Original Article

Knowledge and Beliefs about Chronic Non Cancer Pain Management for Family Medicine Group Nurses

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Abstract:

To provide effective care for chronic pain sufferers, nurses must have a knowledge of chronic pain management. In Quebec, nurses working in Family Medicine Groups (FMGs) could play a major role in helping patients with chronic noncancer pain (CNCP); however, the extent of their knowledge about CNCP management is unknown. The primary goal of this study was to explore the knowledge and beliefs of FMG nurses about CNCP management. The secondary goal was to explore the obstacles seen by these nurses as preventing them from performing CNCP management. We used a mixed-methods design with quantitative preponderance. Fifty-three FMG nurses answered a self-administered mail-in questionnaire. A rigorous data collection method was used. FMG nurses have suboptimal knowledge about CNCP management. They identify their lack of training and lack of knowledge as major obstacles to conducting pain management interventions. There is a need for pain management training specifically designed around the realities of FMG nursing.

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BACKGROUND

To provide effective care for chronic pain sufferers, nurses must have knowledge of chronic pain management (Registered Nurses Association of Ontario [RNAO], 2013). Several studies detail the inadequate knowledge, inaccurate beliefs, and challenges faced by nurses in providing care for patients with acute pain (Abdalrahim, Majali, Stomberg, & Bergbom, 2011; Al-Shaer, Hill, & Anderson, 2011; Broekmans, Vanderschueren, Morlion, Kumar, & Evers, 2004; Coulling, 2005; Layman Young, Horton, & Davidhizar, 2006; Manias, 2003; Manias, Bucknall, & Botti, 2004). However, there is little evidence regarding the knowledge, beliefs, and challenges faced by nurses regarding chronic noncancer pain (CNCP) management.

Currently, CNCP treatment and management are often inadequate (Gilron & Johnson, 2010). The recommended way to ensure the best possible care is to

make an early diagnosis, provide optimal treatment and primary care management, and work in interdisciplinary teams (Debar et al., 2012; Steglitz, Buscemi, & Ferguson, 2012). As part of such teams, nurses can make practical interventions to optimize pain relief for people suffering from CNCP (American Society of Pain Management Nurses [ASPMN], 2010). More specifically, and in collaboration with general practitioners, they can conduct interventions such as detection, assessment, follow-up care, and CNCP-related education (RNAO, 2013; Veterans Health Administration, 2009).

Primary care for CNCP patients is suboptimal in Quebec (Jouini et al., 2014). The introduction of the Family Medicine Group (FMG) model could optimize CNCP management in primary care (Lalonde et al., 2014). An FMG consists of several family physicians working in close collaboration with nurses to provide integrated care and care continuity, especially for vulnerable groups, such as patients with chronic conditions (Pomey, Martin, & Forest, 2009). Given the high prevalence of CNCP, its association with the chronic health issues seen in FMGs (diabetes, chronic obstructive pulmonary disease, etc.; ASPMN, 2010), and its even greater prevalence in cases of multimorbidity (Ramage-Morin & Gilmour, 2010), many FMG patients may be suffering from CNCP.

To intervene adequately, nurses must possess sufficient knowledge and appropriate beliefs about pain management (Patiraki-Kourbani, Tafas, McDonald, Papathanassoglou, Katsaragakis, & Lemonidou, 2004; RNAO, 2013). The challenges they face in conducting pain management must also be understood (Pellico, Gilliam, Lee, & Kerns, 2014; Siedlecki, Modic, Bernhofer, Sorrell, Strumble, & Kato, 2014) and addressed. Those challenges, and the knowledge and beliefs of FMG nurses about CNCP, have not yet been documented.

Goals

The primary goal of this study was to evaluate the knowledge and beliefs of FMG nurses about CNCP management. The secondary goal was to explore the barriers identified by nurses as preventing them from performing CNCP management.

Conceptual Framework

The research presented in this paper is based on the model of Patiraki–Kourbani et al. (2004), which was developed after a review of the literature on how the personal and professional experiences of nurses with pain affected their knowledge and skills in pain management. We chose this model because it provides a way to analyze the different barriers associated with effective pain management by nurses. The factors considered for this study were pain-related training, professional experience with pain, theoretical knowledge about pain, the characteristics of individual nurses, and effective pain management.

MATERIAL AND METHODS

Participants

We used a mixed-methods design with quantitative preponderance (cross-sectional mail survey; Dillman, 2007; Doyle, Brady, & Byrne, 2009; Grove, Burns, & Gray, 2013). The accessible population for the study consisted of nurses on a list of *Ordre des infirmières et infirmiers du Québec* (OIIQ) members working in FMGs. Of the 430 FMG nurses, 195 agreed to be contacted at home for research purposes. An exhaustive sampling of those nurses was performed. Each participant in the study had to be an OIIQ member and able to read, understand, and answer questionnaires written in French.

Procedure

The study was approved by an institutional ethics committee. Data collection by mail was performed using the Dillman strategy (2007) to maximize response rate. The mailing contained a letter of explanation with the researchers' contact information, two copies of the consent form, the questionnaire, and two postage-paid return envelopes. Nurses who agreed to participate had to sign and date one copy of the information and consent form, returning it and the questionnaire in separate postage-paid envelopes. This procedure ensured anonymity and reduced the possibility of social desirability bias.

Reminder mailings were sent 1 and 3 weeks after the initial mailing. To guarantee anonymity, we did not proceed to a second mailing of questionnaires for nurses who did not respond to the first reminder. To maximize response rate, all letters (including reminders) were personalized and signed by the researchers.

Variables

The first variable was knowledge about best practices in CNCP management, which refers to facts based on empirical data that are published and widely available (Watt-Watson, Stevens, Garfinkel, Streiner, & Gallop, 2001). The second variable was beliefs about CNCP management, which refers to statements that are believed to be true but have no scientific basis (Watt-Watson et al., 2001). The final variable was the barriers preventing from performing CNCP management actions, defined as personal or organizational factors