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KNOWLEDGE AND ATTITUDES OF SURGICAL NURSES TOWARDS PAIN MANAGEMENT

MASTER'S DEGREE

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ABSTRACT

Managing patients' acute and chronic pain effectively is a major obstacle in modern healthcare. Quality of life concerns emerge as the population ages and people live longer. The primary goal of this research was to examine surgical nurses' perceptions and understanding of pain management. Participants were registered nurses with at least a bachelor's degree in surgical nursing and at least a year of experience working in a hospital setting who volunteered to take part in the study.

This research utilized primary data using validated questionnaire to determine the level of knowledge and attitude of surgical nurses towards pain management. Two hundred and 230 questionnaires were distributed in three (3) hospitals in Somalia, using proportionate and simple random method. Data was analyzed using descriptive statistics (frequency, percentages, mean and standard deviation) and inferential statistics (independent sample t-test using Special Package for Social Science version 27 for the analysis.

The result indicated that nearly half of the respondents (47.83%) are within the age bracket of 36-46 years, 55.22% of the respondents are female, and 90.87% has bachelor's degree, with 8.26% with master's degree while the remaining 0.83% has PhD. The result further indicated that 90.87% of the respondents work in the surgical unit, while less than 10% of the work in the various units other than surgical. Majority of the respondents were full time workers. The result further indicated that the respondents score more than 80% of the true or false and multiple questions related to their knowledge and attitude towards pain management. However their scores on the case studies were relatively low 48%. In relation to the hypotheses tested the result of the t-test show that there were no significant differences between gender and pain management. The result shows that there was significant difference between age and pain management, those respondents that their ages are above the mean were better in pain management than their counterpart at 5% prob. Level. In addition the analysis shows significant difference between full time workers and those on the part time basis. In relation to the level of education there no significant difference among the respondents level of education and pain management.

Nursing organizations need to invest in their staff members' growth and improvement. According to the requirements of their patients, they should formulate institutional guidelines.

Nurses, on the other hand, should push the envelope when it comes to satisfying their own curiosity. This can be aided by acquiring knowledge from peer-reviewed literature and putting it into practice.

Keywords: knowledge, attitudes, pain management, Nurse, Surgery

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ABBREVIATIONS

APS.....American Pain Society

JCAHO.....Joint Commission on Accreditation of Health Organisation

EBR.....Evidence-Based Practice

PQRST.....Provocation Quality/Quantity Region Severity Scale Timing

NRS.....Nursing

KASRP.....Knowledge and Attitudes Survey Regarding Pain

DCS.....Data Collection Sheet

ANOVA.....Analysis of Variation

SD.....Standard Devia

CHAPTER ONE

1. Introduction

Provision of adequate pain management for people experiencing acute and chronic pain is a major issue in modern healthcare. It's hardly surprising that concerns about people's quality of life would emerge as the population ages and life expectancy increases. Sadly, not all patients can verbally communicate their discomfort. Priority should be given to care and therapy based on the results of a comprehensive pain assessment. No objective tests exist to evaluate pain because it is a subjective sensation (Chou, Loeser, et al., 2009). By adhering to the Joint Commission's established guidelines for pain assessment and management, healthcare providers can demonstrate their respect for patients' dignity and safety. Patients should be assessed for pain at the beginning of care, as well as at regular intervals and when clinically indicated. Furthermore, patients are to be taught techniques for coping with discomfort (Wagner, McDonald, & Castle, 2012). Numerous studies have been conducted on the topic of inadequate pain therapy, with the seminal report appearing in (Rushton, Eggett, & Sutherland, 2003). The majority (73%) of medical inpatients reported moderate to severe pain. Furthermore, in 2002, a panel from the American Geriatrics Society revealed that 45-80% of senior patients in nursing homes experience significant pain that is untreated.

The absence of a reliable pain assessment instrument is cited by doctors and nurses as one of the most challenging obstacles to effective pain management in a study by (Wells, Pasero, & McCaffery, 2008). It's possible that nurses will get mixed signals about their roles in pain treatment. In the existing medical system, doctors are responsible for prescribing analgesics, whereas physiotherapists can use non-pharmacological methods to alleviate pain. As a result, nurses may struggle to understand how to properly include pain evaluation and intervention into their routines (Lui, So, & Fong, 2008).

According to a 2009 report by the American Pain Society, persistent non-cancer pain is a leading cause of patient visits to healthcare providers but is often poorly addressed. The "under treatment of pain and lack of information about pain management have been evident for nearly two decades," as noted in a seminal research on the subject by (Lewthwaite et al., 2011). It is

especially crucial that nurses have expertise in pain management because they are often the first line of defense against suffering.

The United States Congress designated the decade beginning in 2001 as the "Decade of Pain Control and Research" in an effort to overcome gaps in pain management. Individuals' rights to accurate pain evaluation and treatment were also recognized in 2000 when the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) established pain management criteria (Chou, Fanciullo, et al., 2009)

.Surgical nurses often have inadequate knowledge and attitudes about the pain reduction. procedures of surgical nurses have knowledge of 64.5% and an attitude of 56% within pain management whether it should be 95% and 93.3% respectively. Consequently, it has been clarified that the issue regarding lack of adequate attitude and knowledge of nurses is unable to reduce the major surgery pains of patients ((Adams, Varaei, & Jalalinia, 2020).

1.1 Aim

The study's goal is to examine surgical nurses' knowledge with and attitude on hospital pain treatment. The purpose of this study is, therefore, to assess the pain management expertise of surgical nurses and to identify the variables that may influence their choice of pain treatment. The goal is to improve nurses' knowledge and outlook on pain treatment in order to facilitate the achievement of this goal.

1.2 Research Questions

- What is the level of knowledge and attitude of surgical nurses towards pain management in the study area?
- What is the relationship between socio-demographic characteristics of nurses and pain management scores?

1.3 Statement of the Problem

There are many reasons why patients seek medical attention, but pain is one of the most prevalent and feared (Nimer & Ghrayeb, 2017). In addition to negatively impacting one's quality of life, pain increases a population's vulnerability and encourages a greater reliance on health care professionals in order to obtain proper pain treatment (Gordon & Bains, 2005). All patients,

including those who are unable to speak for themselves, must be given pain management and comfort by health care professionals in accordance with the ethical principle of beneficence (Kasasbeh, McCabe, & Payne, 2017). For pain evaluation and management, nurses play a critical role and must be aware about how to best assess and manage pain in clinical settings (Hennessee, 2012). Inadequate assessment or incorrect use of analgesics, particularly opioids, may lead to under treatment of pain (Al-Shaer, Hill, & Anderson, 2011). Barriers to successful pain management are common for both patients and healthcare practitioners. Obstacles to effective pain management can arise from a variety of sources, including patient and physician attitudes and beliefs, as well as actual or perceived legal and regulatory restrictions (Hennessee, 2012). Patients continue to suffer from inadequate pain management due to the lack of knowledge of nurses and physicians, according to a literature review conducted over the past decade (Kaasalainen et al., 2007). Numerous studies have found that nurses have a lack of understanding of pain and the medications used to treat it, as well as a negative attitude toward pain and the drugs used to treat it. There are many nurses who lack fundamental information about the mechanisms of action, dosages, and applications of various drugs, in addition to alternative pain management strategies. (Miftah, Tilahun, Fantahun, Adulkadir, & Gebrekirstos, 2017) stated that all nurses must keep up-to-date on the latest developments in the assessment and treatment of pain. They believed that everyone who suffers from pain should be treated as soon as possible. Studies have shown that nurses' attitudes and knowledge about pain treatment are lacking on the whole. As a result, patients must endure longer hospital stays and suffer lower quality of life as a result of their nurses' inability to appropriately manage pain. Under the above premise this study is conducted to assess the level of knowledge, attitude and perception of nurses in Somalia towards pain management.

1.4 Significance of Study

When trying to alleviate patients' suffering, medical personnel often fail to take the potential negative physical consequences of their care into account. In many cases, pain poses a biological risk. Studies have shown that in addition to causing stress, chronic pain can negatively affect your hormones and metabolism, heart and digestive systems, and immune system. Carbohydrate, protein, and fat catabolism, impaired glucose utilization, and other negative effects result from the endocrine system's response of releasing an excess of hormones. Weight loss, rapid heart rate, difficulty breathing, high body temperature, shock, and even death can result from this reaction when combined with the body's natural inflammatory

response. When pain isn't addressed, it prolongs the stress reaction, which has a chilling effect on the recovery process. One must rely on what a bereaved person says or does to gain insight into their emotional state. It's commonly believed that physical and mental health is inextricably linked, and that relieving a patient's pain will automatically improve their capacity and mood.

This study is operated for the sake of well-being of the patients as well as the surgical nurses. This research emphasizes the role of surgical nurses in increasing their knowledge as well as determining proper attitudes. Apart from that, it has further been found this context assists patients in mitigating major health issues due to pain.

1.5 Limitations

Despite best efforts, every study has flaws that must be accounted for. There were limitations to this study, despite the fact that it did provide a starting point for understanding the skills and outlook of nurses in Somalian hospitals. To begin, the study employed a quantitative research design to inquire into and characterize the skills and outlooks of Somali Hospital nurses. However, the knowledge gained through a quantitative research design may be too abstract and general to be directly applied to specific situations, contexts, or individuals, even though this approach was deemed the most appropriate for examining the phenomenon under investigation. The potential for bias in this study was exacerbated by its inability to include nurses from all adult nursing units. Further, the study did not examine nurses' familiarity with or attitudes toward the pain of patients with complex problems, such as those with chronic pain conditions, cognitive impairment, or who are unable to communicate verbally. Looking back on the study's progress, the researcher sees its flaws and limitations. This study's results can only be extrapolated to the nurses who work at the hospital where the research was initiated.

CHAPTER II

2. Literature Review

Hospitalized patients get stressed for pain which is managed by nurses by using their clinical knowledge and attitude. Physical and mental conditions of patients are promoted by nurses through treating their pain. Untreated pain makes a barrier in maintaining lifestyles which are managed by nurses through proper assessment of pain and delivering them appropriate medicines. Knowledge attitude and perception are the vital aspects that need to be present among nurses who are directly involved in pain management. This chapter is highlighting the benefits of knowledge and attitude of surgical nurses in pain management. Techniques that have been adopted by this nurse for measuring the sale are also analyzed in this chapter. Factors that are indulging knowledge and attitude are determined in literature so that strategies are identified for improving pain management.

2.1 Concept of Pain Management

Pain Management Pain is defined by the International Association for the Study of Pain (IASP) as "an unpleasant sensory and emotional experience connected with actual or potential tissue damage, or explained in terms of such harm" (Koch, 2012). Discomfort is a common symptom of cancer patients, and its care includes the use of both pharmaceutical and non-pharmacological measures to control the patient's recognized pain (Bader et al., 2012). Furthermore, pain treatment is linked to the patient's quality of life, his or her capacity to work successfully, enjoy recreation, and participate normally within society (Raphael et al., 2010).

Nurses are crucial in pain treatment. Untreated and undertreated pain is debilitating and interferes greatly with the patient's physical, mental, and spiritual well-being, affecting the patient's quality of life (Manwere, Chipfuwa, Mukwamba, & Chironda, 2015). According to (Lobo & Martins, 2013), pain is a common symptom in medical unit patients, and good pain management measures can successfully relieve it (Lui et al., 2008). Pain, along with other vital indicators, should be monitored on a regular basis, according to basic pain management principles (Sümer, Kaynar, Topbaş, Hassan, & Gürbüz, 2012).

Nevertheless, rather of concentrating on the patient' behavior, health care providers believe that self-report is the best technique for assessing pain (Clarke & Iphofen, 2008). The most prevalent reasons for failing to act on a patient's report of pain, particularly injectable morphine delivery, are the idea that the patient is or will become addicted to the opioids, respiratory depression, and disguising the patient's symptoms (Manwere et al., 2015). Nurses' knowledge of pain treatment is lacking, with the most inaccurate answers on pharmacology and pain assessment, despite evidence showing that if health care workers assess and treat pain before it becomes severe, sensitization is avoided and less medication is used (Omran, Al Qadire, Ali, & Al Hayek, 2014). Nurses are also in charge of offering non-pharmacological therapies to patients as an adjunct to pharmacological interventions in order to maximize pain alleviation. Non-pharmacological therapies are divided into two categories: cognitive and physical Music and relaxation are two cognitive strategies that focus on mental functioning. Massage and the application of heat and cold are two physical therapies that focus on modifying physiological processes to decrease pain (Bicek, 2004).

2.2 Importance of Pain Managements

To provide quality treatment, pain management and patient satisfaction are critical. Pain has an impact on one's health, physical functioning, social ties, and mental well-being. Pain is also linked to increased symptoms such as fatigue, sleep disruption, loss of appetite, and worry. Pain, if left untreated, can have major harmful consequences. Involving increased hospital utilization, increased length of stay, and increased costs. Inadequate pain control may be caused by a lack of knowledge about pain evaluation among nurses and other medical providers, preconceptions about medication usage, violence, and diversification, as well as misunderstanding about the extent of analgesia therapy. Pain intolerance was a well-known impediment to good control. The World Health Organization (WHO) recommends developing pain-relief policies and methods. Experts can help you improve your pain management abilities and attitudes. Changing method, on the other hand, is more challenging, but it is doable, with far more targeted educational initiatives in the therapeutic setting.

Numerous studies have demonstrated how widespread the impact of technology on the development of pain consciousness among nurses is.

Doctor and Columbia University pain medication department head Sean Johnston co-sat on the NPS Supervisory Committee and oversaw the program's intervention and care, explaining that the program's goal is to provide "physician, interdisciplinary, kindness, better informed, and personalized care to any patient who is experiencing torture." (Mittal & Bavari, 2020).

Dr. Mackey, a recent member of the American Academy of Pain Medicine (AAPM), was also on an 18-part plan to deal with these erratic situations. Finally, it will lead to giving individuals undergoing agony a wide range of administrations that already exist yet are not immediately accessible for everyone." The majority of today's open administrators can be found at the Sanford Pain Management Institute, which was identified by the American Pain Society as a center of excellence which became a benchmark for bio - psychosocial pain therapy.

2.3 Knowledge and attitudes of surgical nurses that facilitates in pain management

Mazilu, Zazu, Nedelcu, and Sfetcu (2018) stated in article that documentation has been conducted by nurses for recording pain assessment which supports in structuring treatment plans. Health condition of patients is improved by offering them proper medical scientific processes to manage the pain. Psychological conditions of patients are controlled by nurses through discarding negative attitudes as well as misconception regarding pain. As per views of (Tong, Lucas, Shah, Foote, & Simhan, 2018), nurses need to have analgesic technique knowledge so that postoperative pain has been managed by proper assessment. For instance, postoperative pain enhances the risk of pulmonary complications in case of open-heart surgery. Lack of training regarding assessing nociceptive, as well as non-nociceptive signals of dynamic pain, create complications in pain management. Brothers, Viera, and Heimer (2021) discussed in article that perception and attitude of nurses influences pain management through implication of behavioral approach. Knowledge regarding pain management facilitates nurses in terms of determining characteristics of patients that support the elimination of biased pain management decisions. Gender-related personality creates complication in managing pain in terms of scaling pain based on their gender stereotyping concept. Sex differences explore pain sensitivity responses which create negative impact on psychological and physiological condition of patient. Most authors like, Munkombwe, Petersson, and Elgán (2020) mentioned that non-pharmacological pain management is conducted by nurses through utilizing their knowledge regarding therapies which explore positive approach while responding to the patient Compared with the previous context,

pharmacological pain management is conducted by surgical nurses through incorporating knowledge regarding opioid dependence and its tolerance by patients.

2.4 Role of surgical nurses in measuring pain

Zaccagnino, Bader, Sang, and Correll (2017) explained in an article that acute postoperative pain has been managed by surgical nurses through assessing morbidity rate. Risk factor such as side effect of pain killer and its complication has been identified by nurses for delivering healthcare to the patients who are in pain. Psychological conditions of service users decline due to preoperative pain and enhance pain sensitivity. Surgical nurses involved in managing coherent risk factors through assigning current evidence that highlights factors which increase pain. Apart from this, scientific method has been implemented for overcoming complications which occur for pain after surgery.

Drake and Williams (2017) stated that nursing training highlights pain education so that reports of the patients are assessed in a proper manner based on clinical guidelines PQRST is a pain assessment tool that supports the selection of medicine that relieves pain. P stands for provocation is a part that helps in identifying factors that cause pain so that medicine is provided according to the risk factor. Q stands for quality or quantity which supports nurses in estimating rate of pain. On the other hand, R stands for region that supports in determining location of pain for localizing medicine dose to accurate site. However, S stands for severity scale that is counted through rating scale of 0-10. On contrary, T stands for Timing which focuses on the duration of pain though addressing signs and symptoms of patients.

van Dijk, Schuurmans, Alblas, Kalkman, and van Wijck (2017) opined that Lack of accurate perception regarding postoperative pain by nurses create challenges in scoring pain severity. Opioids have been served to patients for relieving pain after operations. However, lack of knowledge regarding the negative impact of opioids in terms of delivering high doses may create issues. NRS scores has been another technique that is adopted by surgical nurses which measure treatment that are offered for overcoming post-operative pain. Addiction is a post impact of opioid consumption which has been considered as a side effect of medicine that relieves pain may become a risk factor of health challenges. Pneumonia and thrombosis are the issues that may occur in terms of excess dose of opioid for relieving pain after surgery. Thus, NRS scales are counted through scoring from 4-6. In this specific situation, >4 is unbearable which refuses analgesics and nurses need to provide medicine that controls pain based on guidelines.

2.5 Critical analysis of factor that influences knowledge and attitude of nurse towards surgical pain management

Patricia et al. (2017) claimed in article optimal level of comfort are analyzed by nurses through implication of their knowledge which supports them in achieving the goal of pain management. Pain education influences nurses in indicating pain that supports Healthcare professionals in terms of delivery of adequate medicines to them. Additionally, quality care has been provided by nurses through aligning their theoretical knowledge with their practical expectations. In comparison with previous contact, changing demand for healthcare also influence nurses to involve in an education programs that boosts their knowledge regarding pain management. Pre-emptive analgesia concepts influence nurses to focus on patients' autonomy. Linking with previous context multi-disciplinary approaches that indulge mental condition of a patient and it helps in recovery from pain for the case of non-pharmacological pain.

As opposed by Olufunke (2018), pain assessment is a patient care goal which influences nurses regarding aligning their knowledge for accessing pain that is experienced by patient for their pre-existing disease. Nursing workload has become a major factor that shows a loss of motivation and attitude towards patients. Conductive working environment produces motivations for nurses to assess pain by applying a pain assessment tool. Improper implementations of protocols that are used for pain assessment generate complications in documenting pain. On a similar note, professional behavior supports nurses about communicating with patients and it helps in charting pain.

Fitzgerald, Tripp, and Halksworth-Smith (2017) outlined that ethical approval has become another factor that supports nurses in executing clinical practice by utilizing their professional behavior. Professional behavior supports in determining hidden pain of patients through communication and it has been documented in a professional mechanism. Documentation of plans supports healthcare providers in structuring pharmacological as well as non-pharmacological strategies for offering optimal care to the patients. Additionally, interpersonal skill is vital for nurses that support in structuring patient-nurse relationships and promote better pain management.

2.6 Issues faced by surgical nurses during pain management

Mędrzycka-Dąbrowska, Dąbrowski, Gutysz-Wojnicka, Basiński, and Kwiecień-Jaguś (2018) claimed that lack of technical advancement creates issues for surgical nurses in terms of delivering high-quality care to the post-surgical patients through relieving their pain. On a similar note, untreated pain creates acute neurohormonal changes which lead to enhanced anxiety and complication rate. On the other hand, poor pain education makes a barrier in evidence-based practice (EBP) that supports in structuring health care decisions. Another challenge that is faced by surgical nurses who are directly involved in a surgical department is workload. Excess pressure on nurses about measurement of health conditions on a daily basis creates limitations in focusing on pain that are experienced by patients. However, lack of practical knowledge creates problems in aligning knowledge which is gained during nursing education and it increases time for structuring decisions for pain management.

2.7 Gap in literature

This literature is focusing on the importance of knowledge and attitude among surgical nurses for pain management. Additionally, techniques that are adopted by nurses for measuring pain are also focused in this chapter. However, interrelationship between pain educations with nursing workload has become the limitation of this literature. Both this factor is influencing surgical nurses in aligning their knowledge and

CHAPTER III

3. Material and Method

3.1 Research Design

Researcher of this research has chosen descriptive research design and for determining the knowledge and attitudes of the surgical nurses in an effective manner. It has further been analyzed that descriptive research design has aided this research in obtaining the solutions to the research questions by scrutinizing the data collected from the surgical nurses.

3.2 Study Setting

This study was conducted by in three selected hospitals that represent the health care sector in the city of Somalia Mogadishu and they are the biggest hospitals that are working 24 hour available we have Martini Hospital, Rajib Dayib Ordugan Hospital, and Banadir Hospital. Total sample size for this research is 230 nurses, 88 nurses where from Banadir Hospital, 77 nurses where from Rajib Dayib Ordugan Hospital and finally 68 nurses where from Martini Hospital.

All selected hospitals were referral hospitals. Nurses who work in the surgical ward, and surgical intensive care units in each hospital were invited to participate**.**

3.3. Formula of Sample/ sample selection

The study used Yenane's formula for sample selection which is one of the widely used formula for survey study in social and medical sciences (Wudil, Ali, Hassan, & Mushtaq, 2021). The study was performed on the surgical nurses who work in the three chosen hospitals from the total of 287 nurses work in the three selected hospital, 230 were sampled (Table 3.1). Before administering the questionnaire permission were granted by the government of Somalia and management of the hospitals. The participants were asked for their consent and voluntary participation in the study. However, all nurses participated in the study have at least one year working experience, this is done ensure that only experienced nurses are included in the study. The formula used for the determination of sample size is presented below;

$$n = \frac{N}{1 + N(e)^2}$$

Where;

N= Population

n= sample size

e= Margin of error

Table 3.1. Sampling Procedure

Hospital selected	Number of registered nurses (Population)	Sample size
Banadir Hospital	109	85
Ordugan Hopital	96	77
Martin Hospital	82	68
Total	287	230

Source: Author's computation

3.4. Study Tools

The surgical nurses' responses were collected using a data collection sheet (DCS). The DCS asked questions about the sex, age, employment, education, region, and years of clinical experience of the participants (nurses). Statistics on pain management were gathered using a validated knowledge and attitude survey (KASRP). There are a mix of likert scale and yes/no questions among the questionnaire's 41 items. The test was designed to evaluate the nurses' understanding of pain and their approach to treating it. The survey's demographics section consisted of 5 questions. Frequency tables and percentages were used to summarize the resulting category data in the demographic section. There were additional 12 multiple-choice questions designed to glean information about the respondents' pain management knowledge and outlook. In addition, 15 multiple-choice questions were included, testing knowledge of pain management, pain evaluation, and analgesic administration.

The KASRP is the only tool for assessing nurses' pain management expertise (McCaffery, Ferrell, & Pasero, 2000). The total score is a perfect 100, which indicates that respondents' knowledge

and attitudes towards pain treatment fall somewhere between the lowest (bad) and highest (excellent) categories. Scores below 50% are considered poor, scores between 50% and 75% are considered adequate, and scores above 75% are considered excellent. Due to the lack of interaction between the researcher and the participants, the use of closed-ended questions provides a level of anonymity that would otherwise be impossible.

The American Pain Society, the World Health Organization, and the Agency for Health Care Policy and Research all contribute to the development of standards for the management of pain, which were utilized by a group of pain specialists in order to validate the content of the KASRP. It is not necessary to get permission from the authors in order to use this KASRP survey tool for academic purposes as doing so is not required. It has been decided to write the paper in English due to the fact that nurses are fluent in the language.

The Cronbach's alpha for the KASRP shows dependability (>0.7 in both the knowledge and attitude domains), and test-retest reliability ($r > 0.8$) has been established. It will take about fifteen to twenty minutes to complete the questionnaire. Two trained enumerators were used to administer the surveys to respondents face to face. Researchers individually collected all of the completed questions. While this was happening, the questionnaires' actual content was reviewed for omissions, and the data was cleaned up in preparation for analysis. After receiving approval from the Near East University Northern Cyprus Deanship of Health Sciences Ethic Committee, the researchers began recruiting individuals. Registered nurses who expressed an interest in participating in the study were approached and requested to sign a consent form.

3.5 Data Collection

The data was collected between March and May 2021. The surgical nurses who agreed to participate in the study were included in this study.

3.6 Data Analysis

Statistical analysis was performed using SPSS, version 27. (SPSS Inc., Chicago, Illinois, USA). For categorical variables, results were presented in the form of percentages, whereas for continuous variables, we provide mean values and standard deviations. Using the Independent t-test, we compared the average total scores of males and females and those with and without prior exposure to pain education. The average total knowledge score and the average degree of

schooling were both determined using analysis of variance (ANOVA). The degree of association between the variables was calculated using the Spearman correlation. In this study, a p-value of less than 0.05 was judged to be statistically significant.

3.7. Ethical Considerations

Maintaining appropriate respect among participants, regardless of their personalities, is a cornerstone of research ethics. The researcher has been given clearance to collect data by all three of Somalia's hospitals. Once the researcher received the official permits (APPENDIX 4) from the two administrative institutions participating in the investigation, data collecting began immediately. The questionnaire (APPENDIX 1) was accompanied by a cover letter (APPENDIX 1) that assured respondents that their anonymity and confidentiality would be maintained and that their participation was entirely optional. Participation in the study and the return of the completed questionnaires in an envelope ensured that all participants had read and understood the study's procedures and had given their informed consent.

In order to protect respondents' privacy, the researcher had the nurse manager mail out all of the questionnaires in sealed envelopes. Questions were answered and packed in an envelope and returned. Since only the researcher saw the completed surveys, participants' privacy was protected. SPSS was then used to digitized the collected information (version 27). The articles used in this thesis are trustworthy since they are both recent and relevant to the research topic in practically all of the ways that were taken into account.

In addition, the researcher relied heavily on recent scientific studies, both in general and in terms of the specific portions used to inform this investigation. Even the questionnaire's creators (McCaffery et al., 2000) have proven the question's validity. For added assurance, the questionnaire's original authors (McCaffery et al., 2000) have additionally confirmed the question's validity.

CHAPTER IV

RESULTS

4.1 Demographics

From the analyzed data collected from the respondents, it can be deducted that majority of the respondents (47. 83%) were in the age category 36-46 years, slightly more than 29% of the respondents were in the age category 18-28 years, 20.43% were in the age category of 37- 44 years, while the least percentage of 2.61% were above 45 years of age (Table 4.1).

The analyzed data also showed that most of the nurses were females (55.22%) which are an indication that females are more inclined with the profession, while 44.78% of the respondents were males. The level of education of the respondents were also analyzed and it was found that majority of the surgical nurses had a bachelor degree (90.87%), 8.26% of the respondents had masters degrees, while only 0.87% of the nurses had doctorate degrees as seen in Table 4.1.

The working area in the clinics is also an important criterion and it was deducted that majority of the respondents worked as surgical nurses in the surgery unit (94.78%), while the remaining 5.228% work in other unit of the hospitals. In relation to the occupation status, result in Table 1 also indicated that majority of the respondents work full time (80%) while 20% of the surgical nurses work on part-time basis.

Table 4.1. Socio Economic characteristics of the Nurses

Variables	Frequency	Percentage
Age of the Respondents		
18-28 years	67	29.13
29-36	110	47.83
37-44	47	20.43
45 and above	6	2.61
Gender		
Male	103	44.78
Female	127	55.22
Educational Level		
Bachelor	209	90.87
MSc.	19	8.26
Doctorate	2	0.87
Occupational Status		
Part time	46	20
Full time	184	80
Working area of the nurses		
Surgical Nurse	218	94.78
Intensive care Unit (ICU) nurses	12	5.22

Total	230	100

Source: Author's computation

4.2 Indicators of Attitudes and Knowledge of the Surgical Nurses towards Pain

Table 4.2 presents the result of the attitude of the nurse in the study area towards pain managements. About 22 questions of true or false and their responses were recorded and analyzed in Table 4.2. Result indicated that 97.39% of the respondents correctly do not agree with the statement that says; vital signs are always reliable indicators of the intensity of a patient's pain. Majority (97%) of the respondents disagrees that children under two years of age have decreased pain sensitivity and limited memory of painful experiences due to under developed nervous system.

Patients are able to sleep in spite of severe pain, according to 228 (98%) of those who responded, and aspirin and other non-steroidal anti-inflammatory agents are NOT effective analgesics for painful bone metastases, according to 222 (96%) of those who responded. The majority of respondents (211, or 91%) agreed that distraction can lessen the intensity of pain, and 228 (98%) of those who responded agreed with this statement (Table 2). Two hundred twenty-seven of the respondents, or 97 percent, agreed that respiratory depression rarely occurs in patients who have been receiving stable doses of opioids over a period of months, and 228 of the respondents, or 98 percent, agreed that combining analgesics that work by different mechanisms (for example, combining an NSAID with an opioid) may result in better pain control with fewer side effects than using a single analgesic agent.

Two hundred twenty-six of the responders, or 98 percent, do not agree with the statement that the typical duration of analgesia produced by 1-2 mg of morphine administered intravenously is 4-5 hours. Opioids should not be used in patients who have a history of abusing substances, according to 96% of those who responded, and similarly, the results suggest that 98% of those who did reply do not favor the assertions that say elderly individuals cannot tolerate opioids for pain relief. In addition to this, 97% of those who participated in the survey believe that patients should be urged to endure the maximum amount of pain feasible before turning to opioid medication.

The vast majority of those who took part in the survey, 217, or 98%, are in agreement with the statement that patients' spiritual beliefs might lead them to believe that their pain and suffering are necessary.

The result in Table 4.3 indicates that majority of the respondents have goo knowledge about the correct doses of the pain medication treatment. Virtually all the statements were correctly answered by the respondents is presented in Table 4.3.

Table 4.2: Indicators of Attitudes and Knowledge of Nurses in the study area towards Pain

Variables	True	False
The severity of a patient's pain may always be gauged by checking their vitals.	6 (2.61%)	224(97.39%)
Children under the age of two have reduced pain sensitivity and limited recollection of painful experiences due to the immaturity of their nervous system.	6(2.61)	224(97.39%)
In most cases, patients who are easily distracted do not experience acute discomfort.	19(8.26%)	211(91.74)
Patients may be able to sleep despite intense suffering.	226(98.26%)	4(1.74%)
When it comes to relieving the pain of bone metastases, over-the-counter NSAIDs like aspirin are completely ineffective.	8(3.48%)	222(96.52%)
Patients who have been on constant opioid dosages for several months rarely get respiratory depression.	223(96.96%)	7(3.04%)
Better pain control with fewer side effects may be achieved by combining analgesics that function by distinct mechanisms (such as an NSAID and an opioid).	226(98.26)	4(1.74%)
Analgesia from 1–2 milligrams of morphine intravenously often lasts 4–5 hours.	4(1.74%)	226(98.26%)
Patients with a previous history of substance misuse should not be prescribed Opioids	5(2.17%)	225(97.83%)
Opioid pain relievers are not safe for the elderly.	3(1.30%)	227(98.70%)
Patients should be urged to suffer through as much discomfort as they can stand before they are given an opioid.	6(2.61%)	224(97.39%)
Because children under the age of 11 cannot accurately describe pain, physicians should rely only on the parent's judgment of the child's level of discomfort to determine the child's level of pain.	7(3.04%)	223(96.96%)
Patients may be misled into thinking that their discomfort and suffering are inevitable due to the spiritual beliefs they have.	227(98.70%)	3(1.30%)

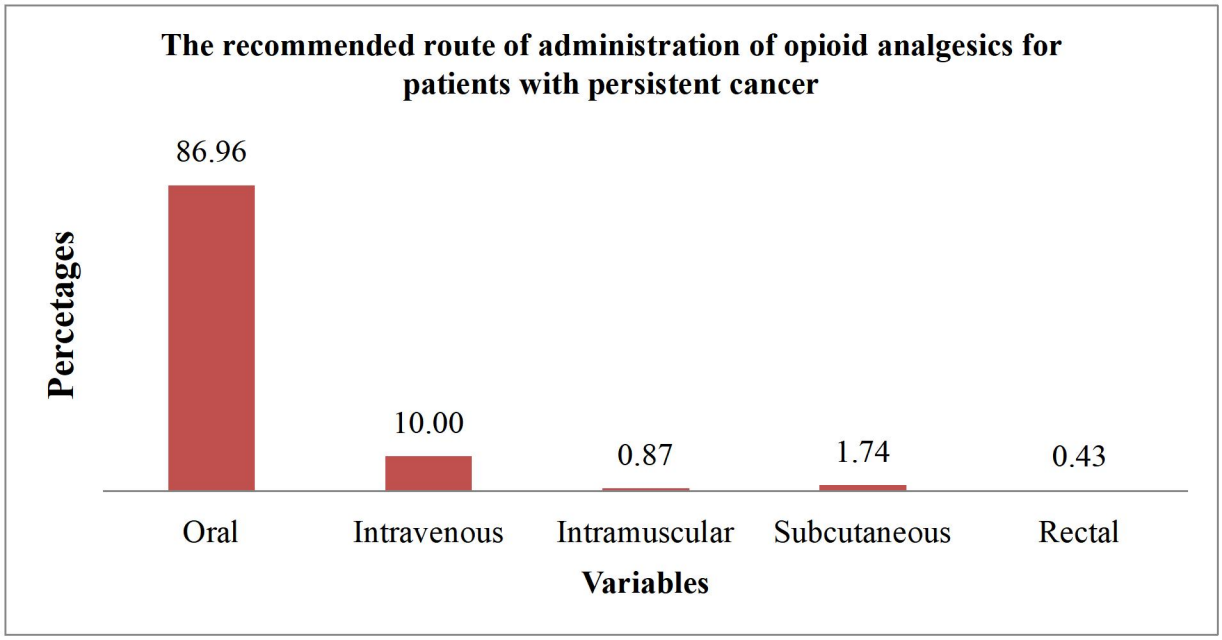
*** Numbers outside the parentheses are frequencies

Table 4.3: Indicators of Knowledge towards Pain

Variables	True	False
Following the administration of the initial dose of an opioid analgesic, successive doses should be modified in accordance with the reaction of the particular patient.	221(96.09%)	9(3.91%)
It is possible to determine whether or not the patient is experiencing true pain by injecting them with sterile water as a placebo.	12(5.22%)	218(94.78)
The oral administration of Vicodin (hydrocodone 5 mg and acetaminophen 300 mg) is approximately equivalent to the oral administration of 5-10 mg of morphine.	222(96.52%)	8(3.48%)
Opioids shouldn't be taken during the pain evaluation phase if the patient's pain source is unknown, as doing so could obscure the diagnosis.	5(2.17%)	225(97.83%)
One dose of an anticonvulsant like gabapentin (Neurontin) is all that's needed to provide effective pain relief.	5(2.17%)	225(97.83%)
As a result, benzodiazepines are not suggested as part of an analgesic regimen, despite popular belief to the contrary.	224(97.39%)	6(2.61%)
Addiction to opiates or other narcotics is considered a chronic neurobiological disorder characterized by the following set of behaviors: the inability to stop using drugs despite negative consequences and engage in risky behavior while high is all symptoms of addiction.	221(96.09)	9(3.91%)
The phrase equianalgesia refers to the degree of pain relief provided by different doses of analgesics, and its meaning is "roughly equal analgesia."	225(2.17%)	5(97.83%)
Since excessive sedation is a precursor to opioid-induced respiratory depression, assessing sedation levels is prudent when utilizing opioids for pain management.	204(86.70)	26(11.30%)

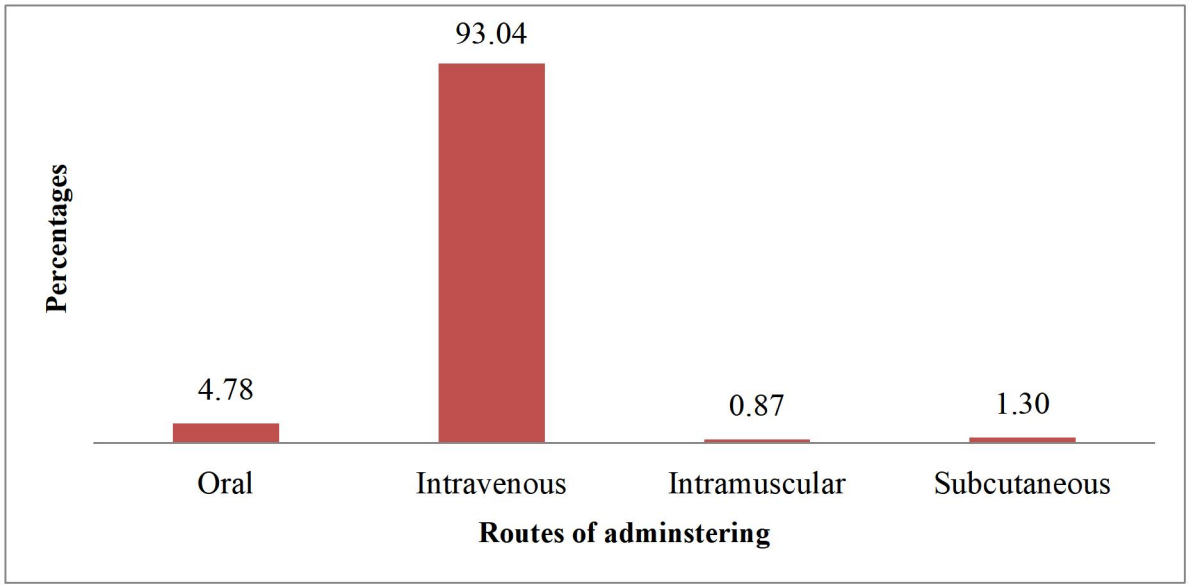
*** Numbers outside the parentheses are frequencies

Figure 4.1. Responses of the respondents about route of delivery for opioid analgesics indicated for patients with advanced cancer



Result in Figure 4.1 indicates that majority of the nurses (86.96%) were of the opinion that the recommended route of administering opioid analgesics for patient with persistent cancer is oral administration, 10% intravenous, 1.74% subcutaneous while less than 1% each for intramuscular and rectal.

Figure 4.2. Recommended route of administration of opioid analgesics for individuals with transient, intense pain of unexpected onset, such as trauma or postoperative pain



As indicated in Figure 2, majority of the nursed stated that the recommended route of admiration of opioid analgesics for patients with brief severe pain of sudden onset, such as trauma or postoperative pain is intravenous 93.04%, some 4.78% recommended oral administration, while 0.87% and 1.3% of the respondents recommended intramuscular and subcutaneous respectively.

Table 4.4: Analgesics people with cancer say work best for relieving moderate to severe pain for an extended period of time

Medications	**Frequency**	**Percentage**
Codeine	12	5.22
Morphine	215	93.48
Meperidine	1	0.43
Tramadol	2	0.87
Total	**230**	**100**

Result in Table 4.4, indicates that majority (93.48%) of the respondents considered Morphine as the best drugs for the treatment of prolong moderate to severe pain for cancer patient, 5.22 of the respondents choose Codeine, while less than 1% each choose Meperidine and tramadol.

Table 4.5: Responses of the nurses about Morphine IV equivalent of 30 mg dose of oral morphine

Medications	**Frequency**	**Percentage**
Morphine 5 mg IV	**15**	**6.52**
Morphine 10 mg IV	**211**	**91.74**
Morphine 30 mg IV	**2**	**0.87**
Morphine 60 mg IV	**2**	**0.87**
Total	**230**	**100**

As presented in Table 4.5, the respondents were asked the equivalence of 30mg dose of oral morphine. The results indicated that over whelming majority of the respondents (91.74%) of the respondents claimed that Morphine 10 mg IV is approximately equivalent to 30 mg dose of oral morphine. In addition to that some 6.52% claimed that it is approximately morphine 5 mg IV,

while the infinitesimal percentage of less than 1% each goes to Morphine 30 mg IV and Morphine 60 mg IV.

Table 4.6: Distribution of the respondents about how analgesics for post-operative pain should initially be given

Variables	Frequency	Percentages
Around the clock on a fixed schedule	206	89.57
Only when the patient asks for the medication	13	5.65
Only when the nurse determines that the patient has moderate or greater discomfort	11	4.78
Total	100	100

Table 4.6, presents the result of the distribution of respondents about how post-operative pain should initially be given. Result shows that approximately 90% of the respondents' responses said that it should be around the clock on a fixed schedule. Moreover, 5.65% of the nurses interviewed opined that it should be only when the patient ask for the medication. The remaining 4.78% said that the analgesics should be given only when the nurse determines that the patient has moderate or greater discomfort.

Table 4.7 Respondents responses about the clinical statement that says “A cancer patient's daily opioid analgesic regimen has been going strong for two months now. The patient was on an intravenous morphine regimen of 200 milligrams per hour yesterday. He has been getting 250 milligrams every hour intravenously all day. When no other medical problems arise, the patient's risk of getting clinically significant respiratory depression is"

Responses	Frequency	Percentages
Less than 1%	219	95.22
1 -10%	10	4.35
11-20%	1	0.43
Total	230	100

Table 4.7 present the result of the surgical nurses about their view on the significant respiratory depression in the absence of new comorbidity. Result indicated that 95.22% of the respondents said the significant of respiratory depression in the absence of new morbidity is less than 1%. Among the respondents, 4.35% said it should be between 1-10%, while 0.43% equivalent to 1 respondent claimed that it could be between 11-20%.

Table 4.8. The most common justification for a pain patient to ask for more medicine is;

Responses	Frequency	Percentages
The pain level of the patient has escalated.	212	92.17
The patient's anxiety or despair levels are rising.	06	2.6
The patient is expressing a desire for increased caregiver involvement.	-	-
Addiction is the driving force behind the patient's demands.	12	5.22
Total	230	100

Source: Author’s computation

Respondents were asked to give the most likely reason a patient with a pain would request increased dose of pain medication Table 4.8. Result indicated that significant portion of the respondents (92.17%) claimed that this can be attributed to the increase pain by the patient. 2.6% says that this is an indication that the patient is experiencing increase anxiety or depression.5.22% were of the opinion that The patient's requests are related to addiction. Similarly, none of the respondents related this to the patient request for more staff attentio

Table 4.9. Distribution of the respondents based on the most useful meication for treatment of cancer pain

Responses	Frequency	Percentage
Ibuprofen (Motrin)	12	5.22
Hydromorphone (Dilaudid)	-	-
Gabapentin (Neurontin)	1	0.04
All of the above	217	94.35
Total	230	100

To further investigate the knowledge of the surgery nursing regarding pain management, the respondents were asked about the most useful treatment for cancer pain. The result (Table 4.9) indicates that virtually 95% of the respondents were of the opinion that all the pain relievers (Ibuprofen, Hydromorphone and Gabapentin) were all useful in cancer pain. More over 5.22% were of the opinion that Ibuprofen (Mortrin) is the most effective.

Table 4.10. Respondents' assessment about the most accurate judge of the intensity of the patient's pain

Responses	Frequency	Percentage
The treating physician	13	5.65
The patient's primary nurse	6	2.61
The patient	211	91.74
The pharmacist	-	-
The patient's spouse or family	-	-
Total	230	100

Respondents were asked to state the accurate judge to explain the intensity of the patient's pain Table 4.10. The result shows that 91.74% of the respondents justifies that the most accurate judge of the intensity of pain is the patient himself. However, some 5.65% suggested that the treating physician could be a good judge to explain the intensity of patient pain. The least number of respondents (6) which is about 2.61% claimed that the most accurate judge could be the patients' primary nurse

Table 4.11: How likely it is that patient who develops pain already have an alcohol and/or drug abuse problem?

Responses	Frequency	Percentage
< 1%	11	4.78
1 – 15%	214	93.05
16 - 30%	-	-
31 - 45%	-	-
> 45 %	5	2.17
Total	230	100

Respondents were asked about the likelihood that patients who pain might already have an alcohol or drug abuse Table 4.11. The result of the analysis indicates that 93% of the respondents obliged that the likelihood is 1-15%, 4.78 of the respondents were of the opinion that, they might be less than 1% while the least percentage of 2.17% claimed that they might be greater than 45%.

Table 4.12: Distribution of the respondents about the time required for peak effect of morphine

Responses	Frequency	Percentage
15 min.	222	96.52
45 min.	5	2.17
1 hour	2	0.87
2 hours	1	0.44
Total	230	100

Table 4.12 presents the result of time lag for the peak effect of morphine 1V. the responses shows that almost all of the respondents 96.52% says that it takes just 15 minutes for peak effect of morphine 1V. This means that the injection takes very little time to release it is full effect.

Table 4.13 Respondents responses about the minimum time to peak effect for morphine given orally

Responses	Frequency	Percentage
5 min.	1	0.44
30 min.	-	-
1 – 2 hours	226	98.26
3 hours	3	1.3
Total	230	100

Table 4.13 present results of the respondents' responses about the minimum time to peak effect for morphine. The result indicates that overwhelming majority of the respondents 98.26% selected 1-2 hours, 3 respondents (1.3%) selected 3 hours while only one person 0.44% selected 5 minutes.

Table 4.14 The following symptoms of physical dependence on opioids appear after their use has been suddenly stopped:

Responses	Frequency	Percentage
Patients experience diarrhea, yawning, sweating, and agitation after suddenly stopping opioid use.	221	96.09
Reduced ability to resist drug use, dependence, and yearning	3	1.30
There must be greater dosages to produce the same results.	2	0.87
a and b	4	1.74
Total	230	100

When an opioid is suddenly stopped, the physical dependence symptoms are shown in Table 4.14.

Sweating, yawning, diarrhea, and agitation are all symptoms of physical dependency on opioids, as reported by the vast majority of respondents (96.09 percent). Abruptly stopping opioid use

results in physical dependence, as indicated by increased tolerance for the drug, reduced self-control about drug use, and increased cravings, according to less than 5% of responders.

Table 4.15. Which statement is true regarding opioid induced respiratory depression?

Responses	Frequency	Percentage
More common several nights after surgery due to accumulation of opioid.	4	1.74
Obstructive sleep apnea is an important risk factor.	223	96.96
Occurs more frequently in those already on higher doses of opioids before surgery.	3	1.30
Can be easily assessed using intermittent pulse oximetry.	-	-
Total	230	100

The respondents were asked about opioid induced respiratory depression Table 13. The result indicates that majority of the respondents (96.96%) hold the view that the obstructive sleep apnea is an important risk factor for opioid-induced respiratory depression.

Summary of the percentages of correct responses of multiple choice questions)

The major goal of this study was to assess surgical nurse knowledge and attitudes regarding pain and its management as a first step in educational and strategic management projects to improve nursing pain education and pain control and management. Overall, the findings show that surgical nursing understanding of and attitude toward pain in Somalia is positive. It was noteworthy that the average score was 84.1%, demonstrating excellent levels of pain management knowledge and attitudes. As a result, in comparison to worldwide norms, the respondents appeared to have acceptable understanding of pain assessment and management. Such a top rating implies that Somalian nurses are well-versed in pain management and have received enough pain management training. The findings of this study contradict prior research

findings about the issue of poor pain management among nurses (Jamshidi-Kia, Lorigooini, & Amini-Khoei, 2018).

The pain knowledge of the respondents was consistent. Although more than 50 % of the respondents agreed that the patients was the most accurate judge of pain intensity, the majority of them mistakenly rated the pain intensity as the patient's self-reported, which was consistent with (Yava et al., 2013). This study also discovered moderate to good understanding in major areas of medication. The majority of the KASRP items are pharmacology-based questions that are relevant in pain treatment. The finding is consistent with other research' findings (Evans & Mixon, 2015). In certain research, the most often incorrect items were mostly linked to pain medicine understanding and administration.

In this study, however, responders indicated excellent knowledge of drug and administration. This study found that respondents had a solid understanding of the activities, routes of administration, adverse effects, tolerance, and dependence associated with the clinical use of analgesic medicines. The study's findings indicated that surgery nurses in the study area had adequate knowledge in the following areas: 1) the use of analgesics, duration of analgesia action, equivalent doses of analgesia, and side effects, 2) the likelihood of developing addictive behavior and respiratory distress, and 3) assessment and integration abilities in making clinical pain assessment and interventions (as reflected in items related to the case studies).

Although the respondents' overall knowledge and aptitude scores were relatively high, they also demonstrated strength in certain areas of the pain management knowledge test. For example, more than 90% of students correctly identified patients as the most accurate and dependable judge of their own suffering.

Table 4.16. Summary of the percentages of correct responses of multiple choice questions (N = 230)

Q/N	Question/ statements	N and %
	The suggested path of administration of opioid analgesics for patients with obstinate cancer-related pain is	200 (86.96)
	Opioid analgesics are best given intravenously to patients experiencing acute pain that has a rapid onset but short duration, such as that caused by trauma or surgery.	214 (93.04)
	Which of the following analgesics is most often prescribed to cancer patients for the management of persistent moderate to severe pain?	215 (93.48)
	A 30 mg dose of oral morphine is roughly corresponding to:	211 (91.74)
	Analgesics are the first line of defense against the pain that comes after surgery.	206 (89.57)
	Two months into daily opioid analgesic treatment for cancer-related pain, the patient's condition has not improved. The patient was on an intravenous morphine regimen of 200 milligrams per hour yesterday. Intravenous doses of 250 milligrams per hour have been given to him today. With no additional co-morbidities, the patient's risk of developing clinically severe respiratory depression is:	216 (95.22)
	In most cases, a patient's need for more powerful painkillers comes from one of the following:	212 (92.17)
	Which of the following is an effective method for treating the discomfort associated with cancer?	217 (94.35)
	The following factors provide the most reliable indication of the degree to which a patient is experiencing pain:	211 (91.74)
	How probable is it that people who acquire pain already have a problem with abusing substances like alcohol or drugs?	214 (93.05)
	The amount of time needed for intravenous morphine to reach its peak impact is	222 (96.52)
	When taken by mouth, morphine takes around an hour and a half to reach its maximal impact.	226 (98.26)
	Following the sudden cessation of opioid use, the following signs and symptoms of physical dependence will become apparent:	221 (96.09)
	Which of the following statements on the respiratory depression caused by opioids is correct:	223 (96.96)

Case Study

The two patient case studies were utilized to examine nurses' abilities to make sound judgements about pain assessment data and actions (Table 4.17). The findings indicated that nurses may mistake a grimacing patient's pain score for that of a smiling patient, even if both patients reported the same pain level. The results showed that respondents gave the smiling patient a lower pain score than the grimacing patient and provided the smiling patient a lower dose of analgesia. As a result, when the patient frowned, more students properly judged pain than when the patient smiled. The study found that students assessed discomfort based on the patient's looks rather than the patient's remarks.

Unfortunately, based on the evaluation results, only 6.7% of students in the first case study and 10% in the second case study indicated that they would deliver the appropriate dosage of morphine. One possible explanation for this finding is that this sample of surgical nurses requires additional training in case studies and understanding the concentration of opioid dosages and their delivery. These findings are comparable with thos Furthermore, numerous studies have found that nurses tend to underestimate their patients' pain level and under-administer painkillers (Bird & Wallis, 2002; Dihle, Bjølseth, & Helseth, 2006). The gap that occurred between the assessment and the students' choice of interventions is also cause for worry. Even when nurses correctly assessed the patients' discomfort, some chose to administer a poor dose or no pain medicine at all. This outcome is comparable to that reported by (Al-Khawaldeh, Al-Hussami, & Darawad, 2013; Evans & Mixon, 2015).

4.17 CASE STUDIES

Cases	Correct Answer	Wrong Answers	Percentage correct
Male patient, age 25, one day after stomach surgery. He greets you with a smile as you enter his room, then continues his conversation with his guest. The following details emerge from your analysis: A scale from 0 (no pain/discomfort) to 10 (highest pain/discomfort) was used, and he rated his pain as an 8. Blood pressure was 120 over 80, heart rate was 80, and respiratory rate was 18.	**125**	**105**	**54.35**
After 2 hours of the morphine 2 mg IV, he felt better. The discomfort he experienced in the half hour after the injection was rated between 6 and 8, and he did not have any clinically significant respiratory depression, drowsiness, or other unfavorable side effects. Morphine IV 1-3 mg q1h PRN pain alleviation" is what his doctor prescribed for him. Take a look at the next step you intend to take.	**92**	**138**	**40**
Case B: Solomon, a 25-year-old man, is in the first post-op day after having stomach surgery. When you walk into his room, he's calmly lying there, turning over in bed with a scowl on his face. The following details emerge from your analysis: A scale from 0 (no pain/discomfort) to 10 (highest pain/discomfort) was used, and he rated his pain as an 8. Blood pressure was 120 over 80, heart rate was 80, and respiratory rate was 18.	**134**	**96**	**58.26**
The discomfort he experienced in the half hour after the injection was rated between 6 and 8, and he did not have any clinically significant respiratory depression, drowsiness, or other unfavorable side effects. He's decided that a score of 2 on a pain scale of 10 is good enough. Morphine IV 1-3 mg q1h PRN pain alleviation" is what his doctor prescribed for him.	**104**	**126**	**45.22**

Relationship between Demographic characteristics and Pain Management

Independent sample t-test was used to determine the relationship between demographic characteristic and pain management (mean of the total correct answers). This type of analysis is used to test the relationship between two groups. A levene's test was also carried out to determine which row to consider in terms of symmetry is concerned. According to the analyzed data, it can be concluded that there is no statistical difference between the gender of the respondents and pain management. This can be interpreted to mean that the male nurses and female are same in terms of pain management in the study area. t (-0.684) $p<0.05$as seen in Table 4.15. The result indicated that there is also no significant difference between educational level of the respondents and pain management; this means that, all the respondents despite their differences in the educational level.

Result of the analysis (Table 4.18) also revealed that there is significant difference between the respondents' age and pain management (prob. 0.05%). the result further indicated that those nurses that are above the mean age of 26.23 years are better in term of pain management then their counterpart. This is probably because as the age increases experience also increase making the surgery nurses more knowledgeable about main management.

The result in Table 4.18 further indicated that there were significant difference between job status (full time or part time) and pain management (prob.0.05%). The result revealed that full time staffs were better off in terms of pain management than their part time counterpart. This is not surprising because full time staff might have more experience than part time who are just visiting casually and most of them might have less experience than the full time nurses.

Finally, the result indicated that there also no significant difference in pain management between surgical nurses and nurses in the Intensive Care Unit (ICU). In other ward the result shows that the mean of the two groups are the same.

Table 4.18: Relationship between Demographic Variables and Pain Management

Variable	N	Mean (SD)	T	DF	p-value
Gender					
Male	92	1.3 (.462)	-0.684	228	-0.163NS
Female	138	1.3 (.478)			
Educational Level					
Bachelors	209		0.329	228	0.745NS
Masters/ Doctorate	21	1.687(1.154)			
Age					
Above mean	132	26.23 (4.67)	-5.543	228	0.014**
Below mean	108	33.54 (5.37)			
Job status					
Part time	46	1.16 (.375)	-3.643	228	0.032**
Full time	184	1.25 (.436)			
Working Area					
Surgical Nurses	218	1.05(.222)	0.765	228	0.154NS
ICU Nurses	12	2 (.675)			

CHAPTER V

5. DISCUSSION

5.1. Implications for practice

Nursing practice involves increasing time devoted to patients for their safety and bringing speedier health recovery among them. Pain control is a way through which patients are treated and untreated pain creates harm to quality of life for patients. Due to under-treatment of pain, results of inadequate assessment create inappropriate use of analogies mainly opioids. Nurses have moral accountability for providing brilliant care to patient's pain (Herr, Coyne, Ely, Gélinas, & Manworren, 2019). Therefore, pain management implies identifying goals for managing pain and awareness for specialized principles for appraisal of distinguishable types of pain. Pain is a diagnosis to serve symptoms in agreement with goals of expert standards of observation.

5.1.1. Acquire knowledge about pain and pain management

The key role of nurses in pain management lies in assessment of pain, analgesic prescription and extension of responsibility to patients. Most of these guidelines are covered under best practices as carried out through assessment as well as treatment. Poor and acute pain administration can guide to an unfavorable level penalty such as complications in post-surgical operations a Study participants were registered nurses from three Mogadishu hospitals chosen to be representative of the city's healthcare system. The purpose of this study was to identify the factors that influence the pain management decisions made by registered nurses and to assess their existing knowledge and attitudes regarding pain management. The end outcome was an improvement in the nurses' ability to perform their jobs and in their general level of knowledge and outlook.

This was accomplished by considering the researcher's epistemological blind spots following data analysis. The study's goals were addressed through the use of three sets of questions: (a) those pertaining to nurses' pain management knowledge and attitudes;

(b) those pertaining to nurses' pain assessment practices; and (c) those pertaining to the various factors influencing nurses' pain management knowledge and attitudes. The investigation revealed optimistic results about the knowledge and outlook of nurses in the study area, with a mean correct response percentage of over 80%. Results from case studies, however, indicate that respondents could benefit from additional education in how to assess patients' mental states in order to provide more effective pain treatment.

Prolonged hospital stays increasing suffering of patients (Drake & Williams, 2017). Pain initiatives that are reliant on enhancement of nurse's knowledge and beliefs do not predict upon clinical behavior of patients. Effective training involves an interactive form of learning and feedback derived though there is a lack of accuracy.

5.1.2. Act as primary agents of change

Nurses need to act as a primary agent of alternation in a process of managing pain among nurses. Provision of clinical care is a means for ensuring safety and maintenance of consent among patients. Clarity about the roles, responsibilities as well as standards of practice implies wide variations in geographical surroundings for devolving roles and career prospects. In contrast to traditional roles of nursing, specific clinical activities and requirements for patient care are not well de-alienated in research practice (Showalter, 2020). This process requires a transformational change for learning that develops a structured level of training and positive role modelling. As a result, a rich amount of training in clinical nurse's novice research nurses for intimidating and isolating established levels of professional identity.

5.2 Collaborate with healthcare specialists to manage pain

Interaction with healthcare specialists involves an experience of mutual trust for healthcare professionals to feel significant to accommodate patient needs and practices. It implies a holistic understanding of support for patient-centred practices to convene needs and expectations of patients. In these methods, nurses have a critical role to play in generating a positive effect on future healthcare services of individuals (Gjesdal, Dysvik, & Furnes, 2019). Nurses are required to form a collaborative approach in pain management for dealing with the patients in a well-formulated manner. In doing so, patient values, needs and expectations have to be identified for managing patients as

well as professionals for expecting a positive outcome to a person-centered approach towards managing pain.

5.3 Implications of findings

This study has provided an insight into the knowledge and attitudes of nurses towards pain management working in the different medical center. Overall, the findings in this study have revealed that the nurses in the study area have required knowledge and sensitive attitudes of working in the medical center surrounding the perspective of pain management.

It is mandatory to consider the attitudes towards pain management to assess the positives of the surgical nurses. According to the analyzed data, it was deducted that the most likely reason a patient will inquire for a pain medication is if the they are experiencing extreme anxiety or depression (36.57%). 33.04% of the respondents thought it depends if the patient is merely exhibiting more pain, while 20.87% of the respondents felt it could be probably as a result of needing more staff attention unlike a case of addiction (6.52%) as seen in Table 4.2. It was observed that the surgical nurses often use of various instruments for measuring pain in the clinics (41.74%).

Pain education is very important in pain management. According to the analyzed results, it can be deducted that majority of the surgical nurses believed the best route of administration of opioid analgesics for cancer-persistent patients is via intravenous (35.65%) unlike oral (13.04%) and via rectal (3.48%) as seen in Table 4.2. According to the analyzed results, it can be deducted that majority of the surgical nurses believed the best route of administration of opioid analgesics for cancer-persistent patients is via intravenous which is very wrong answer the correct answer of this question was oral and that explains there is inadequate knowledge and proper attitude towards the pain management.

Medicines, physical therapy, and other treatments all play a role in pain management (such as acupuncture and massage). Scientists believe that one's attitude and emotional resilience in the face of suffering are major determinants of happiness and longevity. Pain education is very important in pain management. According to the analyzed results, it can be deducted that majority of the surgical nurses believed the best route of

administration of opioid analgesics for cancer-persistent patients is via intravenous (35.65%) or for patients with brief or severe pain (39.57%) unlike oral (13.04%) and via rectal (3.48%).

Moral and ethics in pain management is also regarded as part of the predicament in cancer therapy. Usually before administering pain relievers to patients, it is mandatory to check if they are under any sort of drug abuse, and it takes about 1- 2 hours for morphine to be administered orally (40.87%). morphine medication is generally needed 30 minutes for reducing pain. It has henceforth been understood that no one provided the correct answer to this question. Therefore, it has been clarified that surgical nurses have the issue of lack of adequate knowledge and attitude and it is needed to be educated on an immediate basis.

When an opioid usage dose had been discontinued, physical dependence is usually dependent on sweating, diarrhea, yawning, or agitation with patients (33.04%) as well as obstructive sleep apnoea patterns (39.57%) as seen in Table 4.2. Opioid-induced respiratory depression is the leading cause of opioid overdose fatality (OIRD). By influencing chemo-sensitive cells that respond to variations in partial pressures of carbon dioxide and oxygen in the blood, opioids such as morphine suppress the hypoxic ventilatory response in the brainstem. From the discussion and analysis, it has been summarized that the majority of surgical nurses have the problem regarding the inadequate knowledge and proper attitude towards the pain management. It has further been analyzed that this issue needs to be mitigated on an urgent basis as it can be a major problem for both patients and surgical nurses. It has been understood that surgical nurses can be the victim of job sack and conflict with the patient party due to not handling the pain of patients. Besides, the patient can face crucial health problems like anxiety, depression, and mental trauma.

5.4 Conclusion

Difficulty at the head of the pack Today's healthcare is all about relieving the suffering of people with both short-term and long-term conditions like acute and chronic pain. Inequalities in quality of life are becoming an increasing concern as the human population increases and people live longer. Some people have trouble verbally

reporting their own pain, which is a serious problem. Priority should be given to care and therapy based on the results of a comprehensive pain assessment. Patients should be checked for pain upon admission, when clinically indicated, and at regular intervals thereafter.

In addition, patients must be taught how to cope with discomfort ((Joshi & Kehlet, 2013). This research shows that there are significant obstacles to effective pain treatment. The American Nurses Association (ANA) mandates that nurses be up-to-date on pain evaluation and management techniques (Ware, Bruckenthal, Davis, & O'Conner-Von, 2011).

Patients have a right to obtain proper pain treatment, and nurses have an obligation to deliver it. It is important for nurses to stress that pain is a subjective sensation and that they should never infer that patients are exaggerating their suffering. As a result, nurses must arm themselves with the information, expertise, and optimistic outlook on pain and pain management that will be required to effectively care for their patients. This and other research highlight the critical nature of pain management in the immediate postoperative pain environment for avoiding the development of chronic pain. Nonetheless, the comfort theory provides a concrete illustration of the actions required ensuring patient comfort, and so aids in guiding nursing decisions related to the patient.

The result indicated that nearly half of the respondents are within the age bracket of 36-46 years, and more than halve are female with majority having bachelor's degree. The result further indicated that 90.87% of the respondents work in the surgical unit, while less than 10% of the work in the various units mainly in the intensive care unit. Majority of the respondents were full time workers. The result further indicated that the respondents score more than 80% of the true or false and multiple questions related to their knowledge and attitude towards pain management. However their scores on the case studies were relatively low 48%. In relation to the hypotheses tested the result of the t-test show that there were no significant differences between gender and pain management. The result shows that there was significant difference between age and pain management, those respondents that their ages are above the mean were better in pain management than their counterpart at 5% prob. Level. In addition the analysis shows significant difference between full time workers and those on the part time basis.

In relation to the level of education there no significant difference among the respondents level of education and pain management.

5.5 Contribution of the study to the body of knowledge

This study contributed to the body of knowledge in the flowing ways; (1) most of the studies in the literature focus on general nurses not specifying particular categories of nurses as did in this study, this study is therefore unique in investigating the attitude and level of awareness of surgical nurses towards pain management (2) to the best of my knowledge there were also no study conducted in Somalia to investigate the level of awareness and knowledge of surgical nurses towards pain management. This study is therefore a handy tool for all stake holders in the health sector to understand the level of awareness of the surgical nurses for training and intervention when the need arises.

5.6 Recommendations for further research

The research involves provision of recommendations for implying knowledge and attitudes of surgical nurses towards management of pain are shared. Further research needs to be carried out for exploring the issues and challenges faced by nurses to incorporate effective pain management. Therefore, ethical tenets of beneficence are governing practice that guides in uplifting life care facilities. Through pain management, nurses are obligated to make adequate standards for an improvement in pain management for a given population. In this manner, nurses would be able to establish a positive culture for positively listening to patients and solicit details about the nature of pain that influences people's life and acknowledges the problem faced therein. Therefore, it is recommended for developing extensive research on what nursing practices can be upheld for enabling nurses to get knowledge and serve a better attitude in dealing with pain.

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Appendixes

Appendix 1: Ethics form approval

NEAR EAST UNIVERSITY

INSTITUTIONAL REVIEW BOARD

INFORMED CONSENT FORM FOR NON-PHARMAEUTICAL RESEARCH STUDY ON ADULT SUBJECTS

(Researcher's Explanation)

We are conducting a new research study on.. **Knowledge and attitudes towards of nurses towards pain management.**

Your participation is sought for the following survey. It's up to you if you want to join. Before you make a choice, we'd like to make sure you get all the facts regarding the study. Before deciding to participate in the study, you must read this consent form and ask any questions you may have. If you are considering voluntarily participating in this

study, please take as much time as you need to think about it before signing this form. The study's aim was to profile the expertise and outlook of RNs in the healthcare sector. The purpose of this study was, therefore, to ascertain how well-versed in pain management registered nurses are and to identify the elements that may influence their decision-making process. The Near East University School of Surgical Nursing is collaborating on this study. and your contribution is crucial to the results of the research.

Each of you is helping out with our initiative purely on your own accord. The tasks you'll be required to do as part of this study's participants are outlined in the participant's informed consent. Three hospitals were chosen to represent the health care system in Somalia and the city of Mogadishu in a cross-sectional survey: the Rajab Dayib Ordugan Hospital, the Martiini Hospital, and the Banaadir Hospital. All of the chosen hospitals served as secondary referral centers. Each hospital's ER, OR, medical ward, surgical ward, oncology ward, burn ward, and Intensive Care Unit (ICU) nurses were asked to take part.

Participation in the study will not result in any financial or other form of reward for you. Information about your health obtained during the course of this study that could be used to identify you will be kept strictly confidential and shared with anyone other than authorized study personnel, the Institutional Review Board (IRB), and law enforcement only with your consent or as required by law.

You are under no obligation to take part in this study. Decide for yourself if you want to take part. If you decide to participate in this study, you can back out at any moment without facing any repercussions. If you are participating in this study and you change your mind, your care at this hospital will not be affected, and you will not lose any of the advantages or rights that you are entitled to.

Participant

Name & Surname:

Address:

Tel:

Signature

Witness

Name & Surname:

Address:

Tel:

Signature

Researcher

Name &Surname:fartunhassanmohamud

Title: knowledge and attitudes of nurses towards pain management

Address: tuuma4me@gmail.com.

Tel: 00905531649046

Signature

GOOD CLINICAL PRACTICE DECLARATION

The Title of the Study: knowledge and attitudes of nurses towards pain management.

As researchers performing the aforementioned study, we thus confirm that we will fulfill the obligations outlined in the "Good Clinical Practice Guidelines" released in April 2013 by the Turkish Ministry of Health Pharmaceuticals and Medical Devices Agency.

Principal Researcher : Signature:

Assistant researcher(s): Signature:

After the study was given the go light by the Ethics Review Board at Near East University in Northern Cyprus, the researchers began actively seeking out volunteers to participate in the study.We selected surgical nurses who expressed an interest in participating in the study and had them sign a consent form. Each participant was given a copy of the study questionnaire and instructed to fill it out.

Appendix 2

Knowledge and Attitudes Survey Regarding Pain

- **Data Collection Sheet**

Please indicate your response by marking [X] in the appropriate space given or by writing where necessary.

• Year of Birth	
• Gender	
• Education level	Diploma[ ] Bachelors[ ] Master[ ] Doctorate[ ]
• Working area	Surgical ward[ ] Surgical ICU[ ]
• Occupational status	Full-time [ ] Part-time [ ]

II. Knowledge and Attitudes Survey (KASRP) about Pain Management

True/False – Circle the correct answer.

- **T F**. The severity of a patient's pain may always be gauged by checking their vitals.
- **T F.** Children under the age of two have reduced pain sensitivity and limited recollection of painful experiences due to the immaturity of their nervous system.
- **T F.** In most cases, patients who are easily distracted do not experience acute discomfort.
- **T F.** Patients may be able to sleep despite intense suffering.
- **T F.** When it comes to relieving the pain of bone metastases, over-the-counter NSAIDs like aspirin are completely ineffective.
- **T F.** Patients who have been on constant opioid dosages for several months rarely get respiratory depression.
- **T F.** Better pain control with fewer side effects may be achieved by combining

analgesics that function by distinct mechanisms (such as an NSAID and an opioid).

- **T F.** Analgesia from 1–2 milligrams of morphine intravenously often lasts 4–5 hours.
- **T F.** Patients with a previous history of substance misuse should not be prescribed Opioids
- **T F.** Opioid pain relievers are not safe for the elderly.
- **T F.** Patients should be urged to suffer through as much discomfort as they can stand before they are given an opioid.
- **T F.** Because children under the age of 11 cannot accurately describe pain, physicians should rely only on the parent's judgment of the child's level of discomfort to determine the child's level of pain.
- **T F.** Patients may be misled into thinking that their discomfort and suffering are inevitable due to the spiritual beliefs they have.

- **T F.** Following the administration of the initial dose of an opioid analgesic, successive doses should be modified in accordance with the reaction of the particular patient.
- **T F.** It is possible to determine whether or not the patient is experiencing true pain by injecting them with sterile water as a placebo.
- **T F.** The oral administration of Vicodin (hydrocodone 5 mg and acetaminophen 300 mg) is approximately equivalent to the oral administration of 5-10 mg of morphine.
- **T F.** Opioids shouldn't be taken during the pain evaluation phase if the patient's pain source is unknown, as doing so could obscure the diagnosis.
- **T F.** One dose of an anticonvulsant like gabapentin (Neurontin) is all that's needed to provide effective pain relief.
- **T F.** As a result, benzodiazepines are not suggested as part of an analgesic regimen, despite popular belief to the contrary.
- **T F.** Addiction to opiates or other narcotics is considered a chronic neurobiological disorder characterized by the following set of behaviors: the inability to stop using drugs despite negative consequences and engage in risky behavior while high is all symptoms of addiction.
- **T F.** The phrase equianalgesia refers to the degree of pain relief provided by

different doses of analgesics, and its meaning is "roughly equal analgesia."

- **T F.** Since excessive sedation is a precursor to opioid-induced respiratory depression, assessing sedation levels is prudent when utilizing opioids for pain management.

Multiple Choice , Place a check by the correct answer.

- What is the most likely reason a patient with pain would request increased doses of pain medication?
- The patient is experiencing increased pain
- The patient is experiencing increases anxiety or depression
- The patient is requesting more staff attention
- The patient‟s request are related to addiction

- How often do you use pain measurement instruments in your ward?
  1) Often
  2) Always
  3) Rarely
  4) Never
  - What is the recommended route of administration of opiod analgesics for patients with persistent cancer related pain?

    a. Intravenous

    b. Intramuscular

    c. Subcutaneous

    d. Oral e. Rectal

- The recommended route of administration of opioid analgesics for patients with persistent cancer-related pain is
-
- Intravenous
- Intramuscular
- Subcutaneous
- Oral
- Rectal

- The recommended route administration of opioid analgesics for patients with brief, severe pain of sudden onset such as trauma or postoperative pain is
- Intravenous
- Intramuscular
- Subcutaneous
- Oral
- Rectal

- Which of the following analgesic medications is considered the drug of choice for the treatment of prolonged moderate to severe pain for cancer patients?
- Codeine
- Morphine
- Meperidine
- Tramadol

- A 30 mg dose of oral morphine is approximately equivalent to
- Morphine 5 mg IV
- Morphine 10 mg IV
- Morphine 30 mg IV
- Morphine 60 mg IV

- Analgesics for post-operative pain should initially be given
- Around the clock on a fixed schedule
- Only when the patient asks for the medication
- Only when the nurse determines that the patient has moderate or greater discomfort
- A patient with persistent cancer pain has been receiving daily opioid analgesics for 2 months. Yesterday the patient was receiving morphine 200 mg/hour intravenously. Today he has been receiving 250 mg/hour intravenously. The likelihood of the patient developing clinically significant respiratory depression in the absence of new comorbidity is a. less than 1% b. 1-10% c. 11-20% d. 21-

40% e. > 41% 29. The most likely reason a patient with pain would request increased doses of pain medication is

- The patient is experiencing increased pain.
- The patient is experiencing increased anxiety or depression.
- The patient is requesting more staff attention. .
- The patient's requests are related to addiction.

- Which of the following is useful for treatment of cancer pain?
- Ibuprofen (Motrin)
- Hydromorphone (Dilaudid)
- Gabapentin (Neurontin)
- All of the above

- The most accurate judge of the intensity of the patient's pain is:
- The treating physician
- The patient's primary nurse
- The patient
- The pharmacist
- The patient's spouse or family

- Which of the following describes the best approach for cultural considerations in caring for patients in pain:
  - There are no longer cultural influences in the U.S. due to the diversity of the population.
  - Cultural influences can be determined by an individual's ethnicity (e.g., Asians are stoic, Italians are expressive, etc).
  - Patients should be individually assessed to determine cultural influences.
  - Cultural influences can be determined by an individual's socioeconomic status (e.g., blue collar workers report more pain than white collar workers).

- How likely is it that patients who develop pain already have an alcohol and/or drug abuse problem? < 1% 5 – 15% 25 - 50% 75 - 100% 34. The time to peak effect for morphine given IV is
- 15 min.
- 45 min.
- 1 hour
- 2 hours

- The time to peak effect for morphine given orally is
- 5 min.
- 30 min.
- 1 – 2 hours
- 3 hours

- Following abrupt discontinuation of an opioid, physical dependence is manifested by the following:
  - Sweating, yawning, diarrhea and agitation with patients when the opioid is abruptly discontinued.
  - Impaired control over drug use, compulsive use, and craving
  - The need for higher doses to achieve the same effect.
  - a and b

- Which statement is true regarding opioid induced respiratory depression:
  - More common several nights after surgery due to accumulation of opioid.
  - Obstructive sleep apnea is an important risk factor.
  - Occurs more frequently in those already on higher doses of opioids before surgery.
  - Can be easily assessed using intermittent pulse oximetry.

Case Studies Two patient case studies are presented.

For each patient you are asked to make decisions about pain and medication.

Directions: Please select one answer for each question.

Case A. Male patient, age 25, one day after stomach surgery. He greets you with a smile as you enter his room, then continues his conversation with his guest. The following details emerge from your analysis: A scale from 0 (no pain/discomfort) to 10 (highest pain/discomfort) was used, and he rated his pain as an 8. Blood pressure was 120 over 80, heart rate was 80, and respiratory rate was 18.

A. On the patient's record you must mark his pain on the scale below.

Circle the number that represents your assessment of Andrew's pain. -1

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....1O

No pain discomfort worst pain discomfort

Case A section 2: After 2 hours of the morphine 2 mg IV, he felt better. The discomfort he experienced in the half hour after the injection was rated between 6 and 8, and he did not have any clinically significant respiratory depression, drowsiness, or other unfavorable side effects. Morphine IV 1-3 mg q1h PRN pain alleviation" is what his doctor prescribed for him. Take a look at the next step you intend to take.

1. Administer no morphine at this time.
2. Administer morphine 1 mg IV now.
3. Administer morphine 2 mg IV now.
4. Administer morphine 3 mg IV now.

Case B: Solomon, a 25-year-old man, is in the first post-op day after having stomach surgery. When you walk into his room, he's calmly lying there, turning over in bed with a scowl on his face. The following details emerge from your analysis: A scale from 0 (no pain/discomfort) to 10 (highest pain/discomfort) was used, and he rated his pain as an 8. Blood pressure was 120 over 80, heart rate was 80, and respiratory rate was 18.

- A. On the patient's record you must mark his pain on the scale below. Circle the number that represents your assessment of Robert's pain:

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10

N0 pain discomfort worst pain discomfort

Case B section 2: Your assessment, above, is made two hours after he received morphine 2 mg IV. The discomfort he experienced in the half hour after the injection was rated between 6 and 8, and he did not have any clinically significant respiratory

depression, drowsiness, or other unfavorable side effects. He's decided that a score of 2 on a pain scale of 10 is good enough. Morphine IV 1-3 mg q1h PRN pain alleviation" is what his doctor prescribed for him

Check the action you will take at this time:

1. Administer no morphine at this time.
2. Administer morphine 1 mg IV now.
3. Administer morphine 2 mg IV now.
4. Administer morphine 3 mg IV now.

NAER EAST UNIVERSITY

SCIENTIFIC RESEARCH ETHICS COMMITTEE

09.03.2021

Dear Assist. Prof. Dr. Burcu Totur Dikmen

Your application titled **"Knowledge and Attitude of Surgical Nurses towards Pain Management"** with the application number NEU/2021/87-1265 has been evaluated by the Scientific Research Ethics Committee and granted approval.

Prof. Dr. Rüştü Onur

Near East University

Scientific Research Ethics Committee Director

Best Regards

> On Wed, Feb 24, 2021 at 6:32 PM Burcu Totur Dikmen <burcu.toturdikmen@neu.edu.tr> wrote:
> Dear Doctor,
>
> In your previous e-mail, you sent me your consent of wet signed version of the approval for Fartun Hassan Mohamud's thesis.
> I sent it to the university's ethics committee but they requested the master thesis title and my name as an advisor in the document. Sorry about it.
> Could you please recompose the wet signed document with the student name, my name as an advisor and also title of the thesis. You may find my name and the title of the thesis on the below. Thank you very much for your support.
> Best regards.
>
> Advisor name: Burcu Totur Dikmen
> Thesis title:''Knowledge and Attitudes of Surgical Nurses Towards Pain Management''
>
> > On Tue, Feb 23, 2021 at 1:08 AM Burcu Totur Dikmen <burcu.toturdikmen@neu.edu.tr> wrote:
> > Thank you very much.
> >
> > > On Mon, Feb 22, 2021 at 4:36 PM Fartun Sharif Mohamed <banadirhospital@moh.gov.so> wrote:

FEDERAL GOVERNMENT OF SOMALIA
MINISTRY OF HEALTH AND HUMAN SERVICE
DE MARTINO HOSPITAL

جمهورية الفيدرالية الصومال
وزارة الصحة والرعاية الاجتماعية
مستشفى دي مرتينه

Office of the Director

Date: Feb ,28, 2021

Dear Burcu

Thank you for your E-mail, and this is to confirm that Fartn Hassan Mohamud can interview and collect any necessary information from our Nurse and staff at Demartino Hospital for her study purposes.

Thanks and best regards

DR. Abdirizaq Yusuf Ahmed
Direct General of De-martini Hospital

Address: Via Londra Rd, HamarJajab, Mogadishu-Somalia,
Email: demartinohospital2020@gmail.com

CV

FARTUN HASSAN MOHAMUD

TEL : +90 535 013 54 46
EMAİL : tuuma4me@gmail.com

Qualified Nurse with 3+ years of experience providing quality care to a wide variety of patients, facilitating health promotion and disease prevention by providing individual and group support to meet diverse needs. Possesses MSc in Surgical Nursing and prepared to leverage education, experience, and strengths to take on dynamic position with long-term potential.

Educational Background

Near East University, North Nicosia, Cyprus

MSc in Surgical Nursing 2022

Mogadishu University, Mogadishu, Somalia

BSc in General Nursing 2016

Badbaado Primary and Secondary School, Mogadishu, Somalia

High School 2010

CERTIFICATES AND TRAININGS

Breast Cancer Screening

Mogadishu City Hospital, 2015.

Mogadishu, Somalia

Lung Cancer

Mogadishu City Hospital, 2015.

Mogadishu, Somalia

Emergency Management for Trauma Patient.

Mogadishu City Hospital, 2015.

Mogadishu, Somalia

Nurse Training.

Egyptian Hospital, 2014.

Mogadishu, Somalia

Languages

Somali:	Mother Tongue
English:	Working
Turkey:	Working
Arabic:	Working

Work Experience

OTP Nurse

SOS Children's Village Hospital, Mogadisu, Somalia *2016*

- Conducting health screenings and appraisal of children to detect conditions of severe acute malnutrition.
- Performing daily nursing tasks required in the daily care for children with severe acute malnutrition, which includes administration of drugs, therapeutic feed preparation and monitoring of vital signs
- Providing health and nutrition education to mothers on hand hygiene, cleanliness, waste disposal and other effective practices relevant for safety and infection prevention

General Nurse

Madina Hospital, Mogadisu, Somalia *2017*

- Providing comprehensive primary health care services to beneficiaries and enhancing the data quality of the medical center.
- Participating activities to promoting a good healthy and hygienic environment in the catchment area to prevent the potential health hazards.
- Preparing and submitting weekly, monthly and quarterly reports to the respective manager on the achievement and progress of the HMIS aspects.

Public Health Nurse

Benadir Maternity & Child Hospital, Mogadisu, Somalia *2018*

- Coordinating treatment, convalescence & rehabilitation plans with other healthcare providers.
- Providing maternity & childcare guidance, as well as facilitating interventions, when required.
- Conducting immunization programs, as well as promoting disease prevention & control measures.
- Inventorizing & replenishing medical supplies, as well as maintaining medical equipment.
- Updating & maintaining patient files & medical records.
- Participating in health education initiatives & keeping abreast of advancements in the field of public health