

Translation, and Validation of Perceived Obstacles to Pain Assessment and Management Practices Questionnaire among Vietnamese Nurses

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ABSTRACT

Introduction: Barriers related to patients, physician, nurses, and health system were the mostly responded by nurses as factors influencing them in pain management for patients. So, the valuable and reliable questionnaire is very important to measure the perception of Vietnamese nurses about pain management barriers

The study objective: was to translate, adapt and conduct initial psychometric validation of the Vietnamese version of Perceived Obstacles to Pain Assessment and Management Practices questionnaire (V-POPAMP).

Material and method: Translation, adaptation, and validity and reliability testing were performed. 6 expert panels evaluated content validity, and I-CVI, SCVI were applied to measure the content validity. The Cronbach alpha and ICC were used to measure for internal consistency and stable reliability of V-POPAMP, respectively. A sample of 30 nurses was selected in pre-pilot testing, and 30 other nurses participated in pilot testing.

Results: The study found that I-CVI of each item ranged from 0.83-1 and S-CVI = 0.96, indicating the V-POPAMP is good content validity. In addition, the V-POPAMP is good reliability, with Cronbach alpha for each subscale of 0.729 and more, and ICC for total score was 0.952 and for each subscale ranges from 0.822 to 0.984 ($p = .000$)

Conclusion: The V-POPAMPQ has good psychometric properties. It can be used to measure the perception of nurses about pain management barriers in Vietnam.

KEYWORDS: Obstacles, barrier, pain, management, nurse

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INTRODUCTION

Pain was one of the main reasons lead patients were hospitalized (accounting for 71.6% of hospitalized patients)^[1]. During hospitalization, 55-78.6% of patients experienced moderate to severe pain^[2]. Especially, The state of patients with uncontrolled pain after surgery in developing countries accounts for a high rate of 47-100%^[3]. Without proper pain management, it can affect both physical and mental health of patients, as patients can experience pain-related emotional reactions such as insomnia, anxiety, and despair. Or for untreated acute pain there are additional risks such as increased morbidity, slow recovery time, prolonged opioid use, higher health care costs, and development chronic pain^[4].

Although nurses do not have right to prescribe treatment for patients when they are in pain. However, nurses make a great contribution to timely detection and management of pain for patients because most of the time patients stay in the hospital directly contact with nurses^[5]. However, many studies indicated that pain management practice of nurses for patients was still low and inadequate. For example in the research of Wuni & CS 2020 revealed 42.2% of nurses demonstrated poor pain management practices^[6]. In other study, the authors found out 97.6% of nurses used only basic nursing techniques and rarely used analgesics in pain relief for patients^[7].

Nursing practice of pain management was hindered by many barrier factors. In a systematic review, barrier factors were divided into 4 groups: Barriers belonging to nurses, physicians, patients and factors belonging to the system^[8]. The results

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of this study was similar to a previous study result of Ortis, Carr. & Dikareva (2014) conducted a review of studies from 2003-2013 and also pointed out three main barriers obstructed nurses practicing pain management for patients included: patient, medical staff and health system^[9].

In the literature review, there were many instruments that applied to measure the barriers affect to nurses practice pain management such as The Pain Management Activities Questionnaire^[10], Barriers to Optional Pain Management tool^[11], Perceived Obstacles to Pain Assessment and Management Practices questionnaire (POPAMPQ)^[12].

To the best of our knowledge, there is not yet any research instrument to measure the perception of nurse about nursing pain management practice barriers that used or developed in Vietnam. Therefore, a valuable and reliable of tool is needed. Among the questionnaires above, the POPAMPQ^[12] was chosen to tested the validity and reliability among Vietnamese nurses because it was gone through a rigorous developmental process and covers all dimensions of barriers that nurses mostly responded. Otherwise, it was used in many countries such as Poland^[13], Turkey^[14], United States^[15]. Original questionnaire was analyzed in terms of factor accuracy, internal coherence and discriminating strength. The psychometric parameters obtained were satisfactory^[12]. Cronbach's reliability a coefficient – values of 0.7 and more^[13].

The objectives of the study were to translate the POPAMPQ from English into Vietnamese language and to test its psychometric properties to enable different dimensions of POPAMPQ to be assessed on Vietnamese nurses.

METHODOLOGY

Study design and setting

A cross-sectional descriptive study was applied at Hai Duong Medical Technical University hospital and Hai Duong provincial general hospital from March to May in 2022

Samples and sample size

According to recommendation of Tsang, & et.al.(2017), the sample size appropriate for pre-pilot testing and pilot testing is 30 -50 samples^[16]. In this study we selected 30 nurses who participated in assessing the clarity and understood of the translation POPAMPQ, and 30 other nurses who had practice certificates, and had at least 1 year of experience in nursing care patient participated in the reliability test phase

Measurement

The POPAMPQ was developed by Coker, & CS(2010)^[12]. It contains 40 items and grouped into different subscales included patient-related barriers (11 Items); barriers related to physician (5 Items), barriers related to nurse (14 items), and barriers related to the health system (10 items)^[13] (Dabrowka, Wioletta; Dąbrowski, & CS. 2017). Each item is assessed how often the obstacles defined by nurses on a 7-point scale: 1=Never interferes; 2= Very rarely interferes; 3= Rarely

interferes; 4= Occasionally interferes; 5= Frequently interferes; 6= Very frequently interferes; 7= Always interferes. The original English POPAMPQ version was tested in term of factor accuracy, internal coherence and discriminating strength^[12]. The psychometric parameters obtained were satisfactory. Cronbach's reliability a coefficient equaled to 0.7 and more^[13].

Translation

POPAMPQ was translated in accordance with World Health Organization(WHO) best practice guidelines^[17], which includes a forward translation into Vietnamese language followed by a backward translation into the original English language. The translation process was done through steps as follows:

First step: The original English POPAMPQ was independently translated into Vietnamese POPAMPQ (V-POPAMPQ) by two experts who are nursing lecturers, they are fluent in common English and English for nursing, and their mother tongue is Vietnamese.

Second step, two V- POPAMPQ were synthesised by two translators above and researchers to resolved any variances in the translations.

Third step, the backward translation was done by two bilingual experts in both Vietnam and English language, they are English lecturers. As the WHO recommended, they had had no exposure to the original English questionnaire.

Fourth step, all translations were reviewed by expert committee. Members of committee included: both the forward and backward translators, one nursing doctor she work as a nurse and lecturer, and researcher. The committee compared all versions of the translations and determine whether the translated and original versions achieve semantic, idiomatic, experiential, and conceptual equivalence. Any differences were resolved within a agreement discussion. The expert committee agreed to cutoff the words "older adult" in each question that can apply to a hospitalized adult of any age. After that the prefinal translated version was produced.

The fifth step, prefinal Vietnam version was done preliminary pilot testing on 30 nurses who work at Hai Duong Medical Technical University Hospital to make sure that the translated items retained same meaning as the original items, and ensure all translated items were easily clarified. Participants rated the understanding of each item on a 4-point Likert Scale: "0 - I don't understand anything; 1 - I understand a little bit; 2 - I understand more; 3 - I understand most of items but have some doubts; 4 - I fully understand and I have no doubts". The results showed that 30 nurses rated at level 4 - they fully understood and had no doubts when reading the prefinal translated version. The final translated was produced. The processing of translation and adaptation was prented below. (Figure 1)

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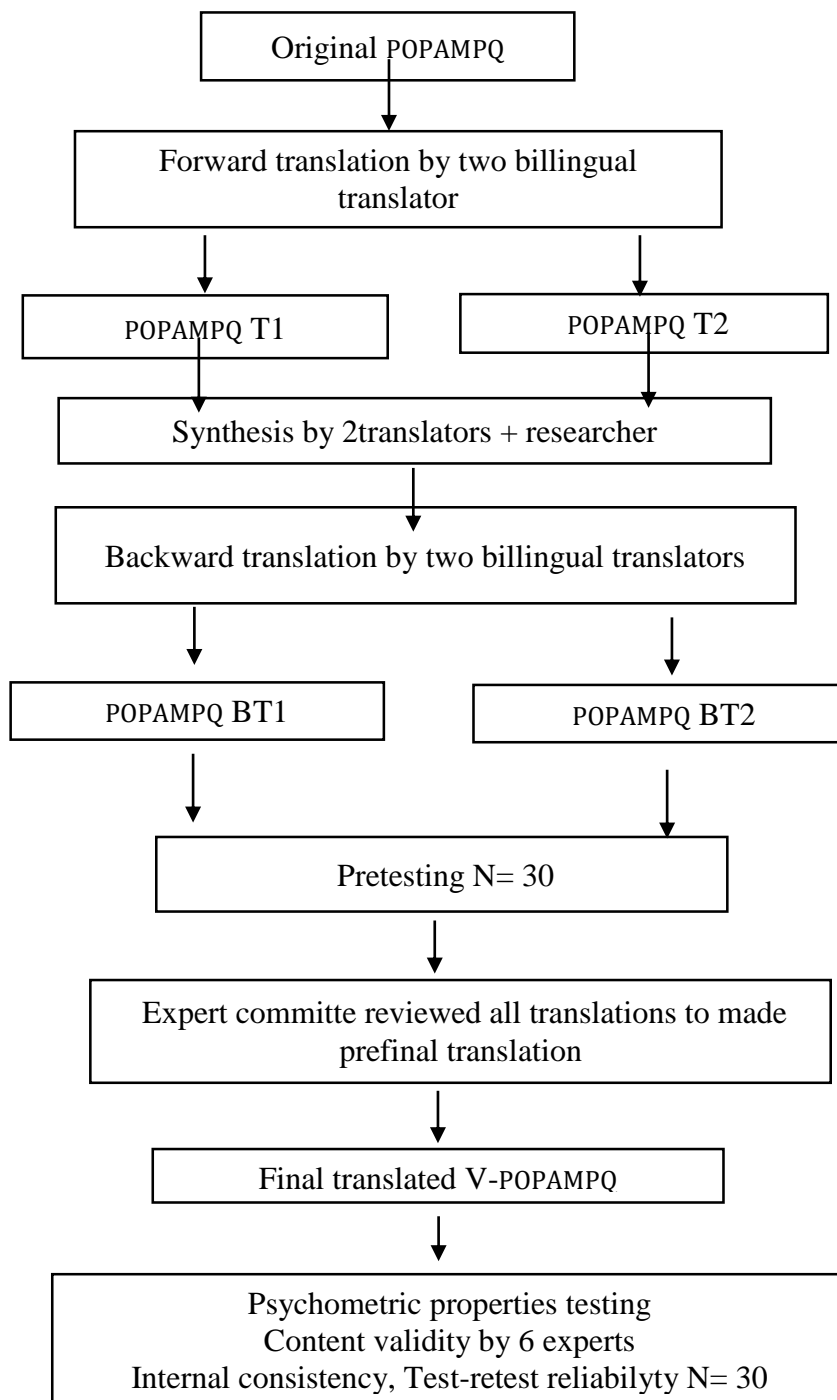


Figure 1. Translation, adaptation and psychometric properties testing procedure the original POPAMPQ and V-POPAMPQ were added in the appendix

Content validity

As recommended by the author Ikart (2019)^[18], the number of evaluators to calculate the content validity ranges from 2-20 experts. Based on Ikart's (2019) expert selection criteria, in this study, we selected 6 experts. These experts have more than 10 years of experience, working in different departments, hospitals, universities, including: 3 experts with master's / specialty 1 degree in nursing work at hospitals, 2 experts have nursing doctor degree who have experiences in researching and pain caring, one Assoc.Prof.Dr. Physician who have more than 30 years in taking care for patients in pain and researching. 6 experts assessed the relevance of the

questionnaire in the Vietnam cultural context by rate CVI of each item as follow: 1= not relevant; 2=somewhat relevant; 3= Quite relevant; 4=highly relevant. The items get a score 3 or 4 was defined as relevant, and the items get a score 1 or 2 meant that not relevant. The content validity index I-CVI and S-CVI was calculated for the V-POPAMPQ. Acceptance scores for I-CVI and S-CVI are 0.78 and 0.9, respectively^[19].^[20].

Reliability

The pilot study for reliability of V- POPAMPQ was test on 30 nurses who work at to obtained data for analyzing internal consistency reliability and test-retest reliability. The repeated

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testing was done on same participants in a one week interval^[21]. The nurses rated for each item on a 7point- scale: 1=Never interferes; 2= Very rarely interferes; 3= Rarely interferes; 4= Occasionally interferes; 5= Frequently interferes; 6= Verry frequently interferes; 7= Always interferes

Internal consistency reliability was measured by using Cronbach's α for each subscale. Cronbach's $\alpha \geq 0.7$ is considered acceptable, with $\alpha \geq 0.8$ considered good, but $\alpha \geq 0.9$ suggesting potential redundancy among scale items^[22]. Otherwise, in each subscale the item-subscale correlation coefficients tested for the homogeneity of the subscale. The item - subscale correlation coefficients were between 0.3 and 0.7, indicating accepbale item. If coefficients were less than 0.3 those items were cut off, also if coefficients were more than 0.7 it indicated repetition^[23].

Intraclass correlation coefficient was used to measured test - retest reliability(ICC) with two-way mix model, absolute

agreement method for total score and subscale score. ICC values less than 0.5 are indicative of poor reliability, values between 0.5 and 0.75 indicate moderate reliability, values between 0.75 and 0.9 indicate good reliability, and values greater than 0.90 indicate excellent reliability^[24].

Statistical analysis was done using excel and SPSS Statistics software package, version 25. For the level of statistical significance, the p -value ≤ 0.05 .

RESULTS

The result of study revealed that 30 nurses paticipated in pilot testing most of them were female, 86.7%, and 70.0% had bachelor degree, 63.3 % had working experience from 5-10 years. Especially, 100% (n= 30) nurses participating in the study have not attended any training course related to pain management. The detaile was showned in table 1

Table 1: Socio-demographic characteristics of participants

Characteristics	Number	%
Sex		
- Nam	4	13.3
- Nũ	26	86.7
Educational status		
- College	0	0.0
- University	21	70.0
- Postgraduate	9	30.0
Working experience(yrs)		
- 1- 5 years	4	13.4
- 5-10 years	19	63.3
- ≥ 10 years	7	23.3
Participate in pain management training		
- Yes	30	100
- No	0	0

Content validity:

Each item of V- POPAMPQ had CVI more than 0.78. There were 31 items had CVI equal to 1.0 and 9 items had CVI of

0.83. Therefore, the S-CVI equaled to $[(31 \times 1) + (9 \times 0.83)] : 40 = 0.96 (> 0.9)$. The detaile of CVI was prented in table 2

Table 2. Content validity of the V- QPOPM

Items	Obtained score (CVI)
Item1	1(>0.78)
Item.2	1(>0.78)
Item.3	1(>0.78)
Item.4	1(>0.78)
Item.5	1(>0.78)
Item.6	1(>0.78)
Item.7	0.83(>0.78)
Item.8	1(>0.78)
Item.9	1(>0.78)
Item.10	1(>0.78)
Item11	1(>0.78)

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Item.12	0.83(>0.78)
Item.13	0.83(>0.78)
Item.14	0.83(>0.78)
Item.15	1(>0.78)
Item.16	1(>0.78)
Item.17	0.83(>0.78)
Item.18	1(>0.78)
Item.19	1(>0.78)
Item.20	1(>0.78)
Item.21	1(>0.78)
Item.22	1(>0.78)
Item.23	1(>0.78)
Item.24	0.83(>0.78)
Item.25	0.83(>0.78)
Item.26	1(>0.78)
Item.27	1(>0.78)
Item.28	1(>0.78)
Item.29	1(>0.78)
Item.30	1(>0.78)
Item.31	0.83(>0.78)
Item.32	1(>0.78)
Item.33	0.83(>0.78)
Item.34	1(>0.78)
Item.35	1(>0.78)
Item.36	1(>0.78)
Item.37	1(>0.78)
Item.38	1(>0.78)
Item.39	1(>0.78)
Item.40	1(>0.78)

The Cronbach Alpha value was calculated to measured for internal consistence reliability of V- POPAMPQ. There were 4 subscales in V- POPAMPQ. Therefore, the Cronbach Alpha value was calculated independently for each subscale.

Cronbach’s α of the subscales were all more than 0.70. Most items in each subsale had item-subscale correlation coefficient value greater than 0.3. The detaile was showed in table 3

Table 3: Intenal consistence reliability of V- POPAMPQ

Items	Corrected Item-Subscale Correlation	Cronbach's Alpha if Item Deleted
Barrier related to patient (Cronbachalpha =0.82)		
Item1	.697	.788
Item.2	.626	.797
Item.3	.492	.810
Item.4	.490	.811
Item.5	.568	.803
Item.6	.443	.815
Item.7	.395	.819
Item.8	.469	.817
Item.9	.441	.816
Item.10	.466	.814
Item.11	.426	.817
Barrier related to phycian (Cronbachalpha =0.729)		
Item.12	.357	.727
Item.13	.384	.720

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Item.14	.686	.591
Item.15	.412	.713
Item.16	.631	.625
Barrier related to nurse (Cronbachalpha =0.84)		
Item.17	.545	.827
Item.18	.404	.836
Item.19	.401	.836
Item.20	.566	.826
Item.21	.604	.822
Item.22	.448	.833
Item.23	.438	.834
Item.24	.491	.830
Item.25	.431	.834
Item.26	.371	.837
Item.27	.337	.839
Item.28	.333	.839
Item.29	.654	.819
Item.30	.649	.818
Barriers related to health system(Cronbachalpha =0.811)		
Item.31	.377	.809
Item.32	.349	.810
Item.33	.459	.797
Item.34	.650	.776
Item.35	.527	.790
Item.36	.610	.780
Item.37	.508	.793
Item.38	.536	.789
Item.39	.476	.798
Item.40	.470	.797

Test- retest reliability was to determined on 30 nurse sample to examine the stability of V- POPAMPQ. In the first test, the mean total score of the 40 Items was 116.63(SD=16.69) and 117.33 (SD = 20.44) in the second test. The stability of V-

POPAMPQ was assessed via a two-way mixed effects ICC, ICC of total V- POPAMPQ =0.95, and for each subscale of 0.822 to 0.984(p=.000). The detaile was presented in table 4

Table 4 Test-retest reliability of V- POPAMPQ

	Intraclass Correlation	95% Confidence Interval		F Test with True Value 0			
		Lower Bound	Upper Bound	Value	df1	df2	Sig
Average Measures of Total V-QPOPM	.953	.901	.978	20.700	29	29	.000
Average Measures of Barrier related to patient	.896	.781	.950	9.603	29	29	.000
Average Measures of Barrier related to phycian	.822	.626	.915	5.623	29	29	.000
Average Measures of Barrier related to nurse	.984	.967	.992	62.923	29	29	.000
Average Measures of Barriers related to health system	.952	.900	.977	20.969	29	29	.000

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DISCUSSION

The purpose of this study was to translate, adapt, and evaluate the psychometric properties of a Vietnamese version of the POPAMPQ (V- POPAMPQ) using a sample of nurses from Hospital of Hai Duong Medical Technical University hospital and Hai Duong provincial general hospital. We found that the V- POPAMPQ had had good psychometric properties.

The development of the V- POPAMPQ involved a rigorous validation process. First of all, the V- POPAMPQ was translated based on standard procedure guideline of WHO^[17], reviewed by expert committee and then prefinal V-QPOPM was tested on nurses to evaluate the intelligibility of the translation tool before performing the validity and reliability testing. The result showed that 40 items of prefinal V-POPAMPQ were rated at level of fully understand and have no doubts. The CV was also established through the 6 expert panels. The experts participated not only in rating CVI of all items but also suggested possible improvements. All 40 items had a CVI range from 0.83-1 and S-CVI equaled to 0.96, indicating the V- POPAMPQ had a good content validity^[19],^[20].

To ensure the internal reliability, the Cronbach's α was calculated. Each subscale had cronbach alpha range from 0.73-0.84 with this result indicated that the POPAMPQ was an acceptable level of internal reliability instrument. Otherwise, the Item-subscale correlation more than 0.3 and less than 0.7, meant that no items of V-POPAMPQ scale were removed and repeated^[23], and also indicating that the scales have similar psychometric properties for different populations.

The study result also revealed an excellent test - retest reliability with ICC = 0.95. For each subscale, the ICC value range from 0.822 to 0.984 ($p=0.000$). These findings suggest an excellent level of stability for the questionnaire, and good to excellent level of stability for each subscale between two times test^[24].

Compared with previous study, the our study results consistence with original English QPOPM version testing. The POPAMPQ was tested the psychometric parameters obtained were satisfactory. Cronbach's reliability coefficient - values of 0.7 and more^[13].

By now, this is the first study performed translated, adapted and validated the POPAMPQ in Vietnam. With the results were revealed above, indicating the V-POPAMPQ is a valuable and reliable questionnaire. However, this study had some limitations such as study only was done on nurses who work at Hai Duong province, so the results may be not generalization for all nurses in Vietnam. In addition, in processing of translation without native English language speaker translators, and primary author of POPAMPQ participated in expert committee, it may lead to some differences with native English language speakers and original author. Other more limitations in our study did not

test construct validity of V-POPAMPQ to ensure the strongest validity.

CONCLUSION

In summary, the V-POPAMPQ has good psychometric properties. It can be used to measure the perception of nurses about pain management barriers. Further studies should test the construct validity of V-POPAMPQ to ensure the strongest validity.

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CONFLICT OF INTEREST

The authors confirm that there are no conflicts of interest in this study.

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APPENDIX

Original questionnaire:

Nurses' Perceived Obstacles to Pain Assessment and Management Practices Questionnaire (Cocker, Papaioannou, Kaasalainen, & CS. 2010)

Your colleagues have reported that a number of factors may interfere with optimal assessment and management of pain in older adults. Please circle the number under the heading which best describes the frequency with which you think the

following barriers interfere with optimal pain assessment and management practices with older adults on your unit.

1= Never interferes; 2= Very interferes; 3= Rarely interferes; 4=Occasionally interferes; 5=Frequently interferes; 6= Very frequently interferes; 7= Always interferes

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No	Barriers	1	2	3	4	5	6	7
Patient-related barriers (11 items)								
1	Older patients' difficulty with completing pain scales (e.g., 0-10)							
2	Older patients' reluctance to take pain medication for fear of addiction							
3	Older patients not wanting to bother the nurses							
4	Older patients denying their disease process by denying pain							
5	Older patients' willingness to put up with chronic pain							
6	Older patients' reluctance to take pain medications because of side effects (e.g., constipation, how it makes them feel, etc.)							
7	Patients reporting their pain to the doctor, but not to the nurse							
8	Difficulty assessing pain in older people due to language barriers							
9	Difficulty assessing pain in older people due to problems with cognition (delirium, dementia, etc.)							
10	Difficulty assessing pain in older people due to sensory problems (hearing deficits, vision deficits, etc.)							
11	Difficulty assessing pain in older people due to alterations in mood (depression, etc.)							
Physician-related barriers (5 items)								
12	Physicians' lack of trust in the nursing assessment of pain in older patients							
13	Physicians' lack of knowledge and experience with prescribing pain medications							
14	Physicians' reluctance to prescribe adequate pain relief in older patients for fear of overmedicating those with dementia or delirium							
15	Antipsychotics are considered before pain medications in agitated patients							
16	The "older person is dying anyway" attitude among colleagues on the unit							
Nurse-related barriers (14 items)								
17	Difficulty contacting or communicating with physicians to discuss pain assessment findings in older patients							
18	Difficulty contacting or communicating with physicians to discuss treatment of pain in older patients							
19	Not expecting pain in older patients on our unit unless the diagnosis provides a clue to pain as a potential symptom							
20	Difficulty believing pain reports by older patients because they are inconsistent from one time to the next, and do not match their non-verbal behaviour							
21	Not knowing how much pain is acceptable to each older patient (e.g., pain tolerance, discomfort level)							
22	Not knowing older patients' pain levels due to inadequate time spent with them							
23	Not knowing whether to believe the older patient's pain report or the family's perception of the person's pain instead							
24	Concentrating on administering regularly scheduled medications and not checking for and offering p.r.n. pain relief unless the patient requests it							
25	My own reluctance to give pain medication to older patients for fear of overmedicating							

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26	Inconsistent practices around giving p.r.n. medications for an older patient (because the decision to administer pain medication is up to the assigned nurse, and varies from one to another)								
27	Uncertainty about how to best time the administration of p.r.n. pain medications when ordered along with scheduled pain medications in older patients								
28	Not having a consistent way of receiving tips from nurses on previous shifts about pain assessment and management strategies for each of my older patients								
29	Lack of clinical confidence in assessing a variety of types of pain in older patients								
30	The tendency to document only if pain relief is not achieved or if the patient refuses pain medication								
Healthcare system-related barriers (10 items)									
31	Lack of opportunity to consult with clinical pharmacist about pain relief in older patients								
32	Disorganized system of care (e.g., having to hunt for narcotic keys, obtain co-signatures, find drugs, etc.)								
33	Not having a consistent way of assessing pain, from one time to the next, in each older patient								
34	Not having policies/procedures/guidelines that contribute to my knowledge of acceptable best practices around pain assessment and management in older adults								
35	Not having a documented approach to pain assessment for each older patient								
36	Not having a documented pain treatment plan for each older patient								
37	Unavailable comfort measures as alternatives/supplements to pain medications in older patients (e.g., hot/cold packs, mattresses, chairs)								
38	Inadequate time to deliver non-pharmacologic pain relief measures								
39	Inadequate time for health teaching with older patients (e.g., p.r.n. drug order, alternatives, addiction, etc.)								
40	Lack of opportunity to discuss an older patient's pain management directly with care team								

Vietnamese version of Perceived Obstacles to Pain Assessment and Management Practices Questionnaire

Nhận thức của điều dưỡng về rào cản ảnh hưởng đến thực hành quản lý đau(Cocker, Papaioannou, Kaasalainen, & CS. 2010)

Anh/chị vui lòng khoanh tròn con số dưới tiêu đề mô tả chính xác nhất tần suất mà anh/chị cho rằng các rào cản sau đây cản trở việc thực hành đánh giá và quản lý cơn đau tối ưu đối với người bệnh trong đơn vị của anh/chị.

- 1= Không bao
- 2 = Rất hiếm khi
- 3 = Hiếm khi
- 4 = Thỉnh thoảng
- 5 = Thường xuyên
- 6 = Rất thường xuyên
- 7 = Luôn luôn

TT	Nội dung	1	2	3	4	5	6	7
Rào cản thuộc bệnh nhân(11 câu)								
1	Bệnh nhân gặp khó khăn khi hoàn thành thang điểm đau							
2	Bệnh nhân ngại uống thuốc giảm đau vì sợ nghiện							
3	Bệnh nhân không muốn làm phiền điều dưỡng							
4	Bệnh nhân phủ nhận tình trạng bệnh của họ bằng cách phủ nhận bản thân đang bị đau							
5	Bệnh nhân sẵn sàng đổi mặt với cơn đau mãn tính							

Translation, and Validation of Perceived Obstacles to Pain Assessment and Management Practices Questionnaire among Vietnamese Nurses

6	Bệnh nhân ngại dùng thuốc giảm đau vì các tác dụng phụ (ví dụ: táo bón v.v.)								
7	Bệnh nhân thông báo cơn đau của họ cho bác sĩ, nhưng không cho điều dưỡng								
8	Khó đánh giá cơn đau ở một số người bệnh có rào cản về ngôn ngữ								
9	Khó đánh giá cơn đau ở người bệnh do các vấn đề về nhận thức (hôn mê, sa sút trí tuệ,								
10	Khó đánh giá cơn đau ở người bệnh do các vấn đề về giác quan (nghe kém, giảm thị lực, v.v.)								
11	Khó đánh giá cơn đau ở một số người bệnh có do tâm trạng thay đổi(trầm cảm, v.v)								
Rào cản thuộc về bác sỹ(5 câu)									
12	Sự thiếu tin tưởng của bác sĩ khi điều dưỡng đánh giá mức độ đau ở bệnh nhân								
13	Bác sĩ thiếu kiến thức và kinh nghiệm kê đơn thuốc giảm đau								
14	Bác sĩ miễn cưỡng kê đơn thuốc giảm đau đầy đủ cho bệnh nhân vì sợ phải điều trị quá mức cho những người bị sa sút trí tuệ hoặc mê sảng								
15	Thuốc chống loạn thần được bác sĩ xem xét trước khi dùng thuốc giảm đau ở bệnh nhân kích động								
16	Thái độ của một số đồng nghiệp đối với người già, bệnh nặng dù sao cũng chết nên ít chú ý đến giảm đau cho họ								
Rào cản thuộc về điều dưỡng(14 câu)									
17	Điều dưỡng khó liên lạc hoặc giao tiếp với bác sĩ khi phát hiện bệnh nhân đang bị đau								
18	Khó liên lạc hoặc trao đổi với bác sĩ để thảo luận về cách điều trị cơn đau ở bệnh nhân								
19	Không thấy cơn đau ở người bệnh trừ khi chẩn đoán cung cấp bằng chứng đau là triệu chứng tiềm ẩn								
20	Khó tin các báo cáo về cơn đau của bệnh nhân vì chúng không nhất quán từ lần này sang lần khác và không khớp với hành vi không lời của họ								
21	Không biết mức độ đau có thể chấp nhận được đối với mỗi bệnh nhân(ví dụ: khả năng chịu đau, mức độ khó chịu)								
22	Không đủ thời gian bên người bệnh nên không biết mức độ đau của họ								
23	Không biết nên tin vào báo cáo đau từ bệnh nhân hay người nhà bệnh nhân								
24	Thực hiện thuốc cho người bệnh chủ yếu chỉ tập trung vào các thuốc dùng thường xuyên mà không chú ý đến cung cấp thuốc giảm đau cần thiết trừ khi người bệnh yêu cầu								
25	Khi cho người bệnh dùng thuốc giảm đau tôi rất dè dặt vì sợ quá liều								
26	Thực hành cho người bệnh dùng thuốc không nhất quán trong khoa vì thực hiện cho người bệnh dùng thuốc phụ thuộc vào điều dưỡng phụ trách chăm sóc và phụ thuộc vào từng loại thuốc								
27	Tôi không chắc chắn về thời gian tốt nhất cho người bệnh dùng thuốc giảm đau thông thường khi được kê đơn dùng cùng với thuốc giảm đau theo lịch trình								
28	Điều dưỡng bàn giao về quản lý đau cho người bệnh giữa các ca trực không nhất quán nhau								
29	Thiếu tự tin về mặt lâm sàng trong việc đánh giá nhiều loại đau ở bệnh nhân.								

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30	Xu hướng chỉ ghi lại trong hồ sơ bệnh án nếu không đạt được hiệu quả giảm đau hoặc nếu bệnh nhân từ chối thuốc giảm đau								
Rào cản thuộc Hệ thống(10 câu)									
31	Thiếu cơ hội hỏi ý kiến được sĩ lâm sàng về cách giảm đau ở bệnh nhân.								
32	Quản lý thuốc giảm đau chưa khoa học ở khoa/phòng(Phải tìm chìa khoá tủ thuốc gây nghiện, xin chữ ký khi dùng thuốc gây nghiện, thuốc để không đúng nơi quy định....)								
33	Không có một cách đánh giá cơn đau nhất quán, từ lần này đến lần khác, ở mỗi bệnh nhân								
34	Bệnh viện không có quy trình/hướng dẫn quản lý đau giúp tôi hiểu biết về các phương pháp đánh giá và quản lý cơn đau								
35	Trong hồ sơ bệnh án không có mục để ghi chép đánh giá đau cho người bệnh								
36	Trong hồ sơ bệnh án không có mục để ghi kế hoạch giảm đau cho người bệnh								
37	Khoa không có sẵn các biện pháp giảm đau thay thế thuốc hoặc hỗ trợ cùng thuốc giảm đau cho người bệnh như ví dụ: chườm nóng / lạnh, nệm....)								
38	Không đủ thời gian để thực hiện các biện pháp giảm đau không dùng thuốc								
39	Không đủ thời gian để giáo dục sức khoẻ cho người bệnh nội dung liên quan đến quản lý đau(đơn thuốc, biện pháp giảm đau thay thế thuốc....)								
40	Thiếu cơ hội để thảo luận trực tiếp về cách quản lý cơn đau của bệnh nhân với nhóm chăm sóc								