

Nurses' Perceptions of Patients in Pain and Pain Management: A Focus Group Study in Thailand

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Abstract: In Thailand, nurses have a key role in the assessment of symptoms and advising on pain management in patients with post-operative in a surgical ward. This study provides insight into nurses' perceptions of patients in pain and subsequent pain management. A focus group discussion method was used with 18 registered nurses working in surgical wards. The data were analysed using qualitative content analysis.

The participants' descriptions of their perceptions of patients in pain and pain management were condensed into four themes. Two themes revolved around their perceptions of patient pain, *uncomfortable patient*, and *restricted mobility and changed mood*. The two remaining themes comprised *intolerable pain would be managed*, and *managing pain through our own experience* seems to be of importance in their professional assumption that evidence-based practice is inadequate for patients' postoperative care. It is suggested that nurses work to a organized pain assessment guideline and pain management models according to cultural contexts. This should be developed within an understanding of the nurse-patient relationship, and specifically holistic nursing models of care can play an important role in bridging the connection between training and practice, not only between personal and professional perceptions of pain and selected strategies, but also between professional knowledge and nurses' perceptions of patients in pain. The findings may have relevance for other similar contexts and settings.

Pacific Rim Int J Nurs Res 2015; 19(2) 164-177

Keywords: Nurses' perception, Patients, Pain, Pain management, Post-operative, Surgical nursing.

Introduction

It has been shown that 50% of patients experience pain during the first 24 hours after an operation, and that such pain gradually decreases within 72 hours after surgery.^{1,2} According to previous research, it is important to consider patients' beliefs, attitudes, and cultures during the assessment and care of post-operative pain.^{3,4,5,6}

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Pain is experienced in the neural networks of the brain and is most often a natural response to certain kinds of environmental stimuli. Melzack⁷ developed the neuromatrix theory of pain as well as the network pattern of neuro-signature. This is the impact of psychological and biological aspects, and as a consequence, pain can be described as both an individual experience and a multidimensional phenomenon. The interaction between the psychological and biological aspects of pain perception may lead to various endocrinological and immunological effects, in turn affecting a patient's potential for recovery and rehabilitation after surgery.^{7,8} The primary aim of post-operative care is to manage pain at the lowest possible levels, given different modules of attention and care guidelines, in order to improve post-operative experiences, reduce patients' suffering and shorten the recovery period.^{2,8,9,10} Suhonen and colleagues¹¹ revealed that nurses' perceptions of the impact of nursing care were based the nursing care to their patients and a distinction was that on nurses' background variables were not associated with their perceptions of individualized care delivery.

Review of Literature

Nurses' perception of patient pain is the recognition information of the individual that relies on the internal and external factors associated. Such information is gathered through the senses, including sight, hearing, taste, smell and touch (p.4).¹² When nurses "perceive" a patient in pain, however, they must rely on their own 'thoughts', 'understanding', and 'estimation' of the pain, by interpreting mostly visual indicators of the discomfort and anxiety. For example, clues from facial expressions such as a grimace or frown, clenched jaw, quivering chin, or acting disinterested can all be indicators of pain.¹¹ Nurses' perceptions of pain, patients in pain and pain management all affect the quality of care. Such perceptions are most likely to be based on their own individual experiences, cognition and emotions in relation to pain, as well as their knowledge and

experiences as professional nurses. Benner, Tanner, & Chesla¹³ state that it is important for nurses to grasp the concerns of a patient in order to act therapeutically. Ontological caring applied to nursing practices is an important function of nursing is to help the patient cope with his or her illness and symptoms.¹⁴ Therefore, it is crucial that a nurse tries to grasp a patient's conceptions of his or her predicament.

One study¹⁵ examined the general understanding of how nurses influence the quality of care in postoperative pain management in terms of three main considerations: (i) the nurses' perception of an unsatisfactory situation concerning the pain management of the surgical patients; (ii) how the nurses personally intervened; and (iii) whether they changed the outcome of the situation in a positive manner. In view of this need to improve pain management practices that are especially able to reduce patients' suffering from pain, there is a need to develop professional and practical skills. However, this study showed narrow gaps between the patients' and the nurses' perception of their pain. Monger & Sangchart¹⁶ suggested that the patients' perceptions of nurses' caring behaviours had a significant positive correlation with patients' perceptions of postoperative pain management; they also found that the nurse-patient relationship was not prioritised by the nurses. The building of good interpersonal relationships between patients and caregivers was strongly recommended, as this could improve understanding and meet nursing care goals for positive outcomes of pain management. The nurses can then assess the impact of pain management strategies and implement more effective methods for reducing post-operative discomfort and suffering.^{5,15,16} Nurses have an important role in post-operative pain management, especially between 24 and 72 hours after surgery.^{1,9,17} Pain management activities include giving information and advice, sufficient pain medication to reduce pain, and the use of appropriate nursing therapeutics. Such therapeutics can involve interpersonal skills such as active listening, acknowledging and valuing the individual's and/or family's perspectives,

and empathy, as well as physical strategies such as breathing exercises, turning and positioning, wound support, therapeutic hot and cold applications, and massage.^{15,16,17} Psychological and behavioural strategies are also important nursing therapies used to help the patients cope with pain, including cognitive behavioural strategies, stress management, patient and family education, self-management counselling in groups, and other collaborations within multi-disciplinary teams of experts.^{11,18-23} Previous studies revealed that both patients and an important quality outcome criterion for health care practitioners are main contributors to insufficient pain management.^{7,11,24} For example, patients' fear of side effects and refusal to take medication can lead to inadequate levels of pain medication.^{22,23} Nurses can also contribute to inadequate pain management^{7,21} and knowledge deficits among nurses may lead to negative beliefs and attitudes toward opioid analgesics and the underestimation of the patients' post-operative pain.^{3,5,7} According to previous studies >50 % of nurses had insufficient knowledge and inappropriate attitudes regarding pain assessment and relating to pain management in post-operative patients.^{21,22,24}

It is important to study pain management post-operatively in Thailand for nurses play a key role in the management of post-operative pain. Important concepts that need to be examined include the relationship between 'perceptions of pain' and 'pain management', cultural perceptions of pain, and the values, beliefs and technical knowledge surrounding pain.^{22,23,25,26} Previous studies have been carried out to explore the knowledge and practices of Thai nurses in pain management; two of these studies showed that only 58% and 54% of nurses had an adequate knowledge of pain management and practice, respectively.^{4,22} Moreover, Charuluxananan and colleagues²⁴ conducted a survey of post-operative pain management in Thailand and showed that pain was often underestimated, untreated or under-treated, and sometimes not noticed at all. According to these previous studies, Thai nurses lack essential knowledge

about pain and pain management and there is a disconnection between nurses' perception of patients in pain and pain management. Thai perceptions of pain based on a Thai point of view and comprise six dimensions: (i) perceived pain as suffering physically and psychologically, (ii) different characteristics between acute and chronic pain, (iii) four levels of pain intensity: mild, moderate, high and severe, (iv) pain effects on four dimensions: physical, psychological, behavioral and societal (family-social-economy), (v) two factors related to pain: alleviating factor and predisposing factor, and (vi) pain management relies on beliefs, culture and religion, that is good deeds in Buddhism affected six dimensions: physical, psychological, social, spiritual, treatment seeking and asking health personnel for help.³ Although studies investigating this subject have been carried out in other countries, there is a lack of such studies carried out in Thailand. This study, therefore, focused on how nurses perceive patients in pain and aimed to describe nurses' perceptions of patients in pain and pain management at surgical wards in Thailand.

Methods

Study design

The study was conducted using a qualitative approach. Focus group discussion (FGD) was chosen for exploring nurses' perception of patients in pain and pain management because the group process was viewed as suitable to help to encourage participants to share perceptions of patients in pain and pain management, through interactions among the members of the group.

Setting and samples

Data was collected in three FGDs and the participants were recruited through purposive sampling. The inclusion criteria were fulltime clinical nurses working in the two surgical wards of the hospital and all 18 registered nurses (RNs) from the two surgical wards participated in the study, divided into three groups. Group 1 (G1) included six RNs with novice skill levels

of practice. In each of groups 2 (G2) and 3 (G3) six RNs participated including advanced beginners with competency, being proficient or expert nurses. The FGDs were conducted in a semi-structured format in Thai, which was the mother tongue of all participants and two of the researchers. The moderator posed open-ended questions to start the discussions, to clarify the participants' statements, and to initiate new topics when necessary in a quiet room in the surgical ward. The FGDs guide included the following open-ended questions: (i) What do you think about pain? (ii) What is the impact of pain on the patients? (iii) What do you think about pain management, (iv) What do you do to manage patients' pain? (v) Can you talk about some examples? and (vii) How do you communicate with patients, relatives, and physicians regarding several pain resources? These main open-ended questions were followed by more specific questions or probing statements like 'I'm a bit unclear with that explanation...', '... but I think I missed why we're responding this way of the patients' pain', and 'I think I might have missed something while I was taking notes here... could you say it again'. The duration of FGDs was between 45–60 minutes. All the FGDs were recorded by digital voice-recorder.

Participant characteristics

The participants were predominantly females (n=17), with a mean age of 40.44 years (age range: 21–55 years). All had academic degrees in nursing sciences. Thirteen participants had no specific certification in pain management or surgical care, though the remaining five had passed some clinical courses in this field. On average, the RNs had 17 years' experience in nursing and had practiced surgical nursing care for 13 years.

Ethical considerations

Ethical approval was first obtained from the appropriate organisations: Research Ethics Committee, Nopparatrajathanee Hospital, Thailand (Code: 16/2555) and the Uppsala Ethical Vetting Board, Sweden (Code: 2012/383). Invitations to attend a discussion session on the topic of pain management were then posted on the notice boards of a public hospital in

Bangkok, Thailand. Information given about the study included the aim of the study that participation was voluntary, and that data would be treated confidentially. In addition, all participants signed a written consent form.

Data Collection

All of the FGDs were held at a surgical ward of a public hospital in Bangkok. The procedure for obtaining informed consent consisted of the following four steps: (i) the first author (MC) asked the nurses if they were interested in participating, (ii) it was explained verbally that participation was voluntary and that the data would be treated confidentially, (iii) the nurses who agreed to participate wrote their names down, and (iv) MC and participants set a date, time, and place for the FGDs²⁷ conducted by MC as moderator leading the discussion. The discussions were relaxed, allowing the participants to enjoy sharing their ideas, points of view, experiences and perceptions of pain and patients in pain. A nurse assistant took notes and she sat in a position to see the group as a whole and take field notes, while assisting with the logistics of recording. The FGD guide was issued to the participants to inform them of the basic topics that would be discussed concerning patients' pain and pain management as group processes can help participants clarify their views and can encourage participation based on previous experience from those who feel that they have little to say.²⁶ It was also thought that discussing in a group context rather than in individual interviews might increase the potential for critical data focused on the aim of the study.

Data Analysis

Recordings of the FGDs were transcribed verbatim and the captured data were analysed using qualitative content analysis.²⁸ The process of analysis followed the steps described by Graneheim & Lundman.²⁸ The researcher was assisted by a professional translator to ensure the accuracy of the translation and to take into

consideration of the influence of different socio-cultural contexts. The transcript was read line by line, and then re-read several times in order to get an understanding of the transcripts as a whole as well as the details of expressions in each transcript. Quotes revealing the surgical ward nurses' perception of patients in pain and pain management were then extracted into an initial 64 different meaning units. The next step was to aggregate these initial meaning units into condensed meaning units. Closed condensed meaning units were grouped together and the groups were labelled in a way

to cover all the meanings. This resulted in 15 meanings which were abstracted into nine sub-themes. Preliminary sub-themes were created by the first researcher and then discussed with other researchers in the same field to come to a consensus regarding the labels assigned to the sub-themes and to ensure they covered the related content. Four themes were extracted from the nine sub-themes. Examples of the meaning unit, condense meaning unit, sub-themes and themes are presented in **Table 1**.

Trustworthiness

Table 1. Example of qualitative content analysis used to examine the interplay of nurses' perceptions of patients' pain and pain management among nurses in a surgical ward (N=18)

Meaning unit	Condensed meaning unit	Condensed meaning unit, Interpretation of underlying meaning	Sub-theme	Theme
It seems to be an uncomfortable feeling, resulting in (the patient) being kept wide awake or unable to eat. All of these helplessly affect their psychological and well-being. As for me (the nurse), I just can't do anything, especially when the pain is too much to bear, even though how hard I try to deal with it. (K1, G1)	- Uncomfortable and distressing feelings - The body affects the mind - Being disturbed	- Discomfort with pain - Being irritable - Feeling anxious - Discomfort feeling - Patients' disturbed activities	- Being irritable - Feeling anxious - Discomfort during pain	Uncomfortable patient
Pain is an uncomfortable feeling, the feeling of being excruciated by injuries, the wound, or the stomach-ache. It is clearly and understandingly a physical thing that affects the psychological and daily living. The physical pain causes suffering so that one can't rest or sleep. (K4, G2)	Effects of physical and emotional involvement			
The pain may be interpreted as a bothering thing. The patient may feel uncomfortable or suffering inside because of it. The patient may then feel depressed, especially when they donot receive nursing care, attention or medical treatment, and the horror and fear coming soon. (K1, G3)	- Avoiding activities - Cannot rest or sleep	- Horrified feelings - Avoiding activities - Mood swing in the patient	- Avoiding activities - Mood change caused by pain	Restricted mobility and changed mood

Lincoln, and Guba²⁹ suggested four principles for ensuring trustworthiness of qualitative research: credibility, transferability, dependability, and confirmability. The credibility of this study was ensured by basing the interview guide on one created from a pilot interview conducted with a similar group. In this pilot interview, six open-ended questions were elaborated on during a FGD with nurses working on a surgical ward. The moderator then asked the participants to discuss issues raised from the participants' responses. Some supplementary questions were asked. Each participant in the main study had adequate time to answer each question completely.²⁷ The first researcher and note taker considered the content of the discussion and the context of the group, the interview guide was prepared according to the aim of this study, the specific research questions, and issues derived from the pilot group interviews described above. The data and coding were discussed with the other authors regularly throughout the analysis. The transcripts and confirmed through a review of the findings and interpretations by the second author an expert in qualitative methodology and Thai nursing to help ensure adequate analysis of descriptive data. To ensure dependability the interview transcripts were analyzed by the four researchers independently, including the inclusion of content, condensed meaning

units, sub-themes, and the themes, and met to discuss, and agree on the findings. Confirmability of results was undertaken between raw data, memos and field notes, data reduction and the products of analysis, and existing relevant literature of postoperative in pain management. With respect to confirmability, the authors were concerned with the aim of this study. In addition, the authors acknowledged bias, tried to maintain neutrality, and objectively presented methods and procedures used in the research in order to enhance the rigor of the research findings by using such techniques as the researchers' team checks.

Results

Data analysis resulted in four themes which address nurses' perceptions of patients in pain and pain management. Nurses perceived patients in pain as 'uncomfortable patient' with 'restricted mobility and changed mood' which consist the first two themes. The other two themes shows nurses' perception of pain management which included 'intolerable pain would be managed' and managing the patients' pain by drawing on their own experiences, (Table 2).

Nurses' perceptions of patients in pain

Table 2. Nurses' perceptions of patients' pain and pain management themes, and sub-themes emerging from focus group discussion (N=18)

	Theme	Sub-theme
Nurses' perception of patients in pain	Uncomfortable patient	-Being irritable
		-Feeling anxious
		-Discomfort
	Restricted mobility and changed mood	-Avoiding activities
Nurses' perception of pain management	Intolerable pain would be managed	-Mood change caused by pain
		-Using medication prescribed by the physician
	Managing the patients' pain by drawing on their own experiences	-Non-pharmacological approaches
		-Pharmacological and non-pharmacological approach
		-Clinical judgment in pain management

Theme 1: Uncomfortable patient

Discomfort of patients was expressed as one of the manifestations of pain. Participants described the notion of feeling discomfort as comprising the two primary symptoms of discomfort and distress that is their interpretation of the patients' pain and its affect on their psychological and physical well-being. One participant expressed:

It seems to be an uncomfortable feeling, resulting in (the patient) being kept wide awake or unable to eat. All of these helplessly affect their psychological and well-being. As for me (the nurse), I just can't do anything, especially when the pain is too much to bear, even though how hard I try to deal with it. (K1, G1)

The participants perceived pain as something that interrupts the basic needs. Moreover, they have perceived patients in pain relevant to their psychological perspective: that patients were in pain because of the tissue injuries by surgery, and were reliant on signs and symptoms of a disease.

In addition, the participants' perspectives included the psychological impact of pain, such as difficulty sleeping, restlessness, and anxiety or stress, for example:

Pain is an uncomfortable feeling, the feeling of being excruciated by injuries, the wound, or a stomachache. It is clearly and understandably a physical thing that affects the psychological and daily living. The physical pain causes suffering so that one can't rest or sleep. (K4, G2)

The participants also regarded patients' pain as a complex phenomenon comprised of emotional anxieties and stresses. As such, they perceived patients with tissue trauma to be affected not only by the physical aspects of their injuries, but also the psychological aspects which in turn had an impact on patient's well-being. The participants shared ideas on how to deal with the

uncomfortable feelings arising from their work. They also perceived patients in pain to be responsive to psychological aspects of pain or delays in healing their wounds:

The pain may be interpreted as a bothering thing. The patient may feel uncomfortable or suffering inside because of it. The patient may then feel depressed, especially when they do not receive nursing care, attention or medical treatment, and the horror and fear...(K1, G3)

As shown above, this also highlights the participants' perception concerning important aspects of relieving pain, including the different psychological risks associated with short and long durations of pain. Hence, the participants experienced both discomfort and anxiety on behalf of the patient; meanwhile, the pain experienced by the patient may have caused damage associated with post-operative mobility restrictions.

Theme 2: Restricted mobility and changed mood

The participants believed that there had been some sort of serious injury to the body and that pain caused mobility restrictions and mood changes in the patients. They also described the use of ineffective or perhaps even earlier ways of coping with the patients' pain, and believed that this could result in negative experiences even when the event is not negative itself. The participants' beliefs were the result of focusing both on the physical aspects of pain as well as the psychological effects, which can be long lasting. The participants also believe that the patients' pain greatly influenced their behaviour, and that the pain was sometimes exacerbated by mobility restrictions, such as resting and avoiding activities.

The participants also commonly expressed the idea that the experience of pain or response to pain differs from person to person, for example:

It is clearly a strong indicative feature of any

human being to have feelings, any one person will certainly react or respond to the physical pain, no matter how severe or not severe it may be. Instinctively or automatically, people react to the pain, but the way they react is different from person to person. Some people cry when maybe they have mild pain. Others, on the contrary, try hard to endure the pain, however severe it may seem. (K4, G2)

In my view, the pain and the tolerance towards the pain vary from person to person. For an instance of this, a patient with appendicitis may experience the pain relatively much more than the one with exploration. (K4, G3)

As these quotes demonstrate, the participants perceived differences in both individual pain tolerance and the expected severity of pain resulting from particular kinds of surgeries. Hence, the participants believed that the patients' experience of pain resulted from a combination of factors, including the physical tissue injuries and the kind of surgery, as well as the individual person's pain tolerance and attitude, based on their physiological and psychological aspects. All the participants concurred that they were in an ideal situation to act on the practical aspects of the patients' pain, as these were generally well known to their patients.

Nurses' perceptions of pain management

Analysis showed that nurses practiced pain management in such a way that (only) intolerable pain was treated and that they used their own experiences to manage their patients.

Theme 3: Intolerable pain would be managed

The majority of nurses reported that managing pain by using medication prescribed by the physician was what they always do for the patients, especially in the first 24 hours after surgery. Pain scores above five out of ten (a numerical scale from 1–10) would be reported by a nurse aide to the medication nurses. The medication nurse or the incharge nurse would then reassess the patients' pain; if the score >5 was confirmed, the nurse would ask the patient if they needed the medication. If the patient declined because the pain

was tolerable to her/him, the nurse would not give the medication and would reassess the patient after four hours. In this case, the nurse believed that pain was a part of experiences that the patient must tolerate. The nurses thought that the patients were able to tolerate a certain level of pain without receiving treatment, because it is a natural consequence of the surgery and must therefore be tolerated

In some case, even when the patient reported the pain scores of eight out of ten, the nurse would first observe the patient's behaviours. If the patient did not express feelings of pain in the face and in gestures, the nurse would not give medication or would tell the patient to wait and then try non-pharmacological approaches such as positioning, talking, and listening to music, for example:

First and foremost, we must assess the severity of pain; before giving medication, we would try other therapeutics such as touch, talking, positioning, and distracting the patient's interest or attention. If these do not work, we then will consider medication, either oral or injectable. (K3, G3)

Because pain medication was not continually given to the patients, their pain was not sufficiently controlled. Though most patients did not tell the nurse directly, they have often asked their relatives to tell the nurses and ask for more medication. In such cases, the nurses felt that the influence of the family and/or relatives increased the patients' experience of pain, as described by one nurse:

The relatives are sometimes as like the patients, our client. It is annoying because they would call very often, press, and press the bell, and say that the patient still feels a lot of pain. We cannot give more medication because it is not yet 4 hours. We gave MO (Morphine) and the Tramol, and cold compress but still the pain is not gone. We don't really know what he (the patient) wants or the relatives, we don't know why he feels so much pain. We do everything to make him better. (K5, G2)

Nevertheless, a few nurses expressed that they must rely on what the patient says and that whenever the patient reports that they had pain, nurses should promptly give medication. As one nurse said:

Nurse must listen more to the patient, and must take what the patient says as true. We shouldn't think that the patient pretends. (K6, G1)

As shown above, the participants perceived that (only) intolerable pain should be managed with practical nursing strategies in response to what the patients and their relatives report about the pain. Likewise, most of the participants believed that pain must be completely abolished before attempting normal activity, as an activity could cause further pain or injury. In addition, some participants believed that pain management in relation to anxious behaviour from relatives should also include a reliable source of information upon which the methods for relieving pain are based (e.g., the duration of drug administration and typical times to recover).

Theme 4: Managing patients' pain through our own experiences

Usually, a nurse aide assesses the pain and vitality signs of each patient every four hours, and the nurse in-charge or a medication nurse would check on the patients every two hours. A typical pain management regime included both pharmacological and non-pharmacological approaches. For patients whose pain scores were at a lower level (one to two out of ten), a non-pharmacological approach was used, primarily changing position or giving advice to the patients on ways of managing their own pain. This strategy is highlighted in the quotes below:

If the pain level is low, as one to two out of ten, I would help with non-pharmacological. Those with three to seven would be given oral medication, while those with eight to ten would be given an injection. (K4, G2)

To relieve the patient's pain, we should first assess the pain level. If the patient has mild

pain, we will first put him in a fowler's position or support the back when he is on his side to ensure his comfort. Later, we will talk in order to distract him from pain. However, if it is a severe pain, the patient couldn't bear it or it is intolerable to him, I will give pain medication. (K6, G2)

Based on their experiences, nurses manage pain differently. Nurses with more experience in this ward would have better clinical judgment in pain management than those with less experience. These expert nurses could often decide on behalf of those with less experience as to when and what kind of medication would be given to the patients or if they would prefer non-pharmacological methods. They would consult the expert nurses in case of patients with severe pain. As a nurse in one group expressed:

If the patients have pain, I must assess pain scores; if they were high scores, I would give medicine for them. Well, I still evaluate after taking medicine to them. If the patient's pain was not relieved, so we will ask senior nurses to confirm the decision to notify the physician. (K4, G1)

As shown above, the informants perceived managing pain as a stepwise process, beginning with inquiring about the level and cause of the patients' pain. In this situation the nurses know that they can often choose a non-pharmacological nursing intervention for relieving pain appropriately, such as developing a relationship, a change of position and massage. Furthermore, they must always assess pain levels before drug administration, and other non-pharmacological methods of pain management may offer more appropriate and beneficial results.

Discussion

Analysis of data from nurses participating in FGDs revealed common perceptions of patients in pain

as discomfort. Their understanding of their patients' pain was subdivided into two themes, discomfort feeling for the patients as well as mobility restrictions and mood changes in the patient. They defined patients in pain as the consensus of shared perceptions regarding their own experiences in terms of clinical contexts. These perceptions were based within cultural contexts, in the same way as those patients whose perspectives³ represented a Thai point of view regarding pain as suffering physically and psychologically. Our findings are in accord with other studies that illustrate that nurses' perception of patients in pain is similar regarding the definition of pain, for example, pain is an individual and a multidimensional phenomenon which relates to the physiological and psychological basis of persons.⁷ The most common perception of pain involves the psychological effects, such as having difficulty in sleeping, restlessness, and anxiety or stress.⁷

The importance of nurses' perceptions in managing post-operative pain was also highlighted in a previous study that found there was inadequate pain assessment and pain management among nurses. For instance, underestimating patients' pain, lack of education about side effects of medication such as risk of addiction and respiratory depression, and limited nurse-patient relationship. As a consequence, the nurses should improve the skills of assessing pain and managing pain that is helpful in understanding patients' pain.^{3,11,17,26}

The FGDs among novice and expert groups revealed no distinctive or different perceptions of patients' pain and pain management. In view of the nurses their perception of patients in pain is not new knowledge. Likewise, the gap of knowledge among nurses regarding the influence of the interaction between the nurses-patient relationships is significant, and nurses need to improve nursing therapeutic relationships with the patients in pain and attempt to control patients' pain and suffering symptom.^{15,17} The nurses believed that the two most important issues surrounding managing pain include that only intolerable

pain would be managed and that nurses manage their patients' pain by using their own experiences. The nurse with more experience had better clinical judgments in pain management compared with the nurses with less experience, also the novice nurses often decided based on ordered medication. The expert nurses often decided to select the kind of nursing management that is suitable for the patients, regardless of being non-pharmacological methods or ordered medication and the result revealed an interplay between nurses' perceptions of patients in pain and pain management patterns. This could have been the foundation of their professional role relevant to pain management in the daily routine influencing the day-to-day practice of their patients. Also, this is supported by the viewpoint of Benner & Wrubel¹⁴ about conducting nursing education in a way that the nursing strategies learned always influence practice in the nature and qualities of caring. In addition, the characterisation of an expert nurse is seen as the intuitive context-driven thinker, and illustrates the role nurses play regarding pain management practices. The nursing competency theory of Patricia Benner¹³ described professional competency as motivating practicing nurses to produce quality of care in the caring sciences, that there was knowledge to be gained from observations and participation with nurses' caring with patients in pain postoperative, distinct from the novice in terms of nursing skills and the power to negotiate within their clinical context.¹⁴

The findings of this study represent an understanding of the diversities of the nurses' perceptions of patients in pain and that the nursing consists of routine practices in relation to pain management. There should be improvement in nursing therapeutic strategies for pain management. However, nurse-patient interactions are of concern when there are conflicts due to a language barrier or the nurse's role; nurses expect patients to express their pain in such a way that they could understand this and that such expressions fit with the nurses' practices within cultural contexts.^{3,9,10} This could be of relevance for other similar contexts and settings since we found that the pain management of nurses

can be connected to their commonly held idea regarding the ways pain is expressed by patients (including the patients who communicate in an understandable and rational way according to the nurses) which not necessarily cover all the patients in pain. This needs to be reflected further by nurses and scholars in the field of pain management.

Limitations

A limitation of this study could be the dominance of group thinkers in the FGDs. Barbour & Kitzinger³⁰ described that group thinking can occur where one member dominates the discussion. Although we appreciate that FGDs gave us access to more informants, we also acknowledge that the moderator may have inadvertently focused on the insights of a smaller selection of the participants, thus giving their contributions greater significance. Conducting face-to-face interviews may have resulted deeper insights from each participant; however, the dynamics of group discussion would have been lost and the level of active involvement decreased.

In our FGDs, all participants were encouraged to speak throughout. The transcripts and the notes from the observer demonstrate that although some participants were more vocal, all participants regularly contributed to the discussion.

Conclusions and Recommendations

In conclusion, the results help us to understand the interplay of pain perceptions and pain management among nurses in a surgical ward. It is concerning that the nurses managed only intolerable pain and that pain management by their own previous experiences such as the clinical judgement of deciding to use pharmacological or non-pharmacological. Pain management relied on individual nurses' assumptions about the way care ought to be delivered, including when and what kind of medication and non-pharmacological treatments should be given to the patients in order to reduce their

pain. The findings regarding clinical judgement are of central importance, as the participants' opinions regarding pain management seemed to indicate that their evidence-based practice was inadequate for post-operative care. However, in reality it is the combination of the nurses' perception of patients in pain and their experience in managing pain that leads to the adequate care of post-operative patients, and any disconnect between nurses' perception of pain and pain management can affect the quality of care.

We suggest that there needs to be a change to a patient-centred care, and further reflection and action on the need for an evidence-based nursing culture. This, we believe, will lead to nurses using organized pain assessment guidelines and pain management models according to cultural contexts, where nurses' responses to pain and discomfort should be based on evidence. Enhancing the nurse-patient relationship and using holistic nursing models of care is important to bridge the gap between training and practice, not only in terms of nurses' personal and professional perceptions of pain and the pain management strategies they select, but also the importance of the cross-over of medical knowledge and perception of patients' pain.

Acknowledgments

The authors wish to thank all the nurses who participated in this study.

References

1. Raksamani K, Wongkornrat W, Siriboon P, Pantisawat N. Pain management after cardiac surgery: are we underestimating post sternotomy pain? *J Med Assoc Thai* 2013; 96(7):824-8. 2.
2. International Association for the Study of Pain (IASP). Managing Acute Pain in the Developing World. Pain: Clinical Update 2011; 19(3), 1-7. Available at: http://iasp.files.cms-plus.com/Content/ContentFolders/Publications2/PainClinicalUpdates/Archives/PCU_19-3_web_revised_1390260400113_4.pdf. Accessed June 6, 2013.

3. Mongkhonthawornchai S, Sangchart B, Sornboon A, Chantarasiri J. Thai perspectives on pain. *J Med Assoc Thai* 2013; 96(4):S91-7.
4. Songkong S, Petpichetchian W, Sae-Sia W. Clinical judgment and care behavior by nurses in postoperative pain management. *SMJ* 2008; 26(5): 460-468
5. Srisawang P, Hirosawa T, Sakamoto J. Knowledge, attitudes and barriers of physicians, policy makers/regulators regarding use of opioids for cancer pain management in Thailand. *J Med Sci* 2013; 75: 201-212.
6. Aziato L, Adejumo O. The Ghanaian surgical nurse and postoperative pain management: A clinical ethnographic insight. *Pain Manag Nurs* 2014; 15(1): 265-272
7. Melzack R. Evolution of the neuromatrix theory of pain. The Prithvi Raj Lecture: presented at the third World Congress of World Institute of Pain, Barcelona 2004. *Pain Pract* 2005; 5(2): 85-94.
8. Al Samarae A, Rhind G, Saleh U, Bhattacharya V. Factors contributing to poor post-operative abdominal pain management in adult patients: a review. *Surgeon* 2010; 8(3): 151-158.
9. Zoëga S, Sveinsdottir H, Sigurdsson GH, Aspelund T, Ward SE, Gunnarsdottir S. Quality Pain Management in the Hospital Setting from the Patient's Perspective. *Pain Practice* 2014.
10. Zoëga S, Gunnarsdottir S, Wilson ME, Gordon DB. Quality Pain Management in Adult Hospitalized Patients: A Concept Evaluation. *Nurs Forum* 2014; Jan: 16
11. Suhonen R, Gustafsson ML, Katajisto J, Välimäki M, Leino-Kilpi H. Nurses' perceptions of individualized care. [Article]. *J Adv Nurs* 2010; 66(5): 1035-1046.
12. Koestler, Angela J, Myers, A. Understanding chronic pain. Jackson: University Press of Mississippi; 2002: 4-5.
13. Benner PE, Tanner CA, Chesla CA. Expertise in nursing practice: caring, clinical judgment & ethics (2nd ed.). New York: Springer Pub; 2009.
14. Benner PE, Wrubel J. The primacy of caring: stress and coping in health and illness. Menlo Park, Calif.: Addison-Wesley Pub. Co; 1989.
15. Söderhamn O, Idvall E. Nurses' influence on quality of care in postoperative pain management: a phenomenological study. *Int J Nurs Pract* 2003; 9(1): 26-32.
16. Monger KS, Sangchart, B. Patients' perceptions of Nurses' caring behaviors and post-operative pain management on the surgical wards of Jigme Dorji Wangchuk National Referral Hospital in Bhutan. *Journal of Nursing Science & Health* 2012; 35(1): 69-82. Available at: <http://www.wdw.tci-thaijo.org/index.php/nah/article/view/1900/1572> Accessed June 3, 2013.
17. Suwanraj M. Current Practice, Perceived Barriers, and Perceived Facilitators of Thai Nurses on using The Evidence -based Practice on Pain Assessment and Pain Management in Older (Doctoral dissertation). The Graduate College of the University of Iowa 2010. Available at: <http://ir.uiowa.edu/cgi/viewcontent.cgi?article=1932&context=etd>. Accessed June 6, 2013.
18. Grinstein-Cohen O, Sarid O, Attar D, Pilpel D, Elhayany A. Improvements and difficulties in postoperative pain management. [Review]. *Orthop Nurs* 2009; 28(5): 232-239.
19. Schreuders L, Bremner AP, Geelhoed E, Finn J. Nurse perceptions of the impact of nursing care on patient outcomes: An exploratory study. *Contemp Nurse* 2012; 41(2): 190-197.
20. Eid T, Manias E, Bucknall T, Almazrooa A. Nurses' Knowledge and Attitudes Regarding Pain in Saudi Arabia. *Pain Manage Nurs* 2014; 1-12.
21. Morgan BD. Nursing Attitudes Toward Patients with Substance Use Disorders in Pain. *Pain Manage Nurs* 2012; 15(1): 165-175.
22. Yimyaem PR, Kritsanaprakornkit W, Thienthong S, Horatanaruang D, Palachewa K, Tantanatewin W, et al. Post-operative pain management by acute pain service in a University Hospital, Thailand. *Acute Pain* 2006; 8(4): 161-167.
23. Payakkaraung S, Wittayasooorn J, Thampanichawat W, Suraseraniwong S. Nurses' Management of Thai Children's Postoperative Pain: A Holistic Case study. *Pacific Rim Int J Nurs Res* 2013; 14(4): 330-345.
24. Charuluxananan S, Thienthong S, Rungreungvanich M, Srirojanakul W, Punjasawadwong Y, Sriprajittichai P. A survey of post anaesthetic pain management in Thailand. *J Med Assoc Thai* 2009; 92(8): 1028-32.

25. Chanvej L, Petpichetchian W, Kovitwanawong N, Chaibandit C, Vorakul C, Khunthong TA. chart audit of postoperative pain assessment and documentation: the first step to implement pain assessment as the fifth vital sign in a University Hospital in Thailand. *J Med Assoc Thai* 2004; 87(12): 1447- 1453.
26. Rejeh N, Ahmadi F, Mohammadi E, Kazemnejad A, Anoosheh M. Nurses' experiences and perceptions of influencing barriers to postoperative pain management. *Scand J Caring Sci* 2009; 23(2): 274-281.
27. Krueger RA, Casey MA. *Focus Groups. A Practical Guide for Applied Research* (3rd eds). Thousand Oaks, CA: Sage Publications; 2000.
28. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today* 2004; 4(2): 105-112.
29. Lincoln Y, Guba E. Establishing trustworthiness. In: Bryman A, Burgess RG (Eds.), *Qualitative Research*, Vol III. Sage Publications, Thousand Oaks, CA; 1999:397-444.
30. Barbour RS, Kitzinger J. (eds.). *Developing Focus Group Research Politics Theory and Practice*, Sage, London; 1999.

การรับรู้ของพยาบาลในผู้ป่วยที่มีความปวดและการจัดการความปวดใน หอผู้ป่วยศัลยกรรม

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บทคัดย่อ : ในประเทศไทย พยาบาลมีบทบาทสำคัญในการประเมินอาการและให้คำแนะนำเกี่ยวกับการจัดการความปวดและการบรรเทาอาการปวดหลังผ่าตัดในหอผู้ป่วยศัลยกรรม การศึกษาเชิงคุณภาพนี้มีวัตถุประสงค์เพื่อให้ได้ข้อมูลเชิงลึกในการรับรู้ของพยาบาลในผู้ป่วยที่มีความปวดและการจัดการความปวดในหอผู้ป่วยศัลยกรรม โดยวิธีการสนทนากลุ่ม (Focus group discussion) ที่พยาบาลวิชาชีพทำงานในหอผู้ป่วยศัลยกรรมมีส่วนร่วม จำนวนทั้งหมด 18 ราย โดยใช้การวิเคราะห์เนื้อหาเชิงคุณภาพ (Qualitative content analysis)

ผลการศึกษาในกลุ่มพยาบาลที่มีส่วนร่วม พบว่า การรับรู้ของพยาบาลในผู้ป่วยที่มีความปวดและการจัดการความปวดรวมทั้งหมด 4 ประเด็นหลัก แบ่งออกเป็น การรับรู้ความปวด 2 ประเด็นหลัก ได้แก่ (1) ไม่สุขสบายและถูกจำกัดการเคลื่อนไหว และ (2) มีอารมณ์ที่มีการเปลี่ยนแปลง และการรับรู้ในการจัดการความปวด 2 ประเด็นหลัก ได้แก่ (1) ทนความปวดไม่ได้ถึงจะได้รับการจัดการความปวด และ (2) การจัดการความปวดจากประสบการณ์ของตนเอง

ทั้งนี้ปฏิสัมพันธ์การรับรู้ของพยาบาลในผู้ป่วยที่มีความปวดและการจัดการความปวดในหอผู้ป่วยศัลยกรรมที่มีส่วนร่วมในการศึกษานี้จะมีความสำคัญในความเป็นวิชาชีพของพยาบาลตามหลักฐานในทางปฏิบัติที่พอเพียงสำหรับการพยาบาลในผู้ป่วยหลังผ่าตัด ซึ่งบ่งบอกถึงความสัมพันธ์ระหว่างพยาบาลและผู้ป่วยที่ได้รับการพยาบาล ในรูปแบบของการพยาบาลองค์รวม โดยสะท้อนให้เห็นถึงการให้ความสำคัญที่เชื่อมโยงระหว่างการที่ได้รับการฝึกอบรม ทั้งในเรื่องของความรู้และการปฏิบัติในการจัดการความปวดระหว่างการรับรู้ของแต่ละบุคคลและกลวิธีที่พยาบาลจัดการความปวด ในสถานะของพยาบาลวิชาชีพที่ยังคงไม่พอเพียงและเหมาะสมกับบริบทของผู้ป่วย

Pacific Rim Int J Nurs Res 2015; 19(2) 164-177

คำสำคัญ : การรับรู้ของพยาบาล ผู้ป่วยที่มีความเจ็บปวด การจัดการความเจ็บปวด หอผู้ป่วยศัลยกรรม

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