of the participants. All participants reported pain ranging from moderate daily pain to severe daily pain (See Table 1). Two nurse supervisors, one from each VCH site, participated in one-to-one interviews, and 10 caregivers participated in focus groups (see Table 1).

Table 1: Participant demographics

| Older adult | Gender | Age group (years) | Time at care home (years) | Cognitive performance score | Pain scores (RAI-MDS, Morris et al., 2012) | | |
|-------------|--------|-------------------|---------------------------|------------------------------------|--------------------------------------------|---------------------|-------|
| | | | | | Before | During | After |
| 1 | M | 61-70 | 11-15 | No data | 2 | No data | 1 |
| 2 | M | 61-70 | 6-10 | No data | No data | No data | 3 |
| 3 | F | 71-80 | 6-10 | 0 | 2 | No data | 2 |
| 4 | F | 81-90 | <1 | 1 | 2 | 1 | 0 |
| Focus group | Gender | Age group (years) | Time at care home (years) | Profession/employment status | Time in practice (years) | Education level | |
| | M | 41-50 | 6-10 | Occupational therapist/part time | 16-20 | Postgraduate degree | |
| | F | 61-70 | 25+ | Registered nurse/casual | 25+ | Batchelors degree | |
| | F | 41-50 | 16-20 | Healthcare aide/ full time | 16-20 | Batchelors degree | |
| | M | 41-50 | 16-20 | Licensed practical nurse/full time | 16-20 | Batchelors degree | |
| | F | 41-50 | <1 | Physiotherapist/part time | <1 | Postgraduate degree | |
| | F | 51-60 | 11-15 | Licensed practical nurse/full time | 11-15 | High school diploma | |
| | F | 51-60 | 11-15 | Healthcare aide/ full time | 21-25 | High school diploma | |
| | F | 41-50 | 1-5 | Recreational therapist/part time | 25+ | High school diploma | |
| | F | 41-50 | 6-10 | Healthcare aide/ full time | No data | High school diploma | |
| | F | 51-60 | 16-20 | Healthcare aide/ full time | 16-20 | High school diploma | |

Appreciative inquiry

Appreciative inquiry has been used in health research (Salyers et al., 2015; Scerri et al., 2015) as an action-based methodology that focuses on developing positive narratives using provocative questions to generate ideas for transformational change, both at the frontline and at the organisational level (Bushe and Kassam, 2005; Hung et al., 2016; Gibson et al., 2017). Its underlying principles of positive inquiry, and collaborative and constructionist approaches guided the research design (Bushe and Kassam, 2005). Appreciative inquiry is a useful strategy for bringing practitioners together to develop knowledge and to take collective action for practice change (Hung et al., 2018). This study incorporated collaborative and constructionist principles by making it a priority to include the members of the system under study and by developing interview guides that included questions intended to gather participants' opinions of what could improve now in their care homes (Bushe and Kassam, 2005).

The Pain Initiative

Two long-term care homes in the VCH region expressed interest in participating in the Pain Initiative. The intervention involved understanding current practices, while building on strengths within teams, by interviewing older adults about their pain experience and conducting focus groups with professional caregivers. Internal reports from a VCH needs assessment powerfully described older adults feeling

‘not heard’ and professional caregivers conveying distress and helplessness when older adults suffered pain. After readiness for change and stakeholder strengths were established, the pain steering group provided education on pain management and strategies to improve team communication. To sustain best evidence in practice, ongoing mentorship and onsite support further supplemented this training. (See Table 2).

| Table 2: Training interventions | |
|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Intervention | Main objectives |
| One-day, care home-specific onsite education | <ul style="list-style-type: none"> Multidisciplinary teams gain a foundational understanding of the multifactorial symptoms of pain and strategies for person-centred pain management |
| Patient-centred care team rounds coaching | Care teams are exposed to useful problem-solving team communication patterns, the components of which include: <ul style="list-style-type: none"> Sharing information about residents from multiple sources Discussion of current and possible treatments and their associated effects Build actionable tasks into the current resident care plan |
| Consulting on specific cases by residential practice team nurse | <ul style="list-style-type: none"> Clinical leaders practice advanced planning for pain management with residential practice team nurse Educators’ coaching (for example, in systems approaches, escalation and planning for critical events related to residents’ declining conditions) |
| Leadership one-day training | <ul style="list-style-type: none"> Multidisciplinary clinical leaders explore and gain an understanding of engaging in and inspiring care teams to think critically about their current pain-management practices, communication patterns and patient-centred care |

Measurement of older adult experience

The research team investigated older adults’ pain experiences after the training interventions in each care home. We asked nurses who were familiar with the older adults to preview the Resident Assessment Instrument (RAI) 2.0 (Morris et al., 2012) and identify older adults who had experienced an improvement in pain according to the RAI pain scales (see Table 3). The nurses and research team used the Cognitive Performance Scale (CPS) (see Table 4), part of the RAI-MDS 2.0, to assess older adults’ cognitive function prior to the interview where possible. The RAI-MDS 2.0 version is used in most of Canada (Morris et al., 2012).

| Table 3: Pain scale | |
|---------------------|---------------------------|
| Score | Description |
| 0 | No pain |
| 1 | Less than daily pain |
| 2 | Daily pain but not severe |
| 3 | Severe daily pain |

| Table 4: Cognitive performance scale | |
|--------------------------------------|----------------------------|
| Score | Description |
| 0 | Intact |
| 1 | Borderline intact |
| 2 | Mild impairment |
| 3 | Moderate impairment |
| 4 | Moderate/severe impairment |
| 5 | Severe impairment |
| 6 | Very severe impairment |

Tables 3 and 4 are adapted from RAI-MDS 2.0 (Morris et al., 2012)

Ethics

Ethical approval for this study was obtained from the University of British Columbia Ethics Review Board (ID: H1702945). An informed consent form was signed by each participant (older adults and professional caregivers). Following best practice recommendations, we treated consent as an ongoing

process, so researchers checked for continued support and co-operation of the older adults during interviews to assess for signs of distress that might be recognised as behavioural and physical rather than verbal (Dewing, 2002). We offered each participant a CAD\$30 giftcard from a local shopping centre in appreciation of their contributions. Finally, we assigned each participant a pseudonym in our reporting phase to protect anonymity.

Data collection

Semi-structured interviews for nurse supervisors were conducted by the fourth author (LF). Older adult interviews were conducted by two nurses from the research team. Focus groups were conducted by the second and third authors (SR, LL) and one other research team member. Focus groups took place in meeting rooms at each care home, led by two researchers. Field notes were taken, with the data corpus digitally recorded and transcribed verbatim. Each focus group/interview lasted between 20 and 30 minutes. All participants were involved in either one interview or one focus group session. Each researcher followed an interview or focus group guide to maintain consistency of approach and to ensure the use of positive inquiry (see Table 5). All researchers who conducted interviews with older adults were experienced clinicians and were prepared to stop an interview at any time if the older adults' verbal or non-verbal cues demonstrated distress or discomfort.

Table 5. Positive inquiry interview guides

| Older adult interview guide |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Please tell me about your pain (use other descriptors if needed, for example, ache/soreness/discomfort) 2. How have staff helped you with your pain? Conclusion: Any other comments that you would like to add? |
| Head nurse interview guide |
| 1. In your opinion, which factors have influenced your team's capacity in pain assessment and management? 2. What role do you play in supporting success and achieving sustainability? Conclusion: Any other comments that you would like to add? |
| Carer focus group guide |
| 1. Can you share examples of when you have made a difference to a resident's pain experience? 2. Can you share your experience of participating in the Pain Initiative? Conclusion: Any other comments that you would like to add? |

Data analysis

The transcripts were analysed using inductive thematic analysis (Sandelowski, 2000). Codes were generated using datasets, and relevant data were extracted, tabulated and coded. Themes pertaining to each research question were discussed by the first and third authors (JA, LL) using collated codes, and then verified by the primary investigator (SR). Results and conclusions drawn by these three researchers were further refined, for clarity and best hierarchy of main theme concepts in relation to subtheme concepts, through ongoing discussion with guidance from the research mentor (see Table 6).

Table 6: Coding structure for inductive thematic analysis

| | | Original codes |
|--------------------|----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Major theme | Enhanced awareness and empathy of pain experiences | <ul style="list-style-type: none"> • Increased awareness of pain • Improved attentiveness • Reduced assumptions • Increased empathy • Culture change |
| Major theme | Ongoing coaching, education and resources are enabling factors for effective pain management | <ul style="list-style-type: none"> • Education • Coaching and mentorship • Leadership support and presence • Improved attentiveness |
| Subtheme | Getting to know the older adult | <ul style="list-style-type: none"> • Older adults previously felt not heard; professional caregivers were distracted • Improvement in rapport and relationships with older adults and family members |
| Subtheme | Teamwork | <ul style="list-style-type: none"> • Improved communication • Multidisciplinary approach • Proactive approach • Engagement of healthcare aides |
| Subtheme | Non-pharmacological solutions | <ul style="list-style-type: none"> • Introduction of non-pharmacological interventions • Sense of purpose and meaning through participation and valued contribution |
| Subtheme | Effective clinical and team processes | <ul style="list-style-type: none"> • Improved pain assessment • Change in medication management • Improved communication with older adult (non-medical terminology) • Common language |

Findings

The Pain Initiative enhanced awareness of older adults' pain experience, and highlighted enabling factors for effective pain management. Participants described person-centred care approaches enacted by professional caregivers that consisted of:

- Getting to know the older adult
- Teamwork
- Non-pharmacological solutions
- Effective clinical and team processes

Enhanced awareness and empathy

Older adults' experiences

Older adults expressed the view that professional caregivers should understand their unique needs and experiences. They said this was best demonstrated when caregivers engaged in more communication about pain with them. Older adults also mentioned that communication about pain needed to make sense to everyone; one person who suffered from neurological pain after experiencing a stroke many years earlier described the ideal communication:

'...As much as anything, that's what the initiative has resulted in. More communication or common sense about it, and less opportunity for operating on old assumptions and old misunderstandings. [The Pain Initiative] also seemed to help people understand that they didn't understand [pain]. They thought they knew about pain because they've had so many patients and [older adults] in pain. So, they assumed that they understood pain. And so, they were always operating on assumptions, not on evidence. And, there's less of a tendency to dismiss what [older adults] are saying as "just more dementia" or whatever, you know?' (Tom, older adult).

Older adults from this study who had experienced pain for many years, even decades, were already educated about their pain-causing conditions but stated that it was good to see caregivers beginning to discuss what they had learned in the pain-management education programme. One person, who experienced neuropathic pain, described having conversations about pain with the caregivers:

'...It is making it aware. You know, to the nurses as well as to the patients. Yeah, it's making it aware and I think that now, people are not so afraid of talking about pain' (Sally, older adult).

Older adults reported that they felt regular discussion of pain increased their ability to engage with caregivers to create a pain-management care plan. Also, the topic of pain was discussed from the perspective of discovery and inquiry about new knowledge of pain, potentially incorporating older adults' perspectives. Further, older adults stated that empathy and attentiveness towards their pain experiences motivated discussion with caregivers.

Caregivers' experiences

Professional caregivers and nurse supervisors expressed concern for older adults' complex pain experiences during focus groups and one-to-one interviews. The professional caregivers and nurse supervisors noticed that participation in the Pain Initiative enabled reflection on the importance of seeing pain as abnormal during regular care, incorporating clear communication and non-pharmacological treatments. Caregivers also commented that they had the confidence to provide empathetic and attentive support for older adults' pain experiences.

The participants commented that the Pain Initiative provided the opportunity to reflect on their own knowledge of pain. Throughout it, caregivers and nurse supervisors were encouraged to speak openly about their knowledge of pain, and further share new knowledge with older adults. Caregivers and nurse supervisors communicated more about pain, and observed that older adults were satisfied with open communication even if their pain was not completely relieved. One caregiver described an encounter with an older adult:

'I have talked with her and I said, "I'm sorry I couldn't do much about your pain". She said, "I feel grateful because it seems that everybody cares about me and everybody tried to find a solution". And, my voice is heard. I know that there is some limitations, but I feel better. So, I'm not sure, at the end, how much we could do about her pain, but on the level of her wellness and feeling good about the situation' (Jamie, caregiver).

The healthcare aides stated that they have confidence to provide non-pharmacological support for pain after receiving education. They noted some delays in older adults receiving medical treatment for pain, and one caregiver talked about the type of support they provide in such cases:

'I was just going to say comfort, bring them a cup of tea or coffee until someone can see them, warm their blanket, touch their hand, like this is more physical stuff just until they can get some medication, and just reporting it to each other as a team, and maybe if they're in a lot of pain that day, maybe see if they want to lay down that afternoon. Not all the time but sometimes if their tailbone [hurts] because they've been sitting too long, you know?' (Mary, caregiver).

Through empathetic and attentive care, caregivers commented on an updated understanding of their roles as advocates for the older adults. One described this change in perspective and what effect this had on their care and reporting practices:

'With me, the Pain Initiative was an eye opener to go through the pain that the [older adults] are experiencing when we are [giving care]. Before, I had the idea that, "oh, it's okay for them or it's normal for them to have pain", but, right now, I am more observant when I'm [giving care] and I am

asking them if they have pain and what is the level of their pain and with that I became an advocate for them and check with the nurse if this resident has pain medication and how much because in... my observation, it looks like he or she probably needs something more or a little bit higher dosage. So, observation. I try to observe more now... before I would see less' (Jack, caregiver).

Benefits of pain education, resources and ongoing coaching

The provision of coaching, education and resources for effective pain management was an important condition for the support of participants in our study. Professional caregivers, nurse supervisors and older adults noticed positive improvements in support. Older adults acknowledged that the provision of this support was a major challenge due to the complex and persistent nature of their pain-causing conditions, but felt that the Pain Initiative was a step in the right direction.

Further, the study participants recalled instances, some recent, in which the provision of effective pain-management resources and support was lacking in their care homes. For example, an older adult from one of the care homes stated he had had constant pain as a result of a stroke years earlier, and that his symptoms had been compounded by diagnosed gout. He described that the medication that he received for treatment helped the pain marginally but not enough to improve his quality of life.

The older adults described their experiences of pain, and their inability to experience relief of their pain. They appreciated professional caregivers' attempts at problem solving for management of their pain, and the provision of comfort, but stated that the complexity of their pain symptoms continued to be beyond any substantial relief. Another older adult described a topical cream treatment she received as unhelpful and a waste of time, and said her primary care provider had told her that there was nothing she could do for the pain.

Lucy, older adult: 'Ah, well, they're using some kind of cream that they come put under my breast, but other than that, no. That's about it.'

Interviewer: 'Does it help?'

Lucy: 'I don't think so.' [Laughs] 'I think it's a waste of time. A waste of everything.'

Interviewer: 'How has your conversation with your doctor been?'

Lucy: [Laughs] '[My doctor] just kind of passing said to me... "it's shingles and there's nothing that we can do about it" you know? So, I just put up with it. That's about it, you know? And, the pain goes right through—I can feel it in my back as well. It sort of goes through.'

Interviewer: 'Is it constant or...?'

Lucy: 'Yeah. Pretty well, yeah.'

The participants in our study described previous failures in pain management, the complexity of many older adults' pain-causing conditions, and limited resources (for example, care contexts in which doctors and specialists are not always onsite). Through the participation in the Pain Initiative, caregivers and nurse supervisors noticed the importance of skilfull and ongoing coaching to enable better pain management. One nurse supervisor who had experience of working closely with care assistants described the process of coaching and the benefits it offered:

'And the coaching that we do. So, especially for the new members of the team, which is the new nurses and new LPNs, so they really require a lot of coaching in doing the assessment... So, I think encouraging the staff to make it a habit, make it a routine to use the [pain assessment] form would be very beneficial in doing the assessment and then also for the doctors, when you inform the doctors, you can also fax the forms to the doctors' (Erin, nurse supervisor).

One nurse supervisor stated that their team benefited from the intensive support provided by the Pain Initiative coaches. The educators and coaches linked the Pain Initiative work to previous programmes in place, namely P.I.E.C.E.S, a process of holistic assessment for which caregivers had received 16 hours of training (P.I.E.C.E.S, 2013):

Interviewer: 'So, from what you're telling me, it sounds as though going through the Pain Initiative brought you together as a team and set up all of you being able to communicate together and it made it easier to do P.I.E.C.E.S?'

Supervisor Erin: 'Yeah, yeah, as well. Yeah, that's true because the Pain Initiative programme is the first one, and then we get used to it, and then when we get to P.I.E.C.E.S. then it's easier.'

With coaching, education and resources, caregivers found they could more effectively collaborate with doctors and advocate for older adults', as described by one caregiver during a focus group discussion:

'So, I think the Pain Initiative helped open that conversation and really advocate for the [older adult] to talk to the doctor about really reviewing the pain and medication and whether or not it was sufficient. The doctor did eventually increase or change the medication and it did give some relief to the [older adult] and his agitation did decrease' (Bria, caregiver).

Participants from the focus groups discussed that the complexity and persistence of older adults' pain necessitates ongoing leadership, coaching, education and sufficient specialist medical resources. These caregivers also communicated that because pain is a difficult symptom to manage there should be dedicated mentors or coaches supporting caregivers to recall important steps in pain management, prompting for empathetic practice and strengthening the awareness of pain-causing conditions in older adults. Caregivers described wanting to consult with pain specialists but said this was not always possible. One caregiver mentioned the very complex steps and processes they felt were important for effective pain-management practices:

'So basically, what I really like about this Pain Initiative is that we understand that pain is not a part of ageing necessarily and then we look into the pain as a multidisciplinary approach from all disciplines and all levels of care... And when we know there is pain, we're looking for a solution, but when we don't know, we can't do much. So, from this initiative, from nursing monitoring, from the scale of pain, the interview, the resident, the healthcare aide monitoring the resident daily activity, so basically focusing on pain because it affects quality of life. The culture of pain as a part of ageing is not good and we're just creating this image [but now] everybody's involved and people are brainstorming' (Jasmine, caregiver).

Our participants described what they found to be enabling factors of improvement of the pain-management and care-planning processes. These enabling factors will be outlined in the following section.

Enabling factors for successful pain management and care planning

Getting to know the older adult

The participants stated that at the beginning of the Pain Initiative both caregivers and older adults had normalised processes that prevented caregivers from gaining deeper understandings of those for whom they were caring. Caregivers were instead accustomed to a daily pattern of work that was strictly timed, with many tasks tightly scheduled leaving little time to enquire about residents' experiences. Caregivers reported being unaware of alternative ways to move through their daily schedules, and as a result of this work pattern they were often ignoring older adults. Caregivers found that the Pain Initiative provided an opportunity to notice that knowing the older adults was a central component, and the first step, in pain management and care planning. This new knowledge was rewarding, as described by one caregiver:

'I found that every day we get brought down by our daily tasks. Sometimes we, sort of, ignore the feedback from the [older adults] because we are too busy. But, this initiative opened our mind to a system, make a systematic approach and try to think from the [older adult's] perspective... in a different approach that is from a new direction. It's not like we take it, "okay, you have pain, right?" and then we just give medication. Instead, we go deeper into our understanding of the patients themselves, how do they feel and how they perceive their environment, or what affects their perception of pain' (Maurice, caregiver).

Another caregiver described how when caregivers were more attentive to older adults' responses, they were able to notice personal pain behaviours and signals of discomfort. A caregiver mentioned the importance of attentiveness while managing pain in those who have difficulties in verbal expression:

'Well, we're really more aware, paying attention, or more sensitive to the resident... Or to the signs, especially for those who can't say it verbally. There's some [older adults] who can't say it verbally' (Mark, caregiver).

Professional caregivers described the impact of learning more about older adults' life stories and unique experiences, saying this was a new driving factor to person-centred pain management.

A culture of teamwork

Caregivers and nurse supervisors demonstrated teamwork by communicating with one another when they saw older adults experiencing pain. Caregivers were able to implement new pain-management practices and procedures, such as a care assistant observation tool and routine pain-scale record keeping by the nurses. Care assistants were informed through the Pain Initiative about evidenced-based actions intended for nurses to take when they receive reports of older adults' pain, and began reporting information to nurses with prompts from the Pain Initiative coaches.

The caregivers reported that learning together about evidence-based practices in pain management enhanced their teamwork practices across disciplines, as one caregiver described:

'I look at it as teamwork, a team effort. I feel that we have a common language to talk about pain. It's not pain medication from nursing or physio doing a miraculous approach to relieve pain' (Marina, caregiver).

Non-pharmacological treatments

Participants described instances in which non-pharmacological methods for pain management were used after the Pain Initiative. Older adults had also asked for, and independently used, the non-pharmacological methods, such as singing, reading, playing interactive games, massage, and going for outings. One caregiver described the use of these methods:

'I believe that our team has an increased awareness of... non-pharmacological interventions we could use. I believe the team has increased the use of music therapy and programmes, using one-on-one time to really help with the [older adults]' (Bria, caregiver).

Both caregivers and older adults discussed the usefulness of learning about the residents' context and personal history. Older adults stated that the pain experience could be very isolating and lonely, therefore personally crafted interventions could serve as a meaningful pain-management technique. One described a personal intervention that made a difference:

'So, I've been chanting for a long time and it's always helped... when I sing with a group like a choir here, my brain releases extra endorphins and this is scientifically proven stuff, and my pain goes away for 20 minutes. It just disappears completely' (Tom, older adult).

Process

The care teams at the long-term care homes reported positive impacts of building team habits for assessment, intervention, re-evaluation, documentation and reporting. These habits became their new process for pain management. Care assistants were assured that their observations could be formally reported to the nurses and other clinicians. A nurse supervisor described the positive change to the pain management process in their care home:

'[The Pain Initiative] helped the teamwork and helped everybody, all the team members recognise the pain, you know, the signs and symptoms of the pain, and then help them to realise that, oh, we need to report and then to get the medication to help. And also, help them how to do the, you know, the care as well. Yeah, it help[s] the care as well... how to reduce the pain... it's improving communication too' (Sam, nurse supervisor).

The caregivers and nurse supervisors referred to a number of pain tools that were influential in encouraging all caregivers to assess and/or observe older adults' pain: the use of pain experience interviewing, a visual analogue scale for pain intensity and a functional observation score. Caregivers and nurse supervisors said using the tools was a change from previous practice when they did not habitually use such techniques. Caregivers found that completion of the correct documentation was a common way to prompt one another to continue inquiring about older adults' pain experiences. The tools enhanced teamwork in some cases. Another caregiver described a positive shift in her thinking about the act of intervening and who held the responsibility to provide interventions:

'I think that the people... are generally more involved, and pain is not black and white or on one discipline's shoulders. No matter how much we can do, we're all doing something and something is more important than doing nothing... I feel relieved, you know, and I feel that... I don't have to come up with a... genius idea to resolve all the arthritis pain of someone so that I won't feel under depression. Then I can brainstorm and then maybe a little of everything, maybe a little positioning, or a little bit more walk, or a little bit of... medication all added together' (Marina, caregiver).

Discussion

Previous research suggests that person-centred care is the best evidenced practice for the identification and management of older adults' pain (Corbett et al., 2016), but that older adults' misconceptions about pain as a normal part of ageing can hinder their engagement in the pain-management process (Boerlage et al., 2008). This study's findings highlight that older adults and caregivers engage more readily in pain management when awareness and coaching from experts and nurse supervisors are increased. The awareness and coaching led to instances of person-centred care, better interdisciplinary teamwork, more effective communication between caregivers and older adults, and greater awareness of older adults' personal experiences of pain.

Older adults feel heard when caregivers practice person-centred care through consideration of their personal histories, preferences and needs. Some older adults living in long-term care have had past experiences of not being heard and mismanaged pain. This study illustrates that their pain experiences are very personal and can lead to negative impacts on quality of life. In an exploratory mixed-methods study, Corbett et al. (2016) identified that knowing older adults personally is a requirement for providing the best person-centred care in relation to pain management. This study illustrates the limited information caregivers had about the personal histories of the older adults they interacted with, and how this affected their ability to problem solve with them, specifically for the identification and interpretation of pain-related behaviours (Corbett et al., 2016).

The Pain Initiative education enabled caregivers to see how older adults could be included in the pain-management process. Through this, caregivers saw transformational changes in some areas of their work with older adults, as described by Bushe and Kassam (2005). Caregivers explained that after participation in the Pain Initiative, they wanted to engage in interdisciplinary teamwork and

personalised care. When caregivers are more engaged through empathetic practices and a deeper awareness of older adults' pain, those being cared for experience a sense of being heard and known. This study contributes to research (Dobbs et al., 2014) showing that including empathetic care skills in pain-management education programmes for long-term care are critical to improve pain experiences.

Research has illustrated that pain is a multifactorial symptom (Warden et al., 2003), and that the frequency of unresolved pain for older adults is a major concern (Jones et al., 2004; Corbett et al., 2016). This study supports the concept of pain as a complex symptom, shows that caregivers have varying degrees of confidence in helping older adults manage their pain, and concurs with research suggesting unresolved pain should be managed by the entire care team (Corbett et al., 2016). Further, this study illustrates that by developing and practising teamwork skills, the interdisciplinary care team can support one another in the complex, difficult and sometimes unsuccessful work of pain management.

Implications for practice

Caregivers and older adults reported that primary care providers such as physicians and nurse practitioners can be reluctant to alter the pain treatment plans for older adults in long-term care, as previous research has shown (Jones et al., 2004). Notably, tools intended to boost communication between care home staff and primary care providers were important in achieving review of pain treatment. One finding from our study is the importance of continued support and coaching for caregivers' pain management skills and practices. This finding concurs with the research of Jones and colleagues (2004) that the challenges of quality improvement projects are best addressed by including all stakeholders. Further, based on the findings it is recommended that ongoing coaching and pain education take place in care homes for workers to support the known challenges within these unique environments and working cultures of high caregiver turnover and varied levels of caregiver training in pain management.

Older adults from our study demonstrated that their life stories play a large part in how they perceive their pain experiences. They also explained what type of treatments, including medical and non-pharmacological, they would prefer to try. All long-term care homes could benefit from implementing processes for learning about residents' personal histories and for sharing this information with all care team members. Person-centred care is recommended as the main approach to pain management (Corbett et al., 2016).

The limited availability of pain experts in long-term care homes and the frequent unwillingness of primary care providers to alter treatment plans or recommend expert referral mean ongoing coaching, pain education and process evaluation is needed for staff in these practice contexts. This study, in common with previous research (Dobbs et al., 2014), highlights the urgent need for quality improvement of pain management and associated education in long-term care homes.

Future research should focus on investigating enabling factors for the sustainability of pain-management coaching, focused assessments and personalised care planning for older adults living in long-term care. Performing mixed-methods studies to incorporate residents' lived experiences, quantitative evaluations of pain scores and quality-of-life improvements could also be beneficial. Future research may also consider looking at the wider healthcare team, as physicians were not involved in the study. The use of appreciative inquiry as a method for research should also be considered as it has the potential to influence transformational changes within long-term care teams. For example, the staff participants in this study said they had found further uses for the knowledge gained from the focus groups and one-to-one interviews. This represents the simultaneity of this method of research, explained as 'the belief that inquiry is intervention, that as we inquire into human systems, we change them' (Bushe and Kassam, 2005, p 166). Some care assistants and nurse supervisors reported that they had a chance during focus groups and interviews to explain what could still improve, and that because the Pain

Initiative had opened up new patterns of communication they expected that care plan changes could be more easily discussed in future clinical situations and team meetings.

Limitations

Our study took place within two care homes with unique practice cultures and older adult populations. The Pain Initiative was targeted to these two care homes based on their expressed desire to be included. The pain steering group had a wider influence that included large single-day interdisciplinary education sessions for multiple care home staff, one-to-one consulting and coaching on pain assessment, and management of special cases throughout the long-term care programmes within the region. However, this study did not capture the experiences of these other caregivers and older adults, and further investigation into a larger programme of improvement for pain management would give a broader picture.

The professional caregiver participants included in our study were self-selecting and viewed the Pain Initiative as positive. Other members of the team who did not participate might have had valuable critiques of the programmes. A separate informal evaluation of the Pain Initiative was conducted from an organisational perspective and that type of information could be a valuable inclusion in future studies similar to this one. The research team attempted to stay true to collaborative approaches with regard to data collection by bringing members of the care team together in focus groups. However, to strengthen the impact of the collaborative approach, it might be useful to hold one focus group session that includes all participants – caregivers, older adults, and nurse supervisors – to discuss experiences together after having initial separate sessions. This was not feasible in this study.

Based on nurse recommendations, older adults were recruited who had shown improvements in pain according to the pain assessment tool. However, when these older adults were interviewed, all indicated that they had limited or no improvement in their experience of pain. All of the older adults contributed to the findings their experience of working with the caregivers and the strategies they see as useful to help with their pain. There was a difference between the caregivers' reports and the older adults' stated experience of pain, and due to limitations of the study's time frame and design it was not possible to investigate what factors contributed to this difference. Future research should focus on what factors play a role in the incongruence between caregiver assessment reports and older adults' stated experience, as this is linked to lack of person-centred care in long-term care homes (Corbett et al., 2016). Given that some of the older adults who did not experience positive change were able to offer valuable insights, it would be useful to seek a broader sample that covers negative experiences from the outset.

Conclusion

This study reports the experiences of older adults, caregivers and nurse supervisors participating in the Pain Initiative. Its findings identified enablers and barriers to practising effective pain management in long-term care. The engagement of caregivers and older adults in the implementation of pain management brought positive impacts for both groups. The changes included developing a culture of teamwork, enhancing awareness of and empathy towards older adults' pain, and challenging common assumptions of their pain experiences. After implementation of the Pain Initiative, healthcare aides noticed the importance of person-centred care and the continued need for coaching and training. Further research is needed on best practices for sustaining a culture of teamwork and empathetic practice for older adults who experience pain in long-term care.

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