**Parents’ experiences of managing their child’s postoperative pain at home:**

**An exploratory qualitative study**

**KEYWORDS FOR REVIEWER SELECTION**

* Pain
* Management
* Parent
* Child
* Paediatric

**SUMMARY BOX**

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| **What does this paper contribute to the wider global clinical community?*** This exploratory qualitative study provides a first-hand account of parents’ experiences of managing their child’s postoperative pain at home
* This research reveals some factors that impact parents’ management of their child’s pain
* The results of this study may aid in the design of theory- and evidence-informed interventions that will improve children’s postoperative pain management at home
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**ABSTRACT**

**Aims and objectives.** To understand parents’ experiences of managing their child’s postoperative pain at home.

**Background.** Recent changes in children’s healthcare services often shift the responsibility of managing children’s postoperative pain to parents. Although pain management is important for good postoperative outcomes, it can be a challenging task for families, and children’s pain is often under-managed.

**Design.** This qualitative study used semi-structured interviews to explore parents’ experiences of managing their child’s postoperative pain at home.

**Methods.** Participants were parents of 10 typically-developing 5- and 6-year-olds, who underwent (adeno)tonsillectomy, and experienced no complications leading to hospitalization in the postoperative period. One-on-one interviews were conducted with parents within three months of their child’s surgery. Interviews were transcribed verbatim and content analysis was used to identify themes in parents’ experiences.

**Results.** All children experienced some postoperative pain. Parents’ experiences of managing their child’s pain were impacted by balancing the pros and cons of administering analgesic medications, managing the emotional and psychological effects of their child’s pain, as well as their information needs.

**Conclusions.** Most parents’ information needs were satisfied yet they still struggled to manage their child’s pain. These findings provide insight into some of the barriers that make this process challenging for many families, and what healthcare centres can do to help support parents manage their child’s postoperative pain at home.

**Relevance to clinical practice.** The results of this study may aid in the design of interventions that will support parents when managing their child’s postoperative pain at home and thus improve children’s experiences.

**Key words:** pain, management, home, parent, child, paediatric

**INTRODUCTION**

Despite well-established evidence to guide pain management (Association of Paediatric Anaesthetists, 2012; Baugh et al., 2011), many children experience moderate to severe pain after common paediatric day surgeries (Kankkunen et al., 2009; Shum et al., 2012; Wiggins, 2009). For example, about three quarters of children report significant pain on the first two days after minor outpatient surgery (Fortier et al., 2009; Hamers & Abu-Saad, 2002). Due to changes in children’s healthcare services, including shorter hospital stays, the task of managing children’s postoperative pain is often transferred to parents. Although adequate pain management is important for positive postoperative outcomes, it can be a challenging task, requiring accurate assessment of and response to children’s pain, using analgesic medications or other physical or psychological interventions (Brasher et al., 2014). Early pain experiences in infancy can increase later vulnerability to pain sensitivity (Grunau et al., 2006; Hermann et al., 2006; Peters et al., 2005). The use of analgesic medications such as morphine can help to mitigate short-term pain in infancy (Bouwmeester et al., 2003); however, the long-term impacts of analgesic medication on pain sensitivity in children is not well understood. Children’s postoperative pain can impact their quality of life and have serious consequences, including chronic pain later in life (Fortier et al., 2011a; Nikolajsen & Brix, 2014; Rabbitts et al., 2015). Unfortunately, evidence suggests that children’s postoperative pain is often undermanaged (Fortier et al., 2009; Shum et al., 2012; Stewart et al., 2012). Therefore, there is a need for improved understanding of how to better support parents in managing their child’s postoperative pain at home.

**BACKGROUND**

Previous research suggests that parents can generally assess their child’s pain, but this does not necessarily lead to adequate analgesic dosing (Fortier et al., 2009; Kankkunen et al., 2009; Zisk-Rony et al., 2010). Parents often fear side effects of medications, think they are addictive, and believe children should receive as little medication as possible (Kankkunen et al., 2003b; Zisk et al., 2007; Zisk-Rony et al., 2010). Additionally, parents may question, misunderstand, or receive insufficient or variable postoperative pain management instructions (Hamers & Abu-Saad, 2002; Kankkunen et al., 2003a; Tait et al., 2008; Twycross et al., 2014). Many parents seek further advice after discharge (Swallow et al., 2000), underscoring the need for adequate preparation and support for families. Chng et al. (2015) found important relationships between parents’ knowledge, attitudes, satisfaction, and postoperative pain management, suggesting a need for further parental education about children’s pain management after surgery. Dorkham et al. (2014) reviewed numerous obstacles that interfere with the prescription and administration of postoperative pain medications to children, and called for more holistic approaches to address the complex nature of children’s postoperative pain management at home.

Research on factors associated with the under-management of postoperative pain has generally focused on parents’ attitudes about analgesic medications. However, current interventions that educate parents about the consequences of untreated pain and medication dosing are only moderately effective (Chorney et al., 2014). Therefore, there is a need to better understand factors that impact parents’ management of their child’s pain. This is particularly pertinent as a recent randomized-control trial by Helgadóttir and Wilson (2014) found that providing parents with education about distraction as an additional pain management strategy in addition to analgesic medications resulted in a decrease in children’s pain.

Although previous studies have begun to describe children’s experiences of postoperative pain (Sng et al., 2013; Twycross & Finley, 2013) and parents’ experiences of managing their child’s postoperative pain at home (Sutters et al., 2012; Twycross & Finley, 2013), further research is required to better understand the barriers and facilitators to pain management. Therefore, the goal of the current study was to explore parents’ experiences of managing their child’s postoperative pain at home with the overall aim of supporting the development of more effective family-informed interventions that will improve children’s pain management in this context. More specifically this study explored:

1. strategies parents used to manage their child’s postoperative pain at home
2. challenges parents faced when managing their child’s pain at home
3. information that may have helped families manage their child’s pain more effectively

**METHODS**

This exploratory qualitative study used semi-structured interviews to explore parents’ experiences of managing their child’s postoperative pain at home. Ethical approval was obtained from the local Institutional Review Board.

**Participants**

Participants were parents of 10 typically-developing 5- and 6-year-olds, who underwent tonsillectomy with or without adenoidectomy at a paediatric tertiary care centre in Eastern Canada. All children were discharged within 23 hours of their surgery and experienced no complications leading to re-hospitalization in the postoperative period. Participants were all biological parents and were fluent in English. None of the children had undergone previous surgical procedures. Participants were recruited from November 2013 to February 2015. The majority of patients served by this clinic are English-speaking Caucasian families (Chorney et al., 2015). Demographic information is summarized in Table 1.

**Sample size**

The sample size of 10 participants provided in-depth data and an insight into the issues being explored. We began data analysis after a few interviews were collected and stopped data collection after 10 participants because no new information was being generated from adding additional interviews.

**Procedure**

A convenience sampling strategy was used to recruit participants. Parents were recruited via letters sent out within two months after their child’s surgery or by posters displayed in the paediatric otolaryngology clinic. A total of 84 letters were sent out to potential participants and 19 parents responded. Of these, 10 participants met the inclusion criteria for the study. Of those excluded, six had children aged 3 years, and three had children who experienced complications that led to re-hospitalization after their procedure. Parents contacted the principal investigator if they wished to learn more about the study. Parents who were eligible and interested were scheduled for a single in-person (n = 1) or telephone (n = 9) interview. Interviews were semi-structured, audio-recorded, and took approximately 45 minutes. All interviews were conducted by one researcher who did not have any previous relationship with the families.

**Data collection tools**

 A semi-structured interview guide was developed based on an extensive literature review and the researchers’ clinical experience (Appendix A). A brief demographic questionnaire was also developed to gain information about participants’ living situation, parental gender and age, child gender and age, and family income.

**Methods of data analysis**

Interviews were transcribed verbatim. Content analysis was then used to analyse the data using a five-step approach advocated by Creswell (1998):

(1) organizing files for qualitative analysis

(2) reading through text and forming initial codes

(3) describing the setting, population, and events

(4) analysing data to identify emerging themes

(5) interpreting the findings

 The primary coder used this process to code all 10 transcripts using the computer software *NVivo* *10* for *Windows*. To minimize researcher bias, another experienced researcher coded three randomly selected interview transcripts by hand, based on the nodes identified by the primary coder. The second coder found that the transcripts were fully coded with the pre-existing nodes and she was able to easily collate coded sections into the themes that were identified by the primary coder. Overall, both coders agreed that the emergent themes reflected the transcripts.

**RESULTS**

Three key themes emerged from the parent interviews:

1. balancing the pros and cons of giving analgesic medications
2. managing the emotional and psychological effects of children’s pain
3. parents’ information needs

See Figure 1 for a visual summary of the findings. The main themes will be discussed in turn below, after a brief description of children’s pain experiences in this context.

**Children’s experiences of postoperative pain at home following tonsillectomy**

Parents reported variability in their child’s pain post-tonsillectomy. Some parents reported that their child experienced very little pain, and their child only made reference to a sore throat after they discontinued using morphine. Other parents reported that although their child experienced some pain, it was easily managed with analgesic medication. Several other parents described fluctuations in their child’s pain, whereas other parents reported considerable pain or emotional distress which one described as “*panicking over the amount of pain he was in*.” (Participant 5)

**Balancing the pros and cons of giving analgesic medications**

*Administering analgesic medications as instructed*

All parents administered some medication to their child; however, there was variability in their use of paracetamol (acetaminophen) and morphine. Most parents reported that they administered medications on a strict schedule, based on guidelines provided by the hospital:

*“We were completely watching the clock right to the minute as far as when we gave her the medication, and I felt like we had really controlled her pain very well.” (Participant 4)*

Whereas, another parent described allowing their child to choose whether or not he wanted to take medication:

“*He refused the morphine after the third night, and then I just said, ‘well okay, it’s your choice. This will help make you feel better, but if you don’t want to take it, then it’s your choice’. And he would go back to sleep or end up taking the medication or just lay there and cry.” (Participant 10)*

*Managing side effects*

Many parents reported struggling to balance the pros of administering the medications with the cons of their child’s side effects. Some parents cited concerns about constipation, drowsiness, and nausea. Some parents also reported increased irritability and changes in their child’s personality, which they attributed to morphine:

*“I was really uncomfortable with the changes in his personality from the morphine, and it seemed like it wasn’t making enough difference in his pain to make it worthwhile…Like he’s normally a very bright, alert, cheerful boy, and when he was having the morphine, his eyes were glazed over, like he wasn’t focusing on anything, and he was cranky.” (Participant 5)*

*“We wanted to transition her off of that when we didn’t think it was creating as much benefit as it was going to create a problem.” (Participant 9)*

Two parents reported problematic reactions to morphine, including night sweats and hallucinations:

*“He would wake up in the middle of the night almost in a night terror, which I think again was the morphine.” (Participant 5)*

Many parents reported that they thought the pain medication was important to administer, despite any negative side effects, because they prioritized managing their child’s pain:

“*He would get quite nauseated after the morphine…Well it was better than the alternative, right? I don’t like to see a child in pain.” (Participant 6)*

*Concerns about addiction*

Although the majority of parents were not worried about addiction, a few did express concerns and felt ambiguous or made a conscious attempt to wean their child off as soon as possible:

*“I was a little leery about keeping him on [morphine] straight time, for the whole week. I was consciously weaning him off that sooner rather than later.” (Participant 5)*

*“I didn’t want to see her in pain, and I felt like it was critical to make sure she got [morphine] at the right time. But at the same time, I was wondering how addictive it was.” (Participant 4)*

**Managing the emotional and psychological effects of children’s pain**

Several parents referred to both the emotional and psychological toll their child’s recovery placed on their family for up to two weeks after surgery. Many parents believed the long-term health benefits for their child made this short-term burden worthwhile; yet, many families struggled during the recovery period. In fact, a couple of parents reported a sense of regret immediately after the surgery, but expressed relief and satisfaction after they started seeing positive changes in their child’s health or well-being:

*"It was a rough week. Once he started to come around and he didn’t need the pain meds so much, and when the pain started to ease up, and he was eating more and getting a little more energy back, everybody kind of relaxed then…If you had asked me in the first day or two, I would have taken it back in a heartbeat. But now this far out, it was definitely worth it.”* (Participant 5)

Since none of the children returned to school for at least one week after surgery, parents needed to be home with their child or arrange for appropriate childcare.

*“I had taken the whole week off work, but those were long days as well and long nights. So when my husband would come home, he’d spend some time with [our son] and try to distract him a little bit, and kind of take breaks from it, so that we were not getting too worn out.” (Participant 5)*

“*If I didn’t have my parents, I don’t know how we would have done it.” (Participant 6)*

Families also experienced a range of challenges including impacts on parents’ sleep and impacts on other members of the family:

*“I didn’t sleep a whole lot that week, and it was more just worrying about him and…you would kind of sleep with one eye open to see what he was doing.” (Participant 5)*

“*You feel bad and you don’t want to have to make him take something he doesn’t want to take, but then you want him to feel better. And then you’re overtired because it’s the middle of the night, and you just want him to take the silly medicine so he’ll just feel better*.” (Participant 10)

“*[My child] was crying and crying, and then [his brother] was sitting next to me crying that he wanted to sleep…I eventually just sent one to my mom’s overnight*.” (Participant 2)

Managing their child’s emotional responses was also distressing for some families, and

parents referred to the important but challenging task of managing their own emotions:

“*There was one night in particular, [my husband] and I were at our wits end, just the sound of the whining it was like, oh my god, if he doesn’t stop, I don’t know what I’m going to do*.” (Participant 5)

 “*It was challenging just to be able to stay calm, so that she was able to stay calm and manage the pain as well*.” (Participant 9)

**Parents’ information needs**

*Met and unmet needs*

When asked what information they received about managing their child’s pain at home, all parents referred to an information booklet that was provided by the children’s hospital as well as information that was given to them by their surgeon, nurse, and pharmacist. Many parents were very satisfied with this information, and particularly appreciated having reference materials:

“*We had very clear instructions about what medications to give, what prescriptions to get, when to give them. The surgeon spoke with me afterwards about things that she could and could not do, activities she could and couldn’t participate in, if there were any foods she could or couldn’t have, all of those sorts of parts. The nurse reviewed all of the medications before we left…The pharmacist also reviewed all those things.”* (Participant 9)

“*I found it very easy, and it was all written down, which is nice because you can be the coolest cat around, but when your baby goes in for surgery, you’re a little vulnerable.”* (Participant 9)

*Seeking or wanting further information from healthcare providers*

Seven of the parents contacted the otolaryngology clinic for further advice. A few families also contacted their local pharmacist or the non-emergency telephone healthcare service to speak with a registered nurse. Most parents seemed to have positive relationships with their healthcare providers and referred to the importance of trusting them and following the information that they provided:

“*I think trusting your healthcare provider is a huge component in managing your child’s pain, because you have to trust the people who are giving you the information, so you can rely on it to manage your child’s pain.”* (Participant 9)

Several parents identified areas where additional information would have been useful:

*“I think maybe if it had been stressed a little more that there’s a potential for a lot of pain, and this is all you can do to help it, just so you’re prepared, that might have been a little helpful…or maybe I could have prepared him a little better too.” (Participant 5)*

“*Don’t meet anxiety with anxiety…just step back from a difficult situation and remain calm.” (Participant 7)*

**DISCUSSION**

Parents’ experiences of managing their child’s postoperative pain at home were impacted by an individual assessment of the pros and cons of administering analgesic medications. Parents considered instructions from the healthcare centre in the context of managing side effects. Parents’ experiences were also affected by challenges managing the broader emotional and psychological effects of their child’s pain. Finally, parents’ experiences were influenced by their information needs (including met and unmet needs) and potential misconceptions about analgesic medications.

**Postoperative pain in children**

This study found variability in parents’ reports of their child’s pain during the recovery period post-tonsillectomy. Some parents reported that their child experienced only minor pain, whereas others described considerable pain and distress, which was not effectively managed with medication or other pain management strategies. This is somewhat inconsistent with previous research that suggests many children experience moderate to severe pain after common paediatric day surgeries (Fortier et al., 2009; Kankkunen et al., 2009; Shum et al., 2012; Wiggins, 2009). Hamers and Abu-Saad (2002) found that, on average, children who underwent tonsillectomy experienced a high degree of pain at home, which gradually diminished over the first week. Similarly, Idvall et al. (2005) found that children aged 7-18 years reported severe physical and psychological pain while hospitalized after tonsillectomy. The current study suggests that things may have improved in recent years and that, at least in this health centre, children’s postoperative pain is now being managed more effectively at home. However, other research findings suggest this is not always the case (Fortier et al., 2009; Shum et al., 2012; Stewart et al., 2012). It is important to identify individual variables that may contribute to significant postoperative pain in children, as undermanaged pain can have serious adverse consequences on children’s recovery and later experiences of pain (Fortier et al., 2011a; Nikolajsen & Brix, 2014; Rabbitts et al., 2015).

**Parents’ feelings and attitudes about using analgesic medications**

All parents administered some type of analgesic to their child, including morphine, paracetamol, and ibuprofen but there was variability in their medication use. As in other studies, some parents were concerned about constipation, nausea, irritability, drowsiness, night sweats, and hallucinations (Dorkham et al., 2014; Kozlowski et al., 2014). However, unlike the results of previous research, many parents reported that adequate pain management was more important than these concerns. This is perhaps attributable to the quality of information that families received from the health centre or the trust they had in their healthcare providers. Additionally, there may be differences between the study populations (e.g., different geographical locations, cultural backgrounds, or age groups) that would affect parents’ perceptions of pain and analgesics. Further research is needed to evaluate factors that may impact parents’ attitudes and behaviours related to using analgesic medications to help manage their child’s postoperative pain.

Despite many parents administering analgesics, in this study, some parents reported feeling ambivalent about administering morphine to their child due to concerns about addiction. Many previous studies have found that over half of parents are worried that analgesic medications are addictive (Zisk-Rony et al. 2010; Twycross et al. 2014) and a recent review demonstrated that erroneous beliefs about analgesic medications continue to persist despite attempts to educate parents about children’s pain management (Dorkham et al., 2014). This is of concern as these misconceptions could be associated with insufficient administration of analgesic medications (Kankkunen et al., 2009). That said, in our study many parents balanced these concerns with their desire to manage pain in their children and still administered analgesics. Findings from this study suggest parents’ experience of managing their child’s postoperative pain is more complex than simply having negative attitudes about pain medication or administering pain medication as prescribed. Indeed many of the parents in this study had concerns about administering analgesics, but still administered medication to their child, suggesting that having negative attitudes might not necessarily be a problem as long as parents are still able to act effectively to manage their child’s pain.

**Parents’ ability to respond to emotional and psychological impacts of pain**

 Parents reported facing numerous short-term burdens, including distress related to managing their child’s emotional responses and difficulty managing their own emotions. These findings are consistent with previous research, which suggests that families face numerous barriers when managing their child’s postoperative pain (Dorkham et al., 2014; Huth & Broome, 2007). Interestingly, most families in this study felt the short-term burdens were worthwhile given the health benefits for their child. Families may benefit from education about the possible short-term burdens they may expect to face, along with support during this challenging recovery period. Although it should be noted that education alone is unlikely to be sufficient to change practice (MacLaren Chorney et al., 2014; Vincent et al., 2012).

**Parents’ information needs**

In contrast with other studies (Hamers & Abu-Saad, 2002; Tait et al., 2008), most parents in this study indicated receiving sufficient information about how to manage their child’s pain at home. However, many parents in this study still struggled to manage their child’s postoperative pain effectively, and as in other research (Homer et al., 2001; Swallow et al., 2000), sought additional advice from healthcare professionals, especially if their child experienced any troubling symptoms. This suggests that there may be a need to provide parents with additional forms of support in this context. Jenkins and Fortier (2014) discussed the potential benefits of tailoring information to meet the needs of each family, based on a variety of factors that may impact pain management, such as the child’s age and developmental level, parental beliefs about pain management, or cultural background. That said, parents may still require opportunities to connect with care providers to address specific concerns.

Previous research suggests that both parents and children want more support with their recovery (Wiggins, 2009). The support families need may not just be in the form of education, but emotional or social support as well, since many parents discussed the importance of managing their own emotional distress so they could effectively manage their child’s pain and distress. Clinicians may want to emphasize that pain post-tonsillectomy can be mild to severe; and that severe pain is “normal” and will not last. Additionally, it may be useful to provide families with access to online information such as *http://mychildisinpain.org.uk* so they can gainfurther information about pain management in children. It will likely be important for hospitals to engage in a multidisciplinary approach, and draw on a variety of local resources including community clinicians. In a hospital context, attempts to increase knowledge translation among healthcare providers have resulted in improvements in children’s pain assessment and management, which has impacted the prevalence and intensity of children’s pain in this context (Zhu et al., 2012). Perhaps parallel interventions could be applied to help parents manage their child’s pain at home.

It is possible that some families may have been engaging in the recommended pain management behaviours but still may have experienced difficulties managing their child’s postoperative pain. It is important to acknowledge that even when parents and healthcare providers work together to provide children with the best care, managing children’s pain at home can still be a stressful experience for many families. Notably, some children who received analgesic medications as prescribed still experienced some pain, which highlights the importance of other physical and psychological pain management strategies and the continued development of better analgesic medications.

**Limitations**

There are several limitations to this study. First, there was a relatively small sample of English-speaking participants from one Canadian hospital who volunteered to take part in this research, so the results may not be generalizable. We did not collect data on families’ ethnicity, which in conjunction with their language and level of acculturation, has been found to be related to parental attitudes about the use of analgesic medications for children (Fortier et al., 2011b). It is also possible that selection bias occurred, as the relatively small proportion of participants who volunteered to take part in this study could potentially differ in some way from the larger population that is served by our local clinic. We only interviewed one parent from each family, so we are missing information from other family members who may have been impacted by the surgery, most notably the children. We also only have information about what parents said they did, and not what they actually did. Additionally, we only enrolled parents of typically-developing children to first understand pain management in this population before extending this research to other populations who may have different needs. However, the results of this qualitative study do provide insight into parents’ experiences of managing their child’s postoperative pain at home.

**CONCLUSIONS**

This study provides a first-hand account of parents’ experiences of managing their child’s postoperative pain at home. Parents’ experiences were impacted by balancing the pros and cons of administering analgesic medications, managing the emotional and psychological effects of their child’s pain, as well as their information needs. The primary purpose of this study was to identify parents’ information needs to help them better manage their child’s postoperative pain; however, it appears that many of their information needs were satisfied yet parents still struggled to manage their child’s pain. Therefore, further qualitative research is required to better understand the specific barriers that make this process challenging for many families, and what healthcare centres can do to help support families in this process.

**RELEVANCE TO CLINICAL PRACTICE**

These findings will help inform healthcare professionals of the strategies that parents use, the challenges they face, and the support families need to help them effectively manage their child’s postoperative pain at home. This research will contribute to the development of more effective patient and family-informed interventions that will improve children’s pain management at home.

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*Table 1*. Demographic Data (N=10)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Parent Gender** | **Living Situation** | **Maternal Age** | **Paternal Age** | **Child Gender** | **Child Age at Surgery** | **Child Surgery** |
| Female n=9Male n=1 | 2 parents at home n=81 parent at home n=2 | 25 to 43 years *(M* = 36, *SD* = 5 years) | 25 to 50 years *(M* = 40, *SD* = 7 years) | Female n=5Male n=5 | 5.08 to 6.00 years*(M* = 5.50,*SD* = 0.33 years) | Tonsils and adenoids n=8 Tonsils onlyn=2 |

*Figure 1*. Parent’s experiences of managing their child’s post-operative pain at home.

Appendix A. Interview Guide

* I’d just like to confirm that your child had a tonsillectomy at the *Paediatric Otolaryngology Clinic* at [*Children’s Hospital*] on [*date of child’s surgery*]. Please tell me a bit about his/her experience with this surgery.
* Immediately after your child’s tonsillectomy, please tell me what your child’s experience of pain was like.
* When you first got home from the hospital after your child’s tonsillectomy, please tell me what your child’s experience of pain was like.
* During the first week after his/her surgery, please tell me what your child’s experience of pain was like.
* During the following weeks after surgery, please tell me what your child’s experience of pain was like.
* How did you help your child with his/her pain?
	+ Did you give him/her medications?
		- Did you have any concerns about the side effects of pain medications?
		- Did you have any concerns about pain medications being addictive?
	+ Did you try anything besides medications?
* Were there any other recovery issues (e.g., issues with sleep or eating)?
* What were the most difficult things about managing your child’s pain?
* What were the easiest or most rewarding things about managing your child’s pain?
* Did the surgery make a difference in your child’s quality of life afterward?
* Before your child was discharged from the [*Children’s Hospital*], what information did you get about managing your child’s pain at home?

How easy was it to understand this information?

* + How did you use this information?
	+ Is there any additional information that would have helped you manage your child’s pain at home more easily?
* Did you contact any other healthcare professionals to seek advice about how to manage your child’s pain following discharge?
* Now that you have been through this experience of managing your child’s pain at home after his/her tonsillectomy, what information would like to share with other families that might help them manage their child’s pain?
* Is there anything else you would like to add?