The assessment and management of pain in older people by nurses in acute care: a focused ethnography

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B.N. (Hons) B.App.Sc (Cons Tech)

A thesis presented in fulfilment of the requirements for the degree of

Doctor of Philosophy, Nursing.

The University of Newcastle

Australia

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Statement of Originality

The thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to the final version of my thesis being made available worldwide when deposited in the University’s Digital Repository, subject to the provisions of the Copyright Act 1968

Signed
Acknowledgements

Undertaking this PhD has involved a lot of people and I wish to take this opportunity to thank you all for your support and encouragement. To begin with I wish to thank my family, and in particular my mum with your endless encouragement to ‘Just go for it Jo’. Without the support of my family, I would not have ever taken the first step and made it to where I am today. So thank you very much. Isabel Higgins who I have worked with not only with this PhD but also with my honours thesis, I cannot thank you enough for crafting me into an independent critical thinking researcher. I am grateful for your tireless input, continued interest and I am still in awe of your intellectualism. A big thank you Peter Summons for not only being there from the beginning with my honours thesis and into the PhD, but also for your input and calm logical advice. Many thanks to Sian Maslin-Prothero for all those skype meetings, and encouraging me to be realistic while keeping me on track. Also heaps of thanks to Erica Southgate for providing much needed advice and input about ethnography. I wish to acknowledge the older persons in this study; I thank you for the honour and privilege in sharing with me your experiences during your period/s of admission into acute care. I also wish to acknowledge and thank the registered nurses within the study sites. I fully appreciated the time and effort that you all set aside to participate in this study. Finally I would also like to thank my many friends and colleagues, who have tolerated many a debrief, whinge, and meltdown over cups of tea or coffee (plus cake). Thanks heaps guys for just being there and keeping me going. I acknowledge Jane Todd for professional copy editing and proofreading advice as covered in the Australian Standards for Editing Practice, Standards D and E.

Cheers and big pats to Leo and Teddie for the many walks together.
The assessment and management of pain in older people by nurses in acute care: a program of research

This thesis presents a program of research that I have undertaken that focuses on the assessment and management of pain in older people by acute care nurses. This research program began with the undertaking of a pilot evaluation study of a prototype pain algorithm for the assessment and management of pain in the older person in the acute care setting that was submitted as a nursing honours thesis. This was then followed on the extension of the study into a PhD when I have continued to write papers, publish and present at numerous national and international conferences.

Publications, papers developed


Day, J. L., Harmon, J., & Higgins, I. (in development). Thinking on your feet: In field decisions made by nursing doctoral students using qualitative research methods. *Nursing and Health Sciences*


Oral conference presentations and refereed conference papers

2015 14th Qualitative methods conference, University of Alberta

*The challenges of using ethnographic methods in acute care settings*
2014 3rd Asia Pacific International Conference on Qualitative Research in Nursing, Midwifery and Health
An Ethnographic Study of Pain in Older Patients in Acute Care Settings: The Barriers and Facilitators to care by Nurses

The methodological challenges of doing research with older person in an acute care setting

Full paper: The methodological challenges of conducting older person research in an acute care setting: reflections from a focused ethnographer

2013 46th Australian Association of Gerontology (AAG) National Conference
Pain management in older people: an ethnographic study

AAG and Ageing and Community Services Rural Conference
The assessment and management of pain by nurses in older people in acute care: a review of the literature

Emerging researchers in Aging National Conference
The methodological challenges of research in acute care: undertaking a focused ethnographic approach

Full paper: The methodological challenges of research in acute care: undertaking a focused ethnographic approach

2012 Emerging researchers in Aging National Conference
The assessment and management of pain in older people in acute care

Full paper: The assessment and management of pain in older hospitalised people: critical review of the literature

2011 9th Asia/Oceania Congress of Geriatrics and Gerontology International Conference
A pilot evaluation study of a prototype pain algorithm for the assessment and management of pain in the older person in the acute care setting

Emerging researchers in Aging National Conference
An evaluation study of a prototype pain algorithm for the assessment and management of pain in the older person in the acute care setting: results of a pilot study

Full paper: Assessment and management of pain in older people within acute care by registered nurses, how close to practice is an algorithmic approach: results of a pilot study

2010 Emerging researchers in Aging National Conference
A pilot evaluation study of a prototype pain algorithm for the assessment and management of pain in the older person in the acute care setting
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Key

The conventions and following abbreviations have been used throughout the presentation of research findings as described in the “Publication Manual of the American Psychological Association (6th ed.)” (American Psychological Association, 2010) have primarily been adopted in this thesis.

Names

Pseudonyms have been used to refer to participants, as well as people and places referred to.

Italicised text

Participant quotes given within text paragraphs. Theme and sub theme headings when referred to in text are also italicised.

“Double quotation marks italicised text”

Participant use of slang or use of invented or coined expressions common within their group. To enclose quotations by participants in transcript excerpts

Indented italicised text

Participant transcript excerpts, medical notes, observation data

[Square brackets]

Researchers’ comments added in square brackets to provide clarity or explanation

[Aligned right text]

Participant name and data source

[Plain type in square brackets]

Comments within participant transcript excerpts to provide clarification or explanation

…

Material leading into the excerpt or the remainder of the participant’s sentence has been omitted for clarity and concision.

---

Short pause in the participant’s conversation.

(…)

Material has been omitted from within transcript excerpts for clarity and concision that is less than two sentences
## Glossary

### Numbers

2/52  
Shorthand for the number of weeks in the year

1-8 RN/EEN  
When nurses are referring to of a numerical value in relation to colleagues qualifications, this is in relation to a pay scale accorded by actual years of clinical experience, (as opposed to years since registration) with the highest pay scale being for a registered nurse eight and thereafter.

+++  
This abbreviation has no official international recognition. It is a written Australian piece of jargon used to indicate ‘an excessive amount’ (e.g.: patient has +++ pain)

<table>
<thead>
<tr>
<th>A</th>
<th>ADL</th>
<th>Activities of daily living</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>APO</td>
<td>Acute pulmonary oedema</td>
</tr>
<tr>
<td></td>
<td>APS</td>
<td>Acute Pain Service</td>
</tr>
<tr>
<td>B</td>
<td>BD</td>
<td>Twice daily</td>
</tr>
<tr>
<td></td>
<td>BIBA</td>
<td>Brought in by Ambulance</td>
</tr>
<tr>
<td></td>
<td>Bi-lat</td>
<td>Bi laterally</td>
</tr>
<tr>
<td></td>
<td>B/G</td>
<td>Background of</td>
</tr>
<tr>
<td></td>
<td>BP</td>
<td>Blood pressure</td>
</tr>
<tr>
<td></td>
<td>BNO</td>
<td>Bowels not open</td>
</tr>
<tr>
<td>C</td>
<td>CAP</td>
<td>Community acquired pneumonia</td>
</tr>
<tr>
<td></td>
<td>CCF</td>
<td>Congestive cardiac failure</td>
</tr>
<tr>
<td></td>
<td>CCU</td>
<td>Coronary care unit</td>
</tr>
<tr>
<td></td>
<td>CiAP</td>
<td>Clinical information Access Portal</td>
</tr>
<tr>
<td></td>
<td>C/O</td>
<td>Complains of</td>
</tr>
<tr>
<td></td>
<td>CNE</td>
<td>Clinical Nurse Educator</td>
</tr>
<tr>
<td></td>
<td>CNC</td>
<td>Clinical Nurse Consultant</td>
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<tr>
<td></td>
<td>CNS</td>
<td>Clinical Nurse Specialist</td>
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<tr>
<td>D</td>
<td>D/C</td>
<td>Discharge charge from hospital</td>
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<td></td>
<td>DVT’s</td>
<td>Deep vein thrombosis</td>
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<tr>
<td>E</td>
<td>EBP</td>
<td>Evidence Based Practice</td>
</tr>
<tr>
<td></td>
<td>ED</td>
<td>Emergency department</td>
</tr>
<tr>
<td></td>
<td>EEN</td>
<td>Endorsed enrolled nurse</td>
</tr>
<tr>
<td></td>
<td>Endone</td>
<td>Instant release Oxycodone hydrochloride tablet</td>
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<td>ECG</td>
<td>Echocardiography</td>
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<td>F</td>
<td>FASF</td>
<td>Forearm support frame for mobilisation</td>
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<td>G</td>
<td>GCS</td>
<td>Glasgow coma scale</td>
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<tr>
<td></td>
<td>GP</td>
<td>General Practitioner</td>
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<td>H</td>
<td>HR</td>
<td>Heart rate</td>
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<td>HTN</td>
<td>Hypertension</td>
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<td></td>
<td>Hx</td>
<td>History of</td>
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<td>I</td>
<td>IADLs</td>
<td>Independent with activities of daily living</td>
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<td></td>
<td>I/C</td>
<td>In-Charge nurse</td>
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<tr>
<td></td>
<td>ICC</td>
<td>Intra-costal catheter</td>
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<tr>
<td></td>
<td>ICU</td>
<td>Intensive care unit</td>
</tr>
<tr>
<td></td>
<td>IIMS</td>
<td>Incident Information Management System</td>
</tr>
<tr>
<td></td>
<td>IR</td>
<td>Instant release</td>
</tr>
<tr>
<td></td>
<td>IM</td>
<td>Intra muscular injection</td>
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<td></td>
<td>IV</td>
<td>Intra venous route</td>
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<td></td>
<td>IVC</td>
<td>Intra venous cannula</td>
</tr>
<tr>
<td></td>
<td>IVAB</td>
<td>Intra venous antibiotic infusion</td>
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<tr>
<td>J</td>
<td>JMO</td>
<td>Junior Medical Officer</td>
</tr>
<tr>
<td>K, L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
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<td>-------------</td>
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<tr>
<td>MIMs</td>
<td>Medication Information Management system</td>
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<tr>
<td>Mane</td>
<td>Morning</td>
<td></td>
</tr>
<tr>
<td>MMSE</td>
<td>Mini mental score exam</td>
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</tr>
<tr>
<td>N</td>
<td>Nausea and vomiting</td>
<td></td>
</tr>
<tr>
<td>NFR</td>
<td>Not for resuscitation</td>
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</tr>
<tr>
<td>NP</td>
<td>Nasal Prongs for delivery of supplemental oxygen</td>
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</tr>
<tr>
<td>Nocte</td>
<td>Night</td>
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<tr>
<td>O</td>
<td>On Arrival</td>
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</tr>
<tr>
<td>OA</td>
<td>Osteoarthritis</td>
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<tr>
<td>OBS</td>
<td>Observations for vital sign monitoring</td>
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<td>Oxycontin</td>
<td>Slow release oxycodone hydrochloride tablet</td>
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<td>Osteo Panadol</td>
<td>Slow release Acetaminophen</td>
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<tr>
<td>Ps</td>
<td>Patient</td>
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<tr>
<td>Panadol</td>
<td>Acetaminophen</td>
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<td>Panamax</td>
<td>Term commonly used for Acetaminophen by Australian older persons</td>
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<td>Paracetamol</td>
<td>Acetaminophen</td>
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<tr>
<td>Panadiene Forte</td>
<td>A combination oral drug of Acetaminophen 500 mg and Codeine phosphate 30 mg</td>
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</tr>
<tr>
<td>PCA</td>
<td>Patient Controlled Analgesia</td>
<td></td>
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<tr>
<td>PICC</td>
<td>Peripherally inserted intra venous</td>
<td></td>
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<tr>
<td>PPM</td>
<td>Permeant pace maker</td>
<td></td>
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<tr>
<td>PRN</td>
<td>Pro re rata (Latin) as needed or when required</td>
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</tr>
<tr>
<td>PR</td>
<td>Per rectal</td>
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</tr>
<tr>
<td>QID</td>
<td>Quarter in die (Latin) four times a day</td>
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<tr>
<td>RespS</td>
<td>Respiratory rate</td>
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</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
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</tr>
<tr>
<td>RMO</td>
<td>Registered Medical Officer</td>
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<tr>
<td>R/O</td>
<td>Removal of</td>
<td></td>
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<tr>
<td>ROM</td>
<td>Range of movement</td>
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</tr>
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<td>RR</td>
<td>Respiratory rate</td>
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<td>RRT</td>
<td>Rapid response team</td>
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<td>RV</td>
<td>Review of</td>
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<td>S</td>
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<td>S4</td>
<td>Restricted drug of dependence</td>
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<td>S8</td>
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<td>SR</td>
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<td>SAGO</td>
<td>Standard General Adult Observation chart</td>
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<td>Pulse oximetry saturation</td>
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<tr>
<td>SOB</td>
<td>Shortness of Breath</td>
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<tr>
<td>Subcut</td>
<td>Subcutaneous route</td>
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<tr>
<td>Temp</td>
<td>Temperature</td>
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</tr>
<tr>
<td>TKR</td>
<td>Total Knee replacement</td>
<td></td>
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<tr>
<td>THR</td>
<td>Total Hip replacement</td>
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<tr>
<td>TDS</td>
<td>Three times a day</td>
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<tr>
<td>U</td>
<td>Ultra sound</td>
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</tr>
<tr>
<td>UTI</td>
<td>Urinary tract infection</td>
<td></td>
</tr>
<tr>
<td>V, W, X, Y, Z</td>
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</tbody>
</table>
Abstract

Introduction.

Pain is one of the main reasons why older people (65 years and over) present to hospital. They have the highest rate of admission to hospital involving a multitude of medical and/or surgical procedures and many are associated with acute pain. Older people also often present with histories of existing and multiple pain sources and types. The most common reason for unrelieved pain in acute care settings is the failure of health care providers to systematically assess and treat pain. Pain affects an older person’s health, their ability to function at their optimal capacity both cognitively and physically, and also reduces their quality of life. Older people who are in pain are at risk of sleep disturbances whilst they are an inpatient as well as delayed rehabilitation. Furthermore, it has been shown that an older person who has a higher postoperative pain score, will have a longer stay in hospital and this can lead to chronic functional impairment.

Methods.

The aims of the study were to explore the culturally mediated practices of registered nurses (RN’s) in acute care settings when assessing and managing pain in older people and to explore the culturally mediated barriers and facilitators to practice. A Qualitative research design was used underpinned by Focused Ethnography. Methods included 1,040 hours in the field with 73 hours of focused observations of nurses (n=9) who cared for older patients (n=42) conducted over a 6 month period. Semi-structured interviews were also held with nurses (n=23) and older patients (n=12). Documents
including ward policies, procedures, patient histories and medical notes were also reviewed. The settings for the study were eight wards: medical, surgical, sub-acute and oncology, of two large tertiary referral hospitals in New South Wales Australia. Data were analysed in a range of ways beginning with a qualitative descriptive approach directed by the undertaking of taxonomies, typologies guided by the work of Spradley (1980) and the use of Leininger’s culture care theory (1988), before a content analysis and thematic analysis.

Analysis of data showed that when caring for older patients with pain, nurses showed leadership by acting as problem solvers around pain issues and concerns, that they mentored new nurses in relation to pain care, they questioned them about the rationales for their approaches and they provided education to staff, albeit within the limitations of their own knowledge. There were tales of success, how they assessed and rated pain, pain that they acknowledged as real and genuine, and stories of how quality improvement audits shaped what they did. Older patients talked of not being heard by nurses when in pain, of enduring pain, of having to retell their pain histories often, of being moved around from ward to ward, and of being a good patient or an unpopular patient. Observations revealed pain assessment mediated by social rules, rituals and routines for pain care and a range of barriers and facilitators to pain care. There was a lack of continuity of pain care provision from shift to shift, ward to ward, and hospital to hospital and the older people in this study spoke about how difficult it was for them to provide one numerical pain score in the light of their multiple pain sites and types. The older people in this study also spoke of not being heard about their pain, that their pain stories were lost and this meant that at times they experienced frustration.
Conclusion

A lack of uptake and use of Evidence Based Practice (EBP) for pain care provision by the acute care Registered Nurses RN’s in this study meant that older hospitalised people endured pain. Uptake and use of EBP for pain care provision requires organisational support along with meaningful input from the older people themselves. There is a need for education of RN’s that focuses pain assessment and management in older people and the mechanisms for the uptake of EBP. Clinical supervision that includes external professional input should be mandated to support critical reflection on the care that is provided to older people with pain and how this can be improved.
Chapter one: Study introduction and overview

Chapter Introduction

This study used focused ethnography to explore the clinical practices of nurses during pain assessment and management of hospitalised older people. Older people constitute over a third of all admissions to acute care (Australian Institute of Health and Welfare (AIHW) 2014) and comprise up to 50% of the inpatient population (AIHW 2014), they also have the longest hospital stay (AIHW 2013, 2014) which predisposes them to adverse and iatrogenic events (Ackroyd-Stolarz, Guernsey, MacKinnon, & Kovacs, 2009; Vaglienti & Grinberg, 2004). Pain is one of the main reasons why older people (65 years and over) present to hospital (Carr et al., 2014; Daoust, Paquet, Lavigne, Sanogo, & Chauny, 2014; Dawood, Dobson, & Banerjee, 2011). Of concern is that older people often have pre-existing multiple pain sites and types associated with chronic and complex diseases (Abdulla et al., 2013; Herr, 2010; Perry, 2009). During hospitalisation older people also succumb to pain inflicted during medical and surgical interventions (Czarnecki et al., 2011; Rawe et al., 2009). The research shows that being in pain leads to negative outcomes for older people; there may be complications associated with unrelieved pain such as falls (Titler, Shever, Kanak, Picone, & Qin, 2011), disrupted sleep (Bowman, 1997; Gardner, Collins, Osborne, Henderson, & Eastwood, 2009), increased distress (Westman, Boersma, Leppert, & Linton, 2011), atelectasis (Thornlow, Oddone, & Anderson, 2014), and side effects associated with analgesic medications (Edwards, Pandit, & Popat, 2006; Thornlow, Anderson, & Oddone, 2009). Pain decreases cognition (Ji et al., 2010) and increases the risk of cascading iatrogenic events with multiple complications (Thornlow et al., 2009).
prolonging hospitalisation and increasing the risk of further adverse events (Kerr et al., 2010). Discharge may be delayed (Elliott et al., 2014) and unrelieved temporary pain may become chronic (Brennan, Carr, & Cousins, 2007). Pain also predisposes older patients to delirium (Robinson & Vollmer, 2010), which if untreated can lead to death (Silverstein, Timberger, Reich, & Uysal, 2007). Hospitalisation with unrelieved pain also leads to increased risk of negative outcomes for older people who are cognitively impaired (Australian Institute of Health and Welfare, 2014; Herr, Coyne, McCaffery, Manworren, & Merkel, 2011; Malloy & Hadjistavropoulos, 2004). However, despite this, little is known about the factors that impact on how nurses assess and manage pain in older people in acute care.

**Why explore pain care provision by nurses for the older hospitalised person?**

My interest in undertaking this study began after I completed a pilot qualitative descriptive study that used an ethnographic approach to explore a prototype pain algorithm for the assessment and management of pain in the older person in the acute care setting (Harmon, Bellchambers, Summons, & Higgins, 2010). The findings of this pilot study revealed a lack of congruence between nurses’ clinical practices when compared to the evidence relating to assessing and managing pain in older people. The findings of this study were presented as a thesis for a Bachelor of Nursing (Hons) (Harmon et al., 2010). A limitation of the pilot study was that older people were not interviewed and those with cognitive impairment were excluded from the study. The findings from the pilot study indicated that further research was needed to explore this issue more deeply and this was the starting point for this PhD research.
Study purpose and research questions.

The aim of the study reported in this thesis was to explore the clinical practice of nurses when they are assessing and managing pain in older people in the acute care setting.

The research questions were:

1. What are the culturally mediated practices of nurses during the assessment and management of pain when caring for older people in acute care?

2. What are the culturally mediated facilitators and barriers to practice?

The research sub questions were:

- What are the values and beliefs of nurses regarding pain in older people, pain assessment and management processes?
- What are the nurses’ motivations when assessing and managing pain in older people?
- What artefacts (such as documentation, policy, guidelines and assessment tools) within the organisation or ward setting are used by nurses to guide their pain assessment and management practices for older people?
- What are the routine care processes undertaken by nurses for the assessment and management of pain in older people?
- Are there rituals associated with assessing and managing pain in older people?
- What is the older person’s experience of having their pain assessed and managed by nurses?
- What are the environmental influences on the practice of nurses when assessing and managing pain in older people?
Study context.

The health care system in Australia is both privately and government funded. Government funding for health care is managed by states or territories, for example the New South Wales (NSW) state government manages and funds the NSW hospital system. As a result, there are mandated state-wide NSW health guidelines for all NSW hospitals to conform and adhere to. There is a division of the state into separate area health services, which also have their own policies and procedures in place for all aspects of health care practice. Specialist support services are also available for nurses including when managing pain, such as acute pain services, however this is not common within all area health services.

The goal of this study was to provide much-needed insight into the provision of pain care for the older hospitalised person in acute care that will facilitate the targeting of improvement of nurses’ clinical practices. This study attempts to identify barriers and facilitators to pain care that may be in place within the acute care clinical environment.

Thesis organisation.

This thesis is presented as nine chapters. Chapter one presents an introduction and background as well as context for the study. Chapter two presents a critical review of the literature that builds on the knowledge gained. Chapter three provides an outline of the conceptual framework that underpins this study, focused ethnography and the use of a focused ethnographic approach in this study. Chapter four presents the research design and methods used in the study. Chapter five presents a prologue that describes the older people who participated in the study. Chapters six, seven and eight represent the findings of the study and capture the perceptions of the nurses and the older persons’ experiences of pain care provision within acute care. Chapter nine contains the
discussion and conclusion. Finally the appendices provide the materials used to conduct the study and include ethics applications and approvals, documentation in relation to recruitment of participants, the semi-structured interview guide as well as how confidentially and security of the data gained has been provided.

**Background information**

This section of the chapter provides background to the study. The first section titled *Pain* begins by providing an outline of the relevant current internationally accepted definitions of acute, chronic and breakthrough pain as well as neuropathic pain. An explanation for how onset of pain may occur is presented along with a discussion on the association between acute and chronic pain.

The second section *Pain care provision and evidence based practice* is a structured account for how the best available evidence for pain care provision can be incorporated into nurses’ clinical practices. It begins by outlining the importance of knowing the context in which the EBP is to be located before noting the barriers for implementation into practice. A discussion on the present-day international situation of nursing clinical evidence sources is outlined which is followed by the current use in acute care of standardised charts for quality improvement projects within acute care.

This chapter concludes with the section on *Organisational culture within hospitals*, which provides insight into the context of the delivery of nursing care within the hospital institution. International situations of when organisational drift occurred within a hospital culture are discussed that lead to negative outcomes for the patients. Provided are the implications of how the social organisational identity and leadership styles of nurses can combine to exert an influence on accepted normalised behaviours.
Pain.

This section begins with a brief description of the history of pain management. It then presents the current internationally accepted definitions of pain. The onset of pain is discussed along with the association between acute and chronic pain.

Pain management has an extensive history that has concerned people, understandably, over the span of time. Missing from these historical accounts are inputs from nursing and a patient’s perspective. Therefore, theoretical perspectives of caring from a nursing perspective are absent within these early accounts.

Extensive scientific theories of pain management really only began to emerge with the industrial revolution and the advent of printing, allowing dissemination of Descartes (1596-1650) Cartesian mind body dualism theory that was based on mathematics and science (Duncan, 2000). Descartes is often cited as the originator of what is known as this traditional view of pain management, being that pain behaviours exhibited by a person are a simple reflex or response purely aligned to that of a sensory stimulus that has no psychological significance (Duncan, 2000). Descartes maintained that pain was only a representation, as part of a conscious experience that was located solely within the mind, in that while pain affirmed a connection between the body and the soul, its experience was ambiguous (Duncan, 2000).

The implication of that proposal for modern pain management practices is a focus on pain as being merely an unpleasant sensation of the mind and actively avoids the emotional or psychosocial factors. The result was a perpetuation of research that focused on the objectification of somatic processes elevated into a position of eminence and indoctrination that they, and only they, are the sole agents that produce pain (Crowley-Matoka, Saha, Dobscha, & Burgess, 2009). This biomedical predominance
has allowed increased understanding surrounding pain as a natural phenomenon within the confines of underlying physiology and pathology (Crowley-Matoka et al., 2009). This is evident with a tendency to categorise into typologies and compartmentalise those aspects which are overtly objective by being measurable, as opposed to those aspects which are subjective and therefore unmeasurable (Crowley-Matoka et al., 2009).

It was not until Merskey and Bogduk (1994) historically argued that pain was to be considered as a symptom, to be alleviated in the short term while awaiting a diagnosis or a cure for its underlying cause, that acknowledgement began of the personal and social factors (Madjar, 1998). The most widely accepted definition of pain was developed initially by Merskey and Bogduk (1994) and was adopted by the International Association for the Study of Pain (IASP) (Baranowski et al., 2012). They defined pain as:

An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

(Merskey & Bogduk, 1994, p. 45)

As Melzack and Wall (1996) note however, this definition, like others, is inadequate. To describe pain as unpleasant falls short of the full reality of the experience of pain.

What is missing in the word ‘unpleasant’ is the misery, anguish, desperation and urgency that are part of some pain experiences.

(Melzack & Wall, 1996, p. 45)

Most people would agree with the definition of pain as an unpleasant sensory and emotive experience associated with actual or potential tissue damage (Hector et al., 2005). Some might argue that no involvement at a tissue level is required for the experience of pain. That argument is based on the view that pain can occur contrary to overt bio-medical objectification, when a person is viewed only by medical imagery
comprised of scans or details of neuronal pathways and chemical markers with no attention to who they are (Gilman, 2011).

A more moderate ideal is that a person’s experience of pain will depend on both the degree of sensory stimulation and how the person perceives their experience. This is because pain is and always remains a deeply personalised and subjective experience (Devine, 2005). Furthermore, not only will a person’s account of pain be subjective, but the reception of their accounts of their pain and its inherent nature will also be received in a subjective manner. In order to counter this there is a prevailing use of objective measurement for standardisation of pain (Gilman, 2011). For instance, the terms used to describe pain that have been summarised and used in the IASP taxonomy, which are shown below in Table 1 Internationally accepted terms used to describe pain (Baranowski et al., 2012)

<table>
<thead>
<tr>
<th>Allodynia</th>
<th>Lowered threshold</th>
<th>Test by a brush with a cotton swab</th>
<th>Stimulus and response mode differ</th>
<th>Pain from a stimulus that does not normally cause pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyperalgesia</td>
<td>Increased response</td>
<td>Pinprick or pinch test</td>
<td>Stimulus and response mode are the same</td>
<td>An increased response to a stimulus that is normally painful</td>
</tr>
<tr>
<td>Hyperpathia</td>
<td>Raised threshold and increased response</td>
<td>Pinprick or pinch test</td>
<td>Stimulus and response mode may be the same or different</td>
<td>A painful syndrome that is an abnormally painful reaction to a stimulus, particularly if it is repeated</td>
</tr>
</tbody>
</table>

A pain threshold is defined as the least or minimum intensity that a person will experience or perceive pain, and not as the intensity measured as an external event (Baranowski et al., 2012). This means that a stimulus such as a broken bone cannot be a sole measure of pain. The tolerance level of pain that a person has will be the maximum intensity that, within their subjective experience, they are willing to accept (Baranowski et al., 2012).
Definitions of pain.

The perceptions held by people regarding pain vary; this is because values are often based on ideals which are founded individual experiences of health. Therefore, any idea held about pain will be a cultural reflection of that society (Napier et al., 2014). The definitions of pain presented in this section are based on the standard definitions devised by the IASP task force on taxonomy (Baranowski et al., 2012).

Nociceptive pain can occur as somatic pain which is localised pain that is detected by the receptors located within the skin, muscles and bone (Hadjistavropoulos et al., 2007). Visceral pain is often poorly localised and is detected by the receptors which are located within an organ such as intra-abdominal or liver (Hadjistavropoulos et al., 2007). Whereas neuropathic pain can result from stroke, herpetic neuralgia, and degenerative diseases of the spine can produce radicular pain as well as peripheral neuropathy to name a few (Hadjistavropoulos et al., 2007). Furthermore, there are other pain conditions such as myofascial pain, and fibromyalgia syndrome as well as chronic back pain (Hadjistavropoulos et al., 2007).

Acute pain.

Acute pain is defined as a time limited response to trauma, surgery, or other ‘noxious experiences’ (Baranowski et al., 2012) and it is generally managed post-operatively or post trauma within the acute care setting in either medical or surgical wards (National Pain Strategy., 2010).

Chronic pain.

Persistent, or chronic, pain is defined as pain that continues past the normal duration of tissue damage or the period of the healing processes, and that lasts for three out of six
months (Calvalien, 2002; Herr, Bjoro, Steffensmeier, & Rakel, 2006; Horgas, 2003; Siddall & Cousins, 2004). The term persistent pain is often used interchangeably with chronic pain (Munk, Kruger, & Zanjani, 2011; Siddall & Cousins, 2004; Voscopoulos & Lema, 2010).

**Breakthrough pain.**

Breakthrough pain can be classified into two categories, idiopathic pain that is either spontaneous, unpredictable in nature, and is not related to an identifiable precipitant or precipitated pain that is related to an identifiable precipitant (Davies, Dickman, Reid, Stevens, & Zeppetella, 2009). The nature of breakthrough pain is that it is not a single entity but can be related to a number of different causes such as cancer, clinical interventions, and concomitant illness. It can have different patho-physiologies either nociceptive, neuropathic or mixed (Davies et al., 2009). For instance, the accepted definition of cancer breakthrough pain is that it is:

...*Transient exacerbation of pain that occurs either spontaneously or in relation to a specific predictable or unpredictable trigger and this will occur despite the person having relatively stable and adequately controlled background pain.*

(Davies et al., 2009, p. 332)

**Neuropathic pain.**

Neuropathic pain is a clinical description and not a diagnosis. It covers a spectrum which is defined by the IASP (Baranowski et al., 2012) as being pain initiated or caused by a primary lesion or dysfunction in the nervous system. Neuropathic pain can be caused by either a multitude of distinct or co-existing aetiologies, these being toxicity, metabolic disease, trauma, compression, autoimmune disorders, and infection as well as
congenital disease like multiple sclerosis (Lema, Foley, & Hausheer, 2010). Chemotherapy can induce neuropathic pain and this results from toxicity induced from oncology drugs with the severity and incidence depending on the regime, dose and schedule (Lema et al., 2010; Seretny et al., 2014).

**Onset of pain: precipitated, non-volitional, and procedural.**

There are common clinical conditions that are associated with pain onset such as orthopaedic injuries from a fall, temporal arteritis, and any bone pain at night as well as vascular compromise (Hadjistavropoulos et al., 2007). Precipitated pain can be sub-classified into one of three categories. The first is volitional incident pain, which is pain that occurs from engaging in voluntary acts such as walking (Davies et al., 2009). The second is non-volitional incident pain which is brought on by involuntary acts such as sneezing and coughing (Davies et al., 2009). The third is procedural pain that is related to therapeutic interventions during care provision, such as wound care or diagnostic tests and interventional procedures (Coutaux et al., 2008; Davies et al., 2009; Rawe et al., 2009).

**Association between acute and chronic pain.**

If left untreated, acute pain that is associated with surgery, trauma or other conditions, can progress to a state of chronicity (Hadjistavropoulos et al., 2007; National Pain Strategy., 2010). When acute pain is not relieved there may be pathophysiological neural alterations, including peripheral and central neuronal sensitisation, that can evolve into a chronic pain syndrome leading into a disease state (Brennan et al., 2007; Voscopoulos & Lema, 2010). Chronic pain is part of a disease state, and this removes the impetus for a focus on curing and for providing an emphasis on prevention (Siddall
When chronic pain is viewed as a disease state this also allows the recognition of the sufferers as having poor overall health and a reduced quality of life (Nicholl et al., 2009). For an older person the presence of chronic pain can lead to maladaptive physical, psychological, familial and social consequences which can also contribute to further decrease their quality of life (Bergeron, Bourgault, & Marchand, 2010; Brennan et al., 2007; Cornally & McCarthy, 2011). It can also lead to older persons experiencing higher levels of depression, anxiety and reduction of physical activity creating a cycle of increasing isolation socially (Cornally & McCarthy, 2011).

**Pain care provision and evidence based practice**

The theories about delivery of care by a nurse to a patient can often be conflicting, however it is the actual act of caring itself that will transcend any particular model or theory and this is the pivotal aspect that is central and defining for the nursing profession (Watson & Smith, 2002). The actual act of caring can be identified by four conceptual inter relating aspects that a nurse will engage in, namely interaction with a patient, application of knowledge, an intentional response and a pre-determined optimal therapeutic outcome (Sherwood, 1997). The seminal theory developed by Leininger, known as culture care theory (1988) proposed that care given by nurses in clinical practice will be based on culturally defined, ascribed or sanctioned modes of enabling patients to complete activities such as personal care or mobilisation.

Nurses use their knowledge for the provision of care in clinical practice that takes into account individual, organisational, and professional influences (Watson & Smith, 2002). However aspects of the actual delivery of care will be influenced by the prevailing culture within that context which can be influenced by the values, beliefs and practices of the individuals within (Cara, 2003). The provision of care by nurses that the patient...
considers safe, satisfying and of benefit is known as care provision which is culturally congruent (Leininger, 1988, 2002, 2006). Pain care provision that is culturally congruent for the patient will be the delivery of pain care that the older person will find satisfying, which relieves their pain, and is provided in a mode or route that is considered by them to be safe and beneficial (Leininger, 1988, 2002, 2006). Furthermore culturally congruent pain care for an older person will also be inclusive of the application of the older person’s own methods for gaining pain relief with an integration of learning new information which fits in with their lifeways (Leininger, 2006). Although the cultural background, cultural competence and the influence of the organisation as a whole will influence a nurse’s practice, it will be the context (Wikberg & Eriksson, 2008) in which the pain care is being delivered, that will have its own independent influence on the behaviour of the nurse and how they will form a relationship with the older person.

The provision of pain care by nurses requires implementation of the current evidence within clinical practices. Evidence based practice (EBP) is the implementation and translation into practice guidelines that contain all the elements of evidence. Rycroft-Malone, Seers, et al. (2004) defined evidence as being composed of four elements: research, clinical expertise, patient experience and context. They noted that unless research is incorporated into standardised guidelines within the clinical setting, the ability for research to have an impact on clinical practice is limited (Rolfe, Segrott, & Jordan, 2008). However Pun, Balas, and Davidson (2013) asserts that, before releasing any pain guideline, not only is prompt re-evaluation of existing guidelines or practice standards within the institution required, but there is also a requirement to know why things are occurring in that way to begin with. Furthermore, Pun et al. (2013) indicated that the context within the setting of the organisation is an important concept that requires consideration, as this knowledge is critical for the success of implementing and
also sustaining EBP (Gallagher-Ford, 2014; Harmon, Higgins, Summons, & Bellchambers, 2012).

**The context of EBP.**

The context for EBP was defined by McCormack et al. (2002, p. 101) as the *environment in which the implementation, utilisation and the creation of evidence may take place*. McCormack et al. (2002) noted that aspects that impinge within the environment for the uptake of EBP were the context, the culture and the leadership present. Furthermore, Dogherty, Harrison, Graham, Vandyk, and Keeping-Burke (2013) noted that these contextual factors within real situations experienced by nurses at point of care occurred at four different levels, categorised as the level of the individual, the environment, the organisation and the culture. It should be noted that all of these factors will act either as facilitators or as barriers for the success of introducing EBP into clinical point of care nursing (Dogherty et al., 2013).

The presence of a weak cultural climate is indicated by elements such as the presence of unclear values and beliefs, a low regard for the individual, and a task driven organisation that lacks consistency of the roles of its members and does not promote learning (McCormack et al., 2002). Leadership that is weak is defined by the presence of a lack of role clarity, teamwork and autocratic decision making incorporating a command and control style that promotes didactic teaching or learning (McCormack et al., 2002). With any setting that is characterised by a weak context for implementation of EBP there will be a lack of clarity around boundaries that are in place and feedback will be absent or of poor quality, resulting in a lack of benchmarking for standardisation (McCormack et al., 2002).
Barriers for implementation of EBP pain care provision.

The seminal study by Brockopp et al. (1998) on barriers to changes in pain management provides valuable insight into the cultural and institutional barriers to implementation of effective pain management. In total Brockopp et al. (1998) identified seven major barriers that are as listed below in table 2:

Table 2 Seven main barriers for implementation of EBP pain guidelines (Brockopp et al. 1998).

| 1.       | Lack of knowledge          |
| 2.       | Non-facilitative attitudes |
| 3.       | Inconsistent leadership    |
| 4.       | Poor working conditions    |
| 5.       | Cultural and religious bias|
| 6.       | Physicians fears of legal repercussions and |
| 7.       | A lack of resources        |

It has been argued that the first two points, lack of knowledge and non-facilitative attitudes, by Brockopp et al. (1998) in table 2 above require not only interventions that target education required for improvement of assessment of pain but also for attitudes of nurses in relation to pain (Howell, Butler, Vincent, Watt-Watson, & Stearns, 2000; Jastrzab, Kerr, & Fairbrother, 2009; Young, Horton, & Davidhizar, 2006). Interventions which target preconceived ideas, beliefs and attitudes as well as provision of education are noted to be more likely to result in real continuous change (Young et al., 2006).

Lacking from the gathering of evidence is often the patients’ viewpoint or inclusion within guideline formation and this is a major barrier. A systematic review by Ista, van Dijk, and van Achterberg (2013) on the comparative evidence for implementation strategies that aimed to improve nurses’ adherence to pain assessment recommendations in hospitalised patients provided no recommendation or preferred strategy. This was in part due to the lack of evidence on how the studies were conducted; they focused only on health professionals and the organisation and excluded input from patients. In
addition, there were ambiguous descriptions for what comprised implementation (Ista et al., 2013).

The research suggests that the barriers to effective pain assessment are largely related to hospital environment and the nurses themselves (Bourbonnais, Perreault, & Bouvette, 2004; Ista et al., 2013; Williams et al., 2012). The environmental factors that will act as a barrier are noted to be mainly organisational and administrative such as a lack of accountability that surrounded pain management (Bourbonnais et al., 2004). For instance, Bourbonnais et al. (2004) identified in their Canadian study that successful implementation and sustaining the use of a comprehensive pain and symptom tool came from having ward champions who were provided with education and involvement in the study. Similarly other studies have noted an increase of positive statements made by patients when ward champions are located within the clinical acute care wards (Williams et al., 2012), oncology wards (McMillan, Tittle, Hagan, & Small, 2005), paediatric wards (Ellis et al., 2007) and emergency wards (Campbell, Dennie, Dougherty, Iwaskiw, & Rollo, 2004). However, the Australian study by Williams et al. (2012) did not show an improvement of reduction of patients’ pain, although it is noted that they did not include any qualitative evidence from the patients’ perspectives. Moreover, Williams et al. (2012) identified that there was a lack of support from the organisation for pain champion nurses. What all these studies have in common is reiteration that outlines the importance of having ongoing support from both a pain service and the organisation that is formally recognised before any attempt of application within the ward context (Bourbonnais et al., 2004; Campbell et al., 2004; Ellis et al., 2007; McMillan et al., 2005; Williams et al., 2012).

The Swedish study by Boström, Kajermo, Nordström, and Wallin (2008) on the barriers to research implementation by registered nurses for nursing older people in nursing
homes identified the main obstacle was a lack of knowledgeable colleagues to confer with. This they reported as a result of a lack of networking as well as inadequate facilities being present for implementation of research (Boström et al., 2008). Similar findings with nurses within acute care hospitals also identified these aspects (Brown, Wickline, Ecoff, & Glaser, 2009; Kocaman et al., 2010; McCleary & Brown, 2003; Moreno-Casbas, Fuentelsaz-Gallego, de Miguel, González-María, & Clarke, 2011; Timmins, McCabe, & McSherry, 2012). Hospital organisations indirectly promoted the lack of uptake of research by not being supportive, not providing mentoring and clinical nurses not having the time to implement research within their setting (Boström et al., 2008; Brown et al., 2009; Dogherty et al., 2013; Kocaman et al., 2010; McCleary & Brown, 2003; Moreno-Casbas et al., 2011; Timmins et al., 2012).

Numerous studies have identified that the processes in place within the organisation are the main barriers to the implementation of research, as opposed to the level of knowledge that an individual nurse holds about undertaking and translating research into practice (Boström et al., 2008; Brown et al., 2009; Kocaman et al., 2010; McCleary & Brown, 2003). While McCloskey (2008) identified differences between the education levels of nurses in being able to critique and implement research, they also identified that a lack of support was present for advancing and promoting those with more advanced educational levels in relation to research implementation. The recommendations of the studies by Boström et al. (2008), Brown et al. (2009), Kocaman et al. (2010), Moreno-Casbas et al. (2011) Timmins et al. (2012) and Olsen and Bradbury-Jones (2013) are that a focus is required on the organisational issues at a nursing leadership management level. Similarly, Olsen and Bradbury-Jones (2013) and Dogherty et al. (2013) highlighted the need for policy development within the hospital organisational structure in order to provide supportive environments for research
utilisation to occur that is inclusive of stakeholders and that delivers ownership. Furthermore the recommendations by McCloskey (2008) and Brown, Ecoff, et al. (2010) note that more research is required that is located within the organisational context that also incorporates qualitative approaches instead of the continued reliance on quantitative surveys.

**Gaining the evidence for best practice.**

The majority of RN’s within Australia work clinically in a hospital setting and less than one percent of Australian nurses are researchers (Australian Institute of Health and Welfare., 2013b). This has led to a situation developing whereby clinical nurses have found conducting their own research as too challenging and therefore they have become reliant on nursing management for access to reports on current available data (known as nursing-sensitive outcomes) for provision of evidence in relation to their clinical practices (Doran & Sidani, 2007). Nursing-sensitive outcomes are the measurement of adverse health outcomes for patients that have been shown to be directly related to patient care (Donabedian, 2005; Schreuders, Bremner, Geelhoed, & Finn, 2014).

The situation for nursing in Australia is that currently there is no locally derived data available, for acute care nursing managers to base any comparison on, in relation to the measurement of nursing-sensitive outcomes (Heslop, 2014; Schreuders et al., 2014). In an effort to rectify this, Schreuders et al. (2014) undertook a retrospective cohort study which aimed to calculate the rates of nursing-sensitive outcomes within three Australian acute care hospitals. A common theme was identified that patients who will experience a nursing-sensitive outcome were likely to be 70 years and over, female and be a direct transfer (27%) from another acute care hospital as well as having spent time in ICU (Schreuders et al., 2014). Although Heslop (2014) noted the limitations within
Schreuders et al. (2014) as being the actual choice of indicators used, the fact remains that within the Australian acute care hospital settings there are no concerted national initiatives to monitor Australian nursing-sensitive quality indicators:

*Without nursing standardised data elements, researchers must rely on proxy measures to establish associations between nursing practice and workplace enhancements and their effects on patient outcomes*

(Heslop & Lu, 2014, p. 2475)

The critical review undertaken by Burston, Chaboyer, and Gillespie (2014) on nursing-sensitive outcome data within the Australian context noted that the majority of this data has been generated from the US (Brown, Donaldson, Burnes Bolton, & Aydin, 2010; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002) and European sources (Patrician, Loan, McCarthy, Brosch, & Davey, 2010). Furthermore the authors Heslop and Lu (2014) noted within their concept analysis that there is variability as to what is being currently defined as a nursing-sensitive outcome indicator and the continued inconsistent application of use has meant a lack of standardisation has resulted. The implications for generalising this data to an Australian context for benchmarking relates to an inability to identify any meaningful association due to vast differences of the structural variables such as; the nurse to patient ratio, education level of the nurses, and levels of nursing experience (Heslop, 2014).

While benchmarking is important, another issue in relation to the use of any nursing-sensitive outcome is a noted lack of inclusion of any measurement in relation to pain that includes the patients’ perspective (Beck et al., 2013). Furthermore Beck et al. (2013) advocate any inclusion that fills a gap within benchmarking will require the use of measurement that can be meaningfully integrated within the current existing care delivery system and electronic health care record. The implication for the nursing
profession in Australia is that currently no standardised clinical benchmarking for measurement of nursing-sensitive outcomes are available for evaluation of nursing practice change within acute care.

**Standardised charts for quality improvement for pain.**

The review undertaken by Gordon et al. (2002) on pain management asserts that when using a standardised outcome as a quality improvement measure any determination of applicability will be dependent on the original purpose of the tool. Although Gordon et al. (2002) noted that when a core set of indicators is used for benchmarking; simultaneous measurement is required that includes both the context of clinical practices that are in place and patient outcomes. Regardless, the study by Samuels and Fetzer (2009) noted that inconsistencies within nursing documentation meant that any measurement for benchmarking for extraction of pain management documentation was hindered by a lack of standardisation.

Standardised charts that were inclusive of the measurement of pain were developed by the Agency for Clinical Innovation (2014) for use in NSW hospitals as a response to a request by the national Pain Interest Group Nursing Issues (PIGNI). This resulted in the development of five observation charts for use within NSW hospitals for patient controlled analgesia, neuraxial (regional anaesthesia by use of a local anaesthetic) opioid single dosage, ketamine infusions, epidural non-obstetric for the non-obstetric environment and contentious opioid infusions for adults (Agency for Clinical Innovation, 2014). However, none of these forms provide an individualised comprehensive pain care plan that outlines both assessment and management of pain that is inclusive of input from the patient. For those patients who do not require the use of any of the afore mentioned observation charts for their pain, then the location of their
day to day pain score is documented on a Standard Adult General Observation chart (SAGO) [as shown in appendix 1 Figure 5 Standard Adult Observation Chart on page 373] and implemented by the Clinical Excellence Commission (2013). This was in response to the recommendations by the Garling Report (2008) (discussed in more detail in the next section) who noted that there was a deficiency in place for the recognition and response to clinical deterioration of adult patients in NSW hospital settings.

The national use of the SAGO chart began as a research project in 2010 initially undertaken by the School of Psychology at the University of Queensland (Horswill et al., 2010). The final product (the SAGO chart) is a system wise response approach for early identification for the seriously ill or patients who are at risk of clinical deterioration (Hillman, Parr, Flavouris, Bishop, & Stewart, 2001). The SAGO chart is notable for the graphical representation of the patients’ vital signs that are colour coded for escalation of care (Elliott et al., 2011; Horswill et al., 2010; Preece et al., 2013). The colour coding of escalation zones are yellow for a review and red for a rapid clinical response (Elliott et al., 2011; Horswill et al., 2010; Preece et al., 2013).

After undergoing heuristic analysis the resultant standardised SAGO chart was then pilot tested for user acceptance in nine different Australian hospitals (Elliott et al., 2011). The pilot study also included an online survey of 347 health care professionals to determine the preferences of clinical staff in relation to the design characteristics (Elliott et al., 2011). Although the majority of the respondents (92%) were nurses, an over representation occurred by two thirds which was noted to be nursing unit managers (NUM’s) and nurse educators (NE’s), leaving the clinical nurses under represented (Elliott et al., 2011). This led to a recommendation by Preece, Hill, Horswill, Karamatic, and Watson (2012) as part of implementation, to not rely on the judgments
of health professionals via the use of a survey. Moreover, the exclusion of meaningful clinical nurse input was extended into the testing phase of the field study by Elliot et al. (2012), who attempted to include the clinical nursing staff by auditing them for compliance (Preece et al., 2012).

The final product of SAGO chart up taken by the Clinical Excellence Commission (2013) followed that of the early development processes by Elliot et al. (2012); Elliott et al. (2011); and Horswill et al. (2010), defines a vital sign in accordance with the Australian Commission on Safety and Quality in Health Care (ACSQHC) (2011a). This definition is titled in point 1.6 “physiological observations should include” respiratory rate, oxygen saturation, heart rate, blood pressure, temperature and level of consciousness (ACSQHC 2011a, p. 8). Omitted is a pain assessment or pain score within that definition of a vital sign and it is instead termed an observation by Horswill et al. (2010). In further research undertaken by this group, pain was still not recognised as a vital sign (Elliot et al., 2012; Elliott et al., 2011). This is opposed to the Australian National pain strategy and international guidelines (as outlined in Appendix 3 Table 14 Current EBP guidelines for pain assessment and/or management on page 375) that identify pain as the fifth vital sign (Closs et al., 2007; National Pain Strategy., 2010).

The two final recommendations within the executive summary by Elliot et al. (2012) for the Clinical Excellence Commission (2013) are the inclusion of routine practice audits to not only determine the frequency of the documentation of vital sign observations but also the completeness of sets of the vital signs undertaken. Current research by Carr et al. (2014); Twycross and Finley (2014); Zeitz and McCutcheon (2006) suggests that pain score documentation, and in particular reassessment, is often not completed independently of vital sign monitoring.
The Australian multi-methods study by Zeitz and McCutcheon (2006) on nurses undertaking observations of vital signs on post-operative patients found that the process of collecting this information was based on a nursing tradition and as such are collected as part of a routine. The detection of complications and their occurrence showed a lack of relationship between vital sign collection not appearing to be based on any patient risk profile, surgical procedure or length of anaesthesia (Zeitz & McCutcheon, 2006). Furthermore Zeitz and McCutcheon (2006) identified an ill-conceived notion existed that if frequency of observations have not occurred and an untoward event unfolds the organisation itself will be covered for blame as instead it will be the individual nurse who is at fault. This resulted in the nurses having a formulated and structured regime which provided them with a false sense of security.

In the observational study by Twycross, Finley, and Latimer (2013) on the pain assessment and management practices by nurses on paediatric ICU patients it was found that the results of the pain assessments were rarely documented. In particular Twycross et al. (2013) observed nurses asking paediatric patients numerous times about their pain with no aspect being subsequently documented. Similarly the UK retrospective study by Carr et al. (2014) found in electronic documentation at the bedside as part of vital sign monitoring, only 0.2% of electronic pain assessment documentation was being undertaken independently of vital signs. The implication was that nurses undertook the electronic documentation pain scores in relation to compliance as opposed to undertaking a timely reassessment of pain nor undertaking assessment of pain independently of gaining routine vital sign measurements (Carr et al., 2014). This is suggestive that even when making pain scoring the fifth vital sign, this has not resulted in the timely re-assessment of pain (Carr et al., 2014). Although the strength of this study was that the data was entered by the nurses themselves electronically at the
bedside, reducing transcription error, it was conducted in one hospital site (Carr et al., 2014). As well, the information in relation to the actual behaviours of what the nurses did or undertook in relation to the actual pain scores gained was not a component of the electronic system in place nor was there any ability of the patients to participate in that study (Carr et al., 2014).

**Organisational culture within hospitals**

Culture within an organisation is defined as being based on anthropological viewpoints of how people behave in communities and their perceptions of the significance or meaning of their work life (Loius, 1985; Manely, 2000; Schein, 1992, 2010). Cultures exist on many levels, and in an organisation it fulfils a purpose by conveying a sense of identity and facilitation of commitment to a larger overall cause (O’Neill, Beauvais, & Scholl, 2001). Hospitals on the whole have a homogeneous culture, and within the sub-groups of professionals unique and divergent subcultures have evolved for each separate context (O’Neill et al., 2001). Therefore, culture within a hospital can be expressed as a paradigm, that is a way of thinking about or viewing the organisation, which when explored can allow gaining a sense of what is valued and how things are done within it by the sub-cultures that it is made up of (McCormack et al., 2002; Scott-Findlay & Estabrooks, 2006).

The most common framework that is used to explore the culture within an organisation is that of Schein (1992, 2010) which allows the capturing of the use of artefacts by those within the culture and the values held as well as the beliefs that are in place which provide unity or development of normalisation within that group (Gershon, Stone, Bakken, & Larson, 2004). Organisations require unison to accomplish their strategic mission/s, and this unity is achieved by placement of mechanisms that reduce variability
by forming a part of the organisational structure (O'Neil et al., 2001). The types of mechanisms that hold the hospital organisational structure together are a combination of co-ordination and control of activities as well as symbolic management of the organisational culture, which directs behaviour through shared values, norms and goals (O'Neil et al., 2001; Schein, 1992, 2010). These mechanisms will work as synergistic glue that will hold an organisation together and direct its purpose to provide unity by outlining what the activities are that it will undertake while also directing or governing the behaviours of those who will enact this.

Hospitals bring together people from different socio-economic backgrounds, diverse geographic locations and different families, submitting them to a projection (and some say the enforcement) of a biomedical model of health (Finkler, Hunter, & Ledema, 2008; Glaeser, 2005; Jones, Cason, & Bond, 2004). Each individual will arrive at an organisation with different motivations, experiences, values, and these natural discrete differences will direct a person's behaviour in often divergent directions (O'Neil et al., 2001). The effectiveness of structures in place to manage diversity in an organisation can have either positive or negative outcomes. This is because the identification processes that are already in place play a central role within the dynamics of a group identity within the same social system (Brickson, 2000). The identification processes within a diverse organisation will affect the motivation and orientation of an individual to become either a part of the collective identity, remain as a relationship partner within that group or continue to identify themselves as an individual within that group (Brickson, 2000).

Recent research notes that an individual develops the placement of their view where they are placed within an organisation by integrating a constructive collaboration between themselves, the group and the organisation which will be more reflective of the
quality of the relationships they have formed with those closest to them (Biggio & Cortese, 2013). This means that an individual’s view on their own well-being within the workplace does not depend exclusively on external conditions such as a top down promotion from management but is mainly subject to internal factors, particularly the manifestation of individual traits and behaviours in the activities of the group as a whole (Biggio & Cortese, 2013).

Organisational drift within a hospital culture.

When the culture within an organisation begins to digress deliberately from established standardised practices, policies and procedures with a constant deviation resulting, the term used to describe this is known as a violation (Amalberti, Vincent, Auroy, & de Saint Maurice, 2006). However, the main identifying aspect of a violation being present is the repeated deviation from a standard instruction over a period of time which results in a long, progressive and sustained drift away from expected levels of compliance (Amalberti et al., 2006). The result is a sustained drift of behaviour within the organisation away from the originally stated goals and culture already in place as expressed in policies or procedures (Amalberti et al., 2006).

Violations as part of organisational drift away from set standards outlined as policies or procedures have been the historical cause of major healthcare incidents (Amalberti et al., 2006). With the latest current incident recently in the UK health care system which was extensively described within the Francis Report (2013) and outlined in more detail below. The most recent Australian example was the Garling Report (2008) that was based within the New South Wales (NSW) state health care system. However, it must be noted that when violations do occur they are the result of a complex multifaceted phenomena that accompanies organisational drift that involves not only individuals or
clinical teams, but the system itself and importantly this may even be tolerated or actively encouraged (Amalberti et al., 2006; Kondra & Hurst, 2009).

Organisational drift becomes the norm when conformance is seen to not only increase efficacy but also increase legitimacy and as such operates as a coercive pressure, particularly evident within government imposed regulatory environments (Kondra & Hurst, 2009). Pressure to achieve conformity delineates acceptable behaviours, leading to the development of a social construction of symbolic management which directs and rewards behavioural drift through shared values, norms and goals which then pervade through to its core, being the groups that make up the sub-cultures (Kondra & Hurst, 2009). Organisational drift within the UK Francis Report (2013) was identified as being due to the presence of an:

...insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. This failure was in part the consequence of allowing a focus on reaching national access targets, financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care.

(Francis Report, 2013, p. 3 Executive summary)

The second recommendation of the Francis Report (2013) was that patients were to be placed as the first priority in all of what the UK National Health Service does, and within a common culture that provides effective services which are compassionate, and caring as well as committed. This was also a similar finding of the Australian Garling Report (2008), who noted that a culture existed that did not see the patients’ needs as being of paramount central concern, but instead a view prevailed that was centred at the convenience of the clinicians and also the hospital administrators.

Both the UK Francis Report (2013) and Australian Garling Report (2008) were critical of the culture that was in place within the hospital systems and they also identified a
prioritisation of performance in meeting targets over people and quality of care (Ross, 2013). This culture within the UK had fostered a regime within those UK nurses of collusion, indifferent neglect and poor care (Ross, 2013). In particular the Francis Report (2013) noted an absence of a culture that listened to the patients and that inadequate processes were in place for dealing with complaints and serious untoward incidents. It was also identified within the Francis Report (2013) that as a direct result of poor leadership and nursing staff policies that the standard of nursing care was completely inadequate on some of the wards within the Mid Staffordshire hospital, resulting in declining professionalism and a tolerance of poor standards by the nurses.

Evident within the Francis Report (2013) and Garling Report (2008) was the lack of effective communication, not only within, but also across the healthcare systems. Noticeable was the lack of sharing information that operated within an insular *silo* mentality of professional care where there was no one person who would necessarily take charge for the patients’ care (Francis Report, 2013; Garling Report, 2008; Ross, 2013). There was a culture present of inappropriate security gained by the management from assurances obtained by performance measures based on auditing that failed to carry out any level of sufficient scrutiny of those sources and instead treated that information as fulfilling its own independent obligations (Francis Report, 2013).

When an individual nurse does not follow a formal policy or procedure and their actions or care delivery deviates away from this, it as an act of subversion which is known as *positive deviance* (Gary, 2013), as part of an overt act (Gary, 2014; Lindberg & Clancy, 2010). A defining principle underlining an act of subversion will be its application by an individual to produce a more positive outcome for one person, when the same subset of resources are applied to others in the same situation (Gary, 2014; Lindberg & Clancy, 2010). Although sounding like an oxymoron, a caveat is placed on this being an
honourable action when its aim is stated to provide patient centred care or to improve patient outcomes, moreover when adherence to a standard guideline within that context has the possibility to result for that patient a negative outcome (Gary, 2013). Recognition of positive deviance is reliant on the identification and existence of rewards or punishments being in place for undertaking those behaviours (Kondra & Hurst, 2009). Furthermore an exploratory approach with insider knowledge is the most complete way in order to un-cover how and why some wards produce better outcomes as well as identify those who under the guise of positive deviance are actually contributing to the problem (Gary, 2013, 2014; Kondra & Hurst, 2009).

When no written policy or procedure is in place to direct or recognise positive deviance within an individuals’ behaviour, then a coercive pressure from within the subculture will operate (Kondra & Hurst, 2009; Schein, 1992, 2010). The individual then will draw upon a combination of formal control expectations that will be located both within visible cultural artefacts and outside (Kondra & Hurst, 2009; Schein, 1992, 2010). Informal coercive pressures are the result of internalisation of positive deviance reinforced by these collective agreements which are unwritten and sanctioned as well as rewarded by reinforcement through peer pressure that has been negotiated by consensus (Kondra & Hurst, 2009). The form in which that reward will be is dependent on the defined set of social rules being reflective of the cultural values and beliefs that are in operation within that subculture (Kondra & Hurst, 2009).

Social organisational identity and leadership within nursing.

In any cultural or social context there are defined norms of behaviour. The social formation or structure of a group can be understood in terms of four elements: the people, their relationship with each other, the cultural forms, and the material
environment (Glaeser, 2005). Over time they become so internalised that the individual and other members of the group are not consciously aware of them and this is demonstrated by their subconscious behaviour (Brink & Edgecombe, 2003). The behaviours displayed by an individual nurse are a reflection of symbolic or emotive beliefs, values, and practices that are indicative of a social formation developed within the context of that cultural group (Glaeser, 2005). The social formation of a cultural group, whilst not being dependant on an individual’s action, are learned, perpetuated, and replicated through interaction of individuals within the group as a whole (Glaeser, 2005; Murchison, 2010).

To determine which behavioural aspects are a result of cultural influences gained by a social formation within that context requires the exploration of values and beliefs that underpin the communication styles used in that context (Jones et al., 2004; McFeat, 1974). This requires a focus on those aspects within the delivery of a set care task by a nurse to an older patient: the social structure in place, a common sense interpretation of the interaction, an explanation by the participant, and how the older patient perceived it (Gobo, 2008; Jones et al., 2004). Accordingly, to understand the dynamics of the processes surrounding the practice of pain assessment and management, a description is required of the actions within that social situation, and these acts will be embedded within routines that are repeatedly performed but have no immediate importance attributed to them by the individual (Glaeser, 2005; Murchison, 2010). For this reason, those behaviours might not be acknowledged by the individual; however, once identified, they can be explored (Brink & Edgecombe, 2003).

Gaining knowledge of the behaviours displayed by nurses during delivery of a set care task can help anticipate the nursing care behaviours of others, not only in that group, but also within other geographically diverse groups of that subculture (Aamodt, 1991;
Gobo, 2008; Leininger, 1988, 2006; Wikberg & Eriksson, 2008). They will be reflective of an individual within a larger group (being a local member of the culture within that ward) on the definition of the task within that environmental context (McFeat, 1974). What is important is how the individual interprets the information gained through completion of the care task, as the process by which this occurs will be a direct product of the cultural phenomena within that ward (McFeat, 1974).

A sub-culture guides the behaviour of an individual towards the completion of a task or the development of an approximation of an outcome, by being based on the internal associations held within that context, and these will also factor in the externally patterned reality of the hospital organisation (McFeat, 1974). However, the direction of the outcome is placement within the sub culture of a ‘best possible fit’ within that context and is perceived by the members of that sub-culture within that environment as acceptable (McFeat, 1974). Whether or not the intervention is the best possible adaptive outcome or use of EBP, will be a result of the formation of the level of requiredness within that culture to circumvent these possibilities when they arise, and this emerges at the intersection of the external system (the hospital) and the environment within the ward (McFeat, 1974).

Organisational culture will develop as part of a natural process within the socio-dynamics that are in place and although it may be in part influenced by management (Schein, 1992, 2010), it is not homogenous with separate departments and sub-groups forming their own unique as well as divergent subcultures (O'Neill et al., 2001). Knowledge about nursing organisational cultures and small group sub cultures within ward specialisations is known to be underdeveloped, despite nurses being the majority of employees (Mallidou, Cummings, Estabrooks, & Giovannetti, 2011). This is an area of research that is lacking within nursing as it is known that small groups within a
subculture provide enhanced feelings of community and a sense of social system stability by guiding as well as shaping a type of consensus behaviour (Lee-Ross, 2008; O'Neill et al., 2001).

Previous studies have concentrated on organisational culture at the higher levels within hospital organisations. A contributing factor to the lack of organisational research about nursing culture within hospitals is what Van der Geest and Finkler (2004) attributed to an incorrect generalisation that all hospitals appear as being the same, and this stems from a perception of familiar informality. Anthropologists note the opposite, and that a hospital culture will have a rich and diverse variety (Van der Geest & Finkler, 2004). A central tenet is that hospitals are an institution in which the core values and beliefs of that biomedical culture are on view (Van der Geest & Finkler, 2004). Hospitals serve as not only a reflection but a reinforcement of the prevailing external dominant social and cultural processes of any given society (Van der Geest & Finkler, 2004). Research in this area by Carlstrom and Ekman (2012) and Mallidou et al. (2011) have identified that nurses within hospital wards will develop their own sub culture. The examination of organisational culture in a quantitative manner is difficult and this is due in part to its dynamic nature as well as constancy of evolving. It is noted that qualitative exploration can occur in order to identify aspects such as barriers and facilitators (Dogherty et al., 2013; Mallidou et al., 2011). Of importance is exploration of the manifestation of organisational culture which is demonstrated by an individual nurses’ interpretation and application of it within the provision of their care within the context of that setting.
Review and summary

In this chapter the background and context of the study has been described. The background was presented giving the reasons why I undertook the study and what I hoped to achieve. Presented was an outline of the context in which the study was located along with an outline of the thesis organisation. The discussion provided insight into the literature that locates pain within an objective biomedical focus, and the theoretical literature that locates the current evidence in relation to implementation of EBP for pain care provision within an organisational context of hospital settings. The next chapter extends and builds on this background knowledge by presenting a systematic search and critical review of the literature that has focused on the nurses’ and older persons’ perspectives within a hospital setting.
Chapter two: Literature review

Chapter Introduction

This chapter presents a systematic search and review of the literature to explore the clinical pain care practices of nurses in relation to pain assessment and management as well as implementation of EBP for the older person. The aim of this critical review of the literature was to inform the researcher (Thorne, Jensen, Kearney, Noblit, & Sandelowski, 2004) for this study and to identify gaps within the grey literature located within the context of the study. The goal was to provide a synthesis and a contribution of the current knowledge within the context of acute care that is inclusive of both nurses and the older persons’ perspectives to provide new and important insights which is inclusive of the nature and provision of pain comfort care within acute care.

The literature review was divided into two sections. The first section titled *Pain assessment and management* builds on the previous biomedical perspectives presented earlier in chapter one. The literature was reviewed in light of the inclusion of EBP for nurses when undertaking pain assessment and management, the experiences of older hospitalised persons and the roles as well as the importance of registered nurses within the acute care setting. The second section titled *Barriers and facilitators to pain care: a critical review of the literature* explored further the current evidence base of both published and grey literature of pain care provision by nurses within the acute care setting. The critique of 34 articles presents the current evidence base of interview and/or observational research that explores aspects of influences of nursing organisational culture within acute care and how that acts as a barrier or facilitator for the assessment and management of pain. This review concludes by a presentation of the current gaps in the literature.
**Rationale.**

Pain management is a fundamental human right (Napier et al., 2014), yet pain is a highly subjective personalised experience, (Madjar, 1998) which is multifaceted (McCaffery, 1968), and its assessment is not only complex (Schiavenato & Craig, 2010), it is often undertaken by nurses (Carr et al., 2014) within a care system that is geared towards procedurally based care (Hickman, Newton, Halcomb, Chang, & Davidson, 2007). The provision of pain care for the older person which they will find of benefit, safe and satisfying is known as culturally congruent care (Leininger, 1988, 2002, 2006; Wikberg & Eriksson, 2008). Pain care provision is more than assessment and management; it also involves the implementation of research and EBP into clinical practices within the context or environment at the point of care (Rycroft-Malone, Harvey, et al., 2004).

Previously noted within chapter one, was the ability of the context for EBP implementation to be either a barrier or facilitator for translation into clinical practice and this will be dependent on the prevailing climate within the culture present (Dogherty et al., 2013; McCormack et al., 2002). Furthermore, the elements within the cultural climate in relation to values and beliefs that are present will determinate the attitudes to guide behaviour, along with the presence of artefacts such as policies or procedures to be embedded within the routine care delivery within the ward by nurses (McCormack et al., 2002; Schein, 2010).

**Search strategy.**

The approach undertaken for the search strategy followed the structure outlined by Kable, Pich, and Maslin-Prothero (2012). The quality assessment of each of the articles reviewed was a critique using the McMaster Critical Review form (Letts, Wilkins, Law,
A systematic search of literature in CINAHL, EMBASE, SCOPUS and the Web of Science databases was conducted by using ‘free text searching’, ‘MESH’ terms (where supported). Subject headings using Boolean operators of: Pain OR Pain assessment OR pain management AND Person OR People OR Elderly OR Aged OR Older person OR Geriatric AND Hospitals OR Acute care OR Surgical patient OR surgical ward OR medical wards OR medical patient OR Inpatients AND Nursing OR Nurses OR Nursing profession were conducted and are as detailed within and is shown in detail within Appendix 2 Table 13 List of search terms page 374. The limits applied were English language, 2000-2015, articles about nursing and older persons, as well as primary research located within hospital settings. Excluded were those articles not written in English, and outside the search dates.
Pain assessment and management

The accepted gold standard for pain assessment was developed over 46 years ago by McCaffery (1968) who provided the seminal statement that:

*Pain is what the person says it is and exists whenever he or she says it does.*

This quote has become the accepted gold standard for pain assessment. It brings the individual to the forefront and places them as an expert about their pain, resulting in the use of self-report as pervasive within clinical practice (Schiavenato & Craig, 2010). The consensus statement of pain assessment in older people outlines the importance of gaining insight of the patient’s history and social circumstances as being fundamental to gaining a holistic pain assessment (Hadjistavropoulos et al., 2007). Similarly, Schiavenato & Craig (2010) propose that the assessment of pain by nurses is part of an ongoing social transaction, or a process that will take into account any internal or external factors. Carr et al. (2014) argue that, while the prevalence of pain within different patient populations is of importance, it is the assessment of the intensity of pain that is an imperative because it predicts the impact of pain on physical function. If pain is consistently referred to as the *fifth vital sign*, it places an emphasis and consideration for the systematic assessment of pain to be undertaken in a measured and monitored manner (Closs et al., 2007). Pain is really only known to the person who is suffering from it, as it is a subjective and deeply personal experience that is based on a conceptualised framework of abstract multi-dimensions. Fundamentally it is known that undertaking any pain assessment for an older person can be extremely challenging due to the possible presence of multiple comorbidities as well as the variety of issues that will impact on their presentation of pain (Hadjistavropoulos et al., 2007).
Pain assessment tools.

There is a multitude and variety of pain assessment tools available and this diversity makes the choice of tool problematic (Toofany, 2007). The systematic review by Hjermstad et al. (2010) on the practices of visual analogue scales, numerical rating scales and verbal rating scales, identified that they have been in use since the 1950s. Furthermore the current systematic review by Lichtner et al. (2014) undertaken on other systematic reviews about pain assessment tools for those older persons with dementia, concluded that no one tool could be recommended because of a lack of evidence in relation to their reliability, validity and clinical utility. While it is beyond the scope of this study to outline them all in detail, previous systematic reviews and consensus based guidelines note that, while there are a range of assessment tools for use with older people, there is no single assessment tool that fits all (Hadjistavropoulos et al., 2007; Hjermstad et al., 2010). The use of an assessment tool can be problematic from the arbitrary values assigned to the lower ends of the scales, being no pain and nothing, with variations at the upper extremes of worst pain ever (Hjermstad et al., 2010).

One of the main defining aspects of the use of a pain assessment tool are the numerous studies undertaken that report of their consistent use within quantitative research studies (Hommel, Ulander, & Thorngren, 2003; Lewen, Gardulf, & Nilsson, 2010; Marco, Kanitz, & Jolly, 2013; Reimer-Kent, 2003; Stomberg, Lorentzen, Joelsson, Lindquist, & Haljamae, 2003; Storm-Versloot et al., 2014). This contrasts with qualitative research studies identifying the lack of their use by nurses (Dihle, Bjalseth, & Helseth, 2006; Eriksson, Wikström, Årestedt, Fridlund, & Broström, 2014; Fry, Chenoweth, MacGregor, & Arendts, 2015; Herr & Titler, 2009; Wikström, Eriksson, Årestedt, Fridlund, & Broström, 2014).
Pain scoring.

The consensus report for pain assessment suggests that when scoring pain there is no requirement for correspondingly evident tissue pathology as source of proof of pain (Hadjistavropoulos et al., 2007). The systematic review by Srikandarajah and Gilron (2011) argue that often pain scores do not reflect the actions of an individual; that most severe post-operative pain will be experienced on movement as opposed to while at rest. Therefore it is imperative that two scores be provided that outline clearly, and separately for post-operative patients, a value for pain at rest and on movement (Srikandarajah & Gilron, 2011). Regardless, one of the problems in relation to using a numerical value to score pain is related to the inherent properties of numbers.

It is known within the multitude of research conducted on the use of pain scoring that the verbal response scale, due to its psychometric properties, is better to use and more reliable than that of numerical scale (Hjermstad et al., 2010). This is because, although numerical scales are more reflective of what the patient’s pain is like, the issue for pain research is in relation to bias in reporting these values and making a claim based on that result (Hjermstad et al., 2010). For example, if a 50% reduction of pain is required to be achieved as a standard within a facility, a problem occurs in relation to the indivisibility of odd numbers as opposed to even numbers (Hjermstad et al., 2010). If a person initially scores an 8/10 for pain, and then on reassessment afterwards, a score of 4/10 is provided, then a reduction by half has occurred for the intensity of their pain, thus achieving a standard set of reduction in half. Problems occur if a patient uses an odd number. When a patient reports 7/10 for pain, then a half will be 3.5/10, but half measures are typically not documented by nurses, and this means that the whole value will be substituted and documented (Hjermstad et al., 2010). Whether or not the nurse
chooses to use either a value of 3/10 or 4/10 will affect the quality improvement documentation, that is, whether the patients achieved over or under the accepted standard of a reduction by half.

This is known as bias within quantitative research and this attribute can be ameliorated within the statistical reporting of pain scores (Hjermstad et al., 2010). Be that as it may, for the patient within the clinical setting, their use of odd numbers for rating their initial pain will result in acceptance by the nurse during reassessment of not reaching a 50% reduction of intensity. Therefore any reliance by research on the use of a percentage of reduction of pain intensity while using a numerical scale for the purposes of auditing may result in underestimation or overestimation of acute pain resolution (Hjermstad et al., 2010).

Numerous studies have shown that nurses and patients hold differences of opinion in relation to values attributed to pain score results, and that this is due to an incongruence held between them about what numerical rating of pain actually means (Blomqvist, 2003; Coker et al., 2008; Manias, Bucknall, & Botti, 2005; van Dijk et al., 2012; Ware et al., 2015). To date there is a lack of research that aims to gain the older persons’ opinion of being asked to rate their pain. The phenomenological study by Blondal and Halldorsdottir (2009, p. 2901) noted that some acute care nurses spoke about their experiences when using a pain scale; that it made the older person more irritated and that the replies they gained from the older person were that they have intolerable pain or that they have just a lot of pain.

The phenomenographic study by Eriksson et al. (2014) on how patients perceive the use of a pain scale in postoperative care noted that, while identifying positive attributes towards the use of a numerical rating scale, patients also expressed negative attributes.
Patients indicated that using a numerical value did not provide enough information for how they experienced their pain, and providing a numerical value for their pain was difficult (Eriksson et al., 2014). The patients in the Eriksson et al. (2014) study described not getting enough information from health care professionals about what the pain score was for and that they felt they had to provide an expected response about their pain both at rest and on movement. Similarly, the descriptive qualitative study by Joelsson, Olsson, and Jakobsson (2010) noted the comments made by patients that they did not understand what a pain score meant until a period of several days had passed after their surgical procedures.

**Pain relief.**

Effective pain management is a reduction of the intensity of pain that is meaningful for the patient (Hadjistavropoulos et al., 2007). It is known that involving the older person in their treatment improves their pain control (Katz & Gibson, 2012; Scottish Intercollegiate Guidelines Network, (SIGN) (2008). Pain management can be delivered by a variety of means, these being pharmacological, non-pharmacological, and cognitive based interventions (Hadjistavropoulos, Hunter, & Fitzgerald, 2009). Reassessment to determine if the provided pain relief, such as medication, has worked is required and inadequate reassessment of pain is a significant barrier for management of pain (Hadjistavropoulos et al., 2007).

The report by Macintyre, Scott, Schug, Visser, and Walker (2010) on acute pain management noted that, for the older person, patient controlled analgesia (PCA) and epidural analgesia are more effective for management of pain than conventional oral opioid regimens. The pain management guidelines for blunt thoracic trauma by Simon et al. (2005) and management of rib fractures for the older person by Winters (2009)
concur. The position statement on procedural pain management with clinical practice recommendations by Czarnecki et al. (2011) notes that IV opioids are a fast acting formulation and when administrated by titration will provide rapid analgesia.

The phenomenological study by Blondal and Halldorsdottir (2009) noted that challenges of managing pain for nurses was reading patient pain cues. Furthermore Blondal and Halldorsdottir (2009) identified that nurses also experienced challenges when attempting to provide pain relief in relation to their own inner conflict when confronted with what they perceived as a moral dilemmas, dealing with gatekeepers and organisational hindrances. A recommendation was made by Blondal and Halldorsdottir (2009) that a there was a requirement for nurses to undertake critical reflection on their theoretical and also personal as well as ethical knowledge held about pain.

Studies have identified that, despite having a high prevalence of pain, patients may report being satisfied with the actions undertaken by staff within a hospital setting. For instance, the Canadian descriptive, cross sectional study of Jabusch, Lewthwaite, Mandzuk, Schnell-Hoehn, and Wheeler (2015) on 88 adult patients in a 530 bed tertiary care teaching hospital aimed to quantify pain in acute care patients. They identified a prevalence of pain at 70.4%, with 26% of these respondents stating their pain had lasted longer than three months (Jabusch et al., 2015). The respondents reported they had a high level of satisfaction with the pain assessment and management undertaken by the staff despite reporting the high prevalence of pain with the lower extremities being the location of most of the pain presence (Jabusch et al., 2015). Not unlike other quantitative studies it appears that, despite indicating that they have pain present, the patients report being happy with the efforts of the staff in managing their pain (Innis, Bikaunieks, Petryshen, Zellermeyer, & Ciccarelli, 2004; Jabusch et al., 2015).
It is known and documented extensively within the current literature that nurses have a deficiency in pharmacological knowledge in relation to pain medication (Sloman, Rosen, Rom, & Shir, 2005; Voshall, Dunn, & Shelestak, 2013). Nurses are known to lack knowledge about how analgesic drugs work, the time taken for onset as well as a lack of understanding in relation to how narcotisation occurs. When Voshall et al. (2013) undertook a survey of nursing faculty members a deficiency of knowledge was noted and this was also identified by Al-Khawaldeh, Al-Hussami, and Darawad (2013) and Duke, Haas, Yarbrough, and Northam (2013). A NZ survey study by Barton, Don, and Foureur (2004) on nurses pain knowledge levels noted that those wards who had access to an acute pain service had improved levels of knowledge as opposed to those whose were less. However the Barton et al. (2004) study did not explore if any clinical change was evident and also a limitation of the study was the low response rate of 48% out of a total of 600.

**Procedural pain management.**

Within intensive care units (ICU) the current consensus-based multidisciplinary clinical practice guideline by Barr et al. (2013) identified that experiencing procedural pain was common for adult ICU patients. Similarly, the study by Rawe et al. (2009), which explored the empowerment of acute care nurses when caring for patients to manage procedural pain, identified that 60% of patients did not receive any pain relieving medication before or during a procedure. The ICU study of Puntillo et al. (2001) on patient’s perceptions and responses to procedural pain identified that the most painful and distressing procedures described by the adult participants were being turned in bed and wound care. Furthermore, they noted that less than 20% of their participants received opiates as analgesia before being turned in bed (Puntillo et al., 2001). The
findings of Rawe et al. (2009) resulted in the development of procedural pain guidelines, however aspects in relation to how it was translated into clinical practice are not reported.

The procedural pain management position statement released by the American Society for Pain Management Nursing (ASPMN) asserts that comfort management needs to be provided for those who are about to undergo a procedure (Czarnecki et al., 2011). Comfort management was defined by Czarnecki et al. (2011, p. 95) as:

...the management of pain and anxiety, as well as any discomfort that may occur with procedures.

Furthermore, the ASPMN does not condone the undertaking of procedures without a plan in place for the provision of comfort assessment as well as management and that nurses are required to advocate or intervene based on the needs of the patient (Czarnecki et al., 2011).

**Pain guidelines and position statements.**

The International Association for the Study of Pain [IASP] (2014) notes that the development of a guideline requires the asking of a clinically relevant question and an analysis of all the evidence in an objective manner, resulting in the making of conclusions and formulation of recommendations. There is a multitude of clinical practice guidelines in relation to pain that are available for use by nurses within the acute care setting. Furthermore, there are guidelines and position statements that are specific to the provision of pain care for the older person. These are listed (in no particular order) in Appendix 3 Table 14 Current EBP guidelines for pain assessment and/or management page 375.
The assessment and management of pain by nurses.

The assessment and management of pain by nurses is an ongoing social transaction or process that takes into account internal and external factors (Schiavenato & Craig, 2010). Kim, Schwartz-Barcott, Tracy, Forthin, and Sjostrom (2005) found that the strategies used by nurses for assessing a patient’s pain were different from decisions used for the management of pain. The Swedish phenomenological study by Söderhamn and Idvall (2003) noted that, although a nurse will not always believe the patient, they would still implement a problem solving process for the patient. Schiavenato and Craig (2010) indicated that this aspect was due in part to the personal and social contextual factors that can influence a patient’s behaviour and the ability of the nurse to engage in a frank and candid discussion about pain with the patient.

Layman-Young, Horton, and Davidhizar (2006) surveyed 52 USA nurses within a single acute care ward and found that 9.6% of respondents held overt negative attitudes towards the use of pain assessment tools. Furthermore, 55% of the respondents held beliefs that the current pain assessment tools in place within that facility were not reliable, and were overly subjective and inaccurate, despite those tools being considered as appropriate by the hospital (Layman-Young et al., 2006). They concluded that, in relation to the validity of a tool, evidence alone does not correspond with positive attitudes about pain assessment tool use and that this was independent of the level of nursing experience (Layman-Young et al., 2006).

This is not an isolated occurrence, with the phenomenological study by Blondal and Halldorsdottir (2009) on Icelandic acute care nurses noting the nurses believed that older patients could not use a pain scale effectively. Conversely the Australian survey study of Jastrzab et al. (2009) on 99 acute care nurses from four different acute care
wards identified that they were incorrectly using the paediatric revised faces pain scale (Wong & Baker, 1988) to observe pain, but documented what they thought correlated with the scale without asking the adult patients for a self-report of their pain. The authors implemented an education strategy to change the nurses’ behaviour but, on a follow up evaluation three years later, they found that no change had occurred in the nurses’ practices (Jastrzab et al., 2009).

**The older hospitalised person in acute care**

A definition of what age a person becomes known as an older person varies, depending on geographical location and socio-economic circumstances. The United Nations (UN) defines older people as those over 60 years of age and the “oldest old” as those aged over 80 years. In Australia the definition of an older person applies to those people aged 65 years or more, while in Malaysia the age limit for retirement and pension eligibility is 55 years of age (AIHW 2008; World Health Organisation, (WHO) 2009). Conversely, within developing countries a person’s chronological age is viewed with less relevance. This is partly due to the physical, environmental and socioeconomic health determinant stressors placed on them (AIHW 2008; WHO 2009). Most developed countries consider old age as the time when a person is eligible to retire and receive a pension. Older people in this study are defined as being those aged 65 or over.

The numbers of older people worldwide are increasing; they are the largest growing demographic group in the developed world. It is projected that in Europe by 2030 almost one in three Europeans will be older than 60 years (WHO 2008). In Australia, the proportion of those aged 65 and over has increased from 11.1% in 1990 to 13.6% in 2010 (Australian Bureau of Statistics (ABS) 2010). This is a proportional increase from 0.9% of the population in 1990 to 1.8% of the population in 2010 and make up one in
eight of the total Australian population (ABS 2010). An ageing population combined with a longer life expectancy creates a situation that contributes to a concomitant increase in the burden of disease and an uptake of health care services (WHO 2009). Older people are at an increased risk of suffering from co-existing pathological conditions or syndromes such as osteoporosis, delirium, and dementia simultaneously (Fitzgerald & Horton, 2005; Neuman, Speck, Karlawish, Schwartz, & Shea, 2010).

**Acute care and reason for admission.**

Acute care settings are defined as a specialised ward or unit in a hospital setting (Byrne, Chung, Bennett, & Silke, 2010). There are essentially four different models or systems used for the actual structure of the delivery of acute care, they are: age defined, needs related, general acute care, and integrated acute care staffed by a variety of physicians that include geriatricians (Byrne et al., 2010). It is known that admission into acute care for an older person will not necessarily result in an improvement of their health (Chang, Chenoweth, & Hancock, 2002). Research has shown that, on hospital discharge, up to a third of older patients have had a decrease in their activities of daily living than they had prior to admission (Chang, Hancock, Hickman, Glasson, & Davidson, 2007; Chang et al., 2003). This meant that many were independent prior to hospitalisation and developed a new disability by the time of hospital discharge.

**The older person inpatient.**

Older inpatients within the acute care setting face considerable challenges and at times are placed at greater risk of adverse events or death, decline in physical function, or psychological stress (Ackroyd-Stolarz et al., 2009; Edvardsson & Nay, 2009; Neuman et al., 2010; Victorian Department of Health, 2012). This increased risk is attributed to
older people experiencing high levels of delirium (Neville, 2008), concurrent complex and chronic co-morbidities (Singh et al., 2012), nutritional problems (Covinsky, 2002), pressure ulcers (Esson, 2007) a decrease in physiological reserve known as geriatric syndrome (Quinlan et al., 2011) and an increased risk of falls and fractures (Watson, Li, & Mitchell, 2011).

Within the acute care system, the care for older people is largely geared towards procedurally based care (Hickman, Davidson, Chang, & Chenoweth, 2011). The system of acute care is designed to provide highly specialised interventions with a focus on the period of hospitalisation being as short as possible (Higgins, Slater, & Peek, 2007). One factor that has been identified as having an impact on the care delivery is the level of nursing expertise specific for older people who have experienced trauma, such as a fall (Pudelek, 2002). The systematic review by Bridges, Flatley, and Meyer (2010) on the older person and their relatives’ experiences in relation to care provision within an acute care setting identified that an admission or visit to hospital made the older person feel worthless, fearful and that they lacked autonomy during decision making. Furthermore, these feelings stemmed from a lack of connection within the acute care communities, not being seen as an individual and not being included within decision making about their care (Bridges et al., 2010).

Numerous studies have identified that, while being an inpatient in acute care, an older person will express feelings of not being included in decision making (Berwick, Ogle, & Wright, 2003; Dilworth, Higgins, & Parker, 2012), of having reduced personal control (Lin, Wang, Liu, & Chen, 2013; Lindberg, Horberg, Persson, & Ekebergh, 2013) and a loss of dignity (Tadd et al., 2011). Studies have shown that the older person finds the acute care environment depersonalised, noisy and disruptive and that this all contributes to a reduced sense of personal control (Bailey, 2009) that has an impact on
their ability to engage in negotiations with nurses in relation to gaining pain care provision (Nordgren & Fridlund, 2001).

Simply being admitted into an acute care ward for the first time was spoken of by older patients as a period of emotional distress and potential embarrassment of not knowing what was required of them during care routines (Berwick et al., 2003). This, coupled with not being able to express their own will, meant that the older person felt as though they were struggling from a position of disadvantage, which extended into not being believed when asking for pain relief (Nordgren & Fridlund, 2001). For those older persons who were being readmitted into acute care after their earlier hospital discharge, the Australian qualitative descriptive study by Dilworth et al. (2012) identified that this was also a cause of distress. A lack of case management with notable gaps within service provision was identified by Dilworth et al. (2012) as a contributing factor for the older person to continue feeling let down on their return into acute care, when they continued to receive the same instances of a lack of inclusion and participation in their care.

Once admitted as an inpatient, older people frequently report that they find communication with health care professionals difficult (Williams, Kemper, & Hummert, 2005). The systematic review and thematic synthesis by Joseph-Williams, Elwyn, and Edwards (2014) identified that patients are unable to communicate about their care provision due to a power imbalance. This power imbalance was expressed as a normalised expectation by the clinicians for patients to be passive recipients, and the patients themselves feared retribution from being described as a difficult or unpopular patient, leading towards a decrease of care quality (Joseph-Williams et al., 2014). Other studies on the older persons’ communication experience of acute care found that nurses in particular will not actively listen to, or wait to hear, what the older person has to say
in response to their speaking (Horgas, 2003; Kumar & Allcock, 2008; McDonald et al., 2008; Russell, 2007; Williams et al., 2005). Older people perceive this style of communication to be demeaning, patronising and implies incompetence on their behalf (McDonald, Thomas, Livingstone, & Severson, 2005; Williams et al., 2005). Hence contributing to the older person’s perception that communication with health care providers will be fraught. This is more so when an older person experiences stereotypical responses that imply that they are not perceived as self-determining in the decision-making process for pain management (Horgas, 2003; Kumar & Allcock, 2008; McDonald, LaPorta, & Meadows-Oliver, 2007; McDonald et al., 2008; Russell, 2007; Williams et al., 2005).

The literature shows that older people express that what they require during their acute care stay is a good physical environment that supports and encourages positive encounters with health care providers (Browall, Koinberg, Falk, & Wijk, 2013; Lindberg et al., 2013). They also prefer an environment within acute care that provides a semblance of everyday life (Lindberg et al., 2013), and one where they are able to feel that they are a unique person (Browall et al., 2013). Above all, studies have identified that the older person inpatient in acute care highly values a quiet place to withdraw and rest (Bailey, 2009; Browall et al., 2013).

**Older person pain communication.**

Crowley-Matoka et al. (2009) contend that the presence of a biomedical focus is a limiting factor for consideration of other determinates of health, by decontextualising and oversimplification of a person’s experience, resulting in a narrow focus onto the physical manifestations of a disease and its attributable causes. When a decontextualisation occurs, taking the patient’s illness away from their experiences and
placing the emphasis onto the physical manifestations, this becomes a source of disconnect between the nurse and the patient (Crowley-Matoka et al., 2009).

An older person who consciously holds back from discussing their pain will experience higher levels of psychological disability and be at an increased risk of pain catastrophising (Porter, Keefe, Wellington, & de Williams, 2008). Druley, Stephens, Martire, Ennis, and Wojno (2003) proposed that an older person would often not verbalise their true pain status for fear of distressing their partners and/or carers. This is particularly so when the partner or carer has negative connotations associated with the pain experienced by the older person, or if they are experiencing carer stress (Druley et al., 2003). If the nurse and the patient hold divergent views about pain and what is important or not in relation to pain, then often a dismissal of patients’ concerns occurs, conflict arises and this results in frustration (Crowley-Matoka et al., 2009). When frustration occurs in relation to pain, the patient will often be characterised by the nurses as being ‘difficult’, resulting in them becoming unpopular with the nurses.

This notion or perception of unpopular patients within nursing was explored by Stockwell (1972), who released a seminal book titled ‘The unpopular patient’. Within her study, Stockwell (1972) identified that patients whom nurses regarded as unpopular were those patients who:

...grumbled and complained, communicated a lack of enjoyment at being in hospital. Implied that they were suffering more than what was believed by the nurses. Suffered from conditions the nurses felt could be better cared for in other wards or specialized hospitals...

(Stockwell, 1972, p. 49)

Stockwell (1972) indicated that nurses’ responses to unpopular patients were that of frustration and impatience and nurses were observed to engage as a group to reward as
well as deter behaviours of those deemed unpopular. She also noted the enactment of those nurse behaviours as being:

...entirely task related. Nurses did not approach patients unless they were going to carry out some treatment or provide some service or unless they had some specific information they wanted to collect...

(Stockwell, 1972, p. 54)

Although the study of Stockwell (1972) is somewhat dated, it remains to be seen if things have really changed much since that seminal study 42 years ago. The qualitative study by Fraenkel and McGraw (2007) identified that patients will avoid attempting to participate in their care in order to avoid irritating the provider of that care. Certainly within the US focus group study by (Frosch, May, Rendle, Tietbohl, & Elwyn, 2012) on community members about their primary care providers, participants felt that their concerns were not being heard and that they did not want to complain as they feared retribution. The study by Idvall (2002) noted that patients spoke about wanting to be a good patient and to not blame staff for the pain that they were experiencing. Recent Canadian surveys conducted by Bédard, Purden, Sauvé-Larose, Certosini, and Schein (2006) and by Cogan et al. (2014) on the attitudes and beliefs about pain held by post-operative patients identified that patients indicated that being a good patient meant not speaking or complaining about their pain. In those studies a question within the survey asked them to indicate their agreement with a statement that good patients don’t complain about their pain and also that complaining of pain will divert the physician away from my treatment process (Bédard et al., 2006, p. 86; Cogan et al., 2014, p. 574), which could be argued to be a leading question. Kim et al. (2005) found that the strategies used by nurses for assessing a patient’s pain were different from decisions used for the management of pain.
Research has shown that patients speak about ‘not wanting to be troublesome and bother the staff’ as well as not providing a pain score that was outside of what was expected and could result in them being known as an individual who will complain (Eriksson et al., 2014; Idvall, 2002). However, this aspect of not wanting to be known as a complainer when providing a pain score was not explored in any further detail within the Eriksson et al. (2014) study. The study conducted on emergency department (ED) patients by Buchbinder, Wilbur, McLean, and Sleath (2015) identified three main strategies used by patients to request analgesia. Mainly it was found that the patients would not request analgesia directly, instead they used processes of mitigation, deference, and indirect requests in order to present themselves as deserving patients whilst still expecting to receive analgesia (Buchbinder et al., 2015). Other studies have noted that, while patients will say that they are happy and satisfied with the care that they received, this is incongruent with their actual descriptions of their pain (Idvall, 2002; Joelsson et al., 2010).

**Pain expression for those with a complex communication need or cognitive impairment.**

When the older person has a cognitive impairment or a disability that impairs their ability to communicate verbally, then any ability to provide a verbal self-report may become impaired or be absent (Closs et al., 2007; Hadjistavropoulos et al., 2007; Hemsley, Balandin, & Worrall, 2011). The estimation of pain intensity based solely on facial expressions or behaviour in the older person is not reliable, regardless of whether or not any cognitive impairment or complex communication need is present (Closs et al., 2007; Hemsley et al., 2011). The Australian qualitative narrative study by Hemsley et al. (2011) on 15 hospitalised adults with a developmental disability and complex
communication needs identified that being able to communicate the presence of pain effectively was a main theme expressed by those patients. Furthermore the patients in the Hemsley et al. (2011) study spoke of having difficulties communicating their pain to the nurses and this was despite the nurses stating that they used an array of EBP tools. However, the Hemsley et al. (2011) study did not include observations or a document review and identified that this was a limitation of the study as well as concluding that observational research was required to provide further insight.

For those older persons with a cognitive impairment Hadjistavropoulos et al. (2007) advise caution in the use of a mini-mental state examination (MMSE) to determine their cognitive level for an assessment of pain as levels of education will influence the score. It is known that the presence of pain will further reduce a person’s cognitive functioning ability (Karp et al., 2006; Moriarty, McGuire, & Finn, 2011). Literature shows that nurses find it difficult to manage pain for an older person who has a cognitive impairment (Blondal & Halldorsdottir, 2009; Draper, Karmel, Gibson, Peut, & Anderson, 2011; Herr et al., 2011). An older person with a cognitive impairment will require different strategies for assessment (Herr et al., 2011; Schofield, 2008; Toofany, 2007). An observational assessment of that individual’s pain behaviour is required, such as an examination of their facial expressions, body movement or vocalisation (Hadjistavropoulos et al., 2007; Herr et al., 2011; Schofield, 2008; Toofany, 2007). This type of assessment requires prior knowledge, or the insight of the patient’s family or carer, for an explanation of the meaning behind the pain behaviour (Schofield, 2008; Toofany, 2007). The focus group study by Fry, Chenoweth, et al. (2015) on ED nurses’ perceptions of the roles of family members for caring for the older person with a cognitive impairment noted that the nurses identified a dualistic role of family members/ carers. In that, whilst they are important for gaining information about
behavioural patterns for pain expressions, the ED nurses conversely viewed them as an obstacle when attempting to provide nursing interventions (Fry, Chenoweth, et al., 2015).

It has been consistently identified that the older person who experiences pain and has a concomitant cognitive defect, from either dementia, disability or delirium, will experience a delay in receiving analgesic medication (Decker, 2009; Fry, Arendts, Chenoweth, & MacGregor, 2015; Kerner, Plakht, Shiyovich, & Schlaeffer, 2013; Malloy & Hadjistavropoulos, 2004). The Australian retrospective ED audit study by Fry, Arendts, et al. (2015) on the time taken by ED nurses to provide analgesia for an older cognitively impaired person with a fractured femur indicated that the median time for receipt of analgesia was 149 minutes after their admission into ED. For those older persons with a fractured femur and cognitively intact the wait time noted by Fry, Arendts, et al. (2015) to received analgesia was 72 minutes from their admission into ED. The actual reasons for the delay of analgesia was explored by Fry, MacGregor, Hyland, Payne, and Chenoweth (2015) in a focus group study of ED nurses that explored their perceptions of reflexivity, confidence and self-efficacy for managing pain in the older person with a cognitive impairment. That focus group study identified a lack of confidence, and self-efficacy from those ED nurses who lacked experience in assessing pain for those who have a cognitive impairment and asserted that nurses gained knowledge from embodiment within clinical practice that supported reflexivity (Fry, MacGregor, et al., 2015). However within the reporting of the studies by Fry, Arendts, et al. (2015); Fry, Chenoweth, et al. (2015); Fry, MacGregor, et al. (2015) there is a lack of observational research to provide consideration for the context in which care is being delivered.
Specifically pain assessment and management for people with cognitive impairment in acute care wards has been identified as an area that requires observational research in regards to improvement of nursing clinical practice (Apel, Koch, & Fetherstonhaugh, 2009; Malloy & Hadjistavropoulos, 2004; Seeher, Withall, & Brodaty, 2011; Wilson, O’Donnell, McAuliffe, Nay, & Pitcher, 2008). The recommendations by the Apel et al. (2009) study are that identification of the barriers to nursing documentation of pain assessment and management practices is required, and that there is a requirement for more up-to-date EB information about pain in cognitively impaired older patients. The systematic review by Wilson et al. (2008) recommends the requirement for more research to gain understanding of the factors that impact on professional caregivers in the assessment and management of pain in older adults with dementia. Moreover, it is consistently noted that a main barrier towards pain assessment and management in older people with dementia in acute care is the lack of EB available about this group (McAuliffe, Nay, O’Donnell, & Fetherstonhaugh, 2009; Seeher et al., 2011; Wilson et al., 2008).

**Registered nurses**

The importance of having nurses in hospitals with a Baccalaureate degree qualification cannot be underestimated for an older person. This was identified within the recent observational study published in the Lancet by Aiken et al. (2014) on the hospital discharge data for patients aged 50 years and over in nine different European countries. It was found that those hospitals that had a predominance of degree educated nurses who cared for an average of six patients per shift had 30% lower mortality than those hospitals that employed fewer (30%) nurses with a bachelor degree (Aiken et al., 2014). In the Australian context, during 2013 there were 296,029 registered nurses and midwives and 90% of RNs are currently employed within a direct clinical role with
patient contact in a hospital setting, 3.8% are nurse educators or teachers and less than 1% of RN nurses undertake research (AIHW 2013b).

The implication for the older person and their pain care is in relation to the education levels of nurses and their ability to implement EBP without compromising care delivery or rationing care tasks within a positive workplace environment (Aiken et al., 2014; Aiken, Sloane, Bruyneel, Van den Heede, & Sermeus, 2013; Coetzee, Klopper, Ellis, & Aiken, 2013). The survey of 181 Chinese hospitals conducted by You et al. (2013) identified that 61% of the nurses described their work environment as being of a poor quality and the nursing care that 29% of nurses provided within their own acute care unit was only of fair quality. Similarly, the Swiss cross sectional multi-centre study of Schubert et al. (2013) on 35 hospitals that provided acute care identified that the comprehensive assessment of the newly admitted patient and development of care plans, along with the provision of emotional or psychological support, were the most often rationed or incomplete nursing care tasks. Schubert et al. (2013) also reported that important nursing tasks had often not been undertaken and that the occurrence of adverse events was common. Research exists to support that, when a higher nurse to patient ratio was present in acute care in combination with a lower percentage of degreed nurses then there is a strong association to poorer patient outcomes, stemming from the rationalisation or incomplete provision of EBP nursing care (Aiken et al., 2014; Ausserhofer et al., 2013; Coetzee et al., 2013; Schubert et al., 2013; You et al., 2013).
The call for registered nurses to care for the older hospitalised person.

The UK Francis Report (2013) noted previously in chapter one within the section titled organisational culture within hospitals identified the issues in relation to the presence of organisational drift away from patient centred care principles. A recommendation to address the suffering that the older patients were experiencing in the Francis Report (2013) made the following recommendation [labelled as number 200] for the creation of a specific registered nurse status within acute care:

*Consideration should be given to the creation of the status of a registered older person’s nurse.*

(Francis Report, 2013, p. 106)

This recommendation was made by the Francis Report (2013) to recognise and reflect within the nursing profession the specialist skills, commitment and compassion that is required by nurses when providing care for the older person. Likewise, Gregory and Haigh (2008) and Barnett, Mulvenon, Dalrymple, and Connelly (2010) reported that an improvement of nursing skill levels, attitudes and knowledge was required for pain care provision for the older person. This aspect was explored within the Australian setting by the Garling Report (2008), who recommended, in order to deal with the lack of leadership from senior nurses for junior nurses:

*The creation of new clinical designation for registered nurses with over 10 years’ experience who continue to carry out patient clinical care, entitled ‘Senior Registered Nurse’ with appropriate competency based increments.*

(Garling Report, 2008, p. 277)

The response provided by the NSW Department of Health (2009) to the Garling Report (2008) was that, while it supported 134 of the 139 recommendations, a proviso was placed on the creation of any new nursing clinical designations, and this was due to a
claim by the NSW Nurses Association before the industrial relations commission at that time. The Francis Report (2013) indicated that conflict existed between the professional representation of nurses by the UK Royal College of Nurses (UK RCN) and nursing trade union functions, and this had resulted in the diminished voice of the UK RCN on professional issues. Within the Australian context, as of 2015, no new clinical designation for RNs with over ten years of experience and who are still clinical has occurred.

**Registered nurses work in acute care.**

Nurses’ work in acute care was explored in the micro-ethnographic study of Ebright, Patterson, Chalko, and Render (2003), which explored factors that affected nurses’ performance while caring for five patients a day in medical/surgical wards. Ebright et al. (2003) clearly identified the dynamic complexity of work activities undertaken by nurses. In particular it was noted that nurses engaged in a lot of repetitive travel actions, such as trips every three hours to the same supply areas, along with multiple interruptions from divergent sources that ranged from patients, to colleagues and administrative staff (Ebright et al., 2003).

The Ebright et al. (2003) study indicated that acute care nurses’ used an array of knowledge patterns in their reporting and this was evident when they were referring to knowing typical patient profiles that they used to guide their work within the routines of the unit. A similar finding was identified by Groves, Fingfeld-Connett, and Wakefield (2014) and Papastavrou, Andreou, Tsangari, Schubert, and De Geest (2014) that nurses provided care based on what they described as ‘knowing what is normal for the patient’ and that this was based on procedural norms. To provide care in this manner the achievement of conflicting goals was attempted by the stacking of activities while
waiting for resources, anticipating events, and maintaining constant vigilance of proactive monitoring (Ebright et al., 2003).

This was termed *prioritisation* by (Groves et al., 2014) and *rationalising of care provision* by (Papastavrou et al., 2014). Rationing of care by nurses is the withholding or failure to carry out an aspect of nursing care in relation to inadequate time, staff or skill mix. Papastavrou et al. (2014) noted that, on average, the main task rationed by nurses was reading the patient’s notes before a shift, which ties in with the findings of Ebright et al. (2003) that RNs used patterning of knowledge of typical patient profiles to care for their patients. Papastavrou et al. (2014) also noted that RNs in acute care would ration tasks in relation to areas involved with monitoring and safety of patients. This included taking vital signs and monitoring those confused or impaired whilst still trying to respond promptly to patients’ use of call buzzers.

**Knowledge about pain care provision.**

Not all pain education provision is standardised and this applies across the health care disciplines. The UK multi-disciplinary survey study by Gregory and Haigh (2008) noted discrepancies of the levels of pain management knowledge present within varying education providers of the health care professional groups working with older patients on acute care medical wards. These included a continued lack of further training by the multi-disciplinary group, along with minimal educational input since gaining their degrees had left, in particular the RNs, a low level of knowledge regarding use of analgesia (Gregory & Haigh, 2008). In an effort to rectify this an inter-professional pain management consensus summit held within the USA by Fishman et al. (2013) has resulted in the development of a basic multi-disciplinary consensus that is based on core
competencies for pain management education to provide standard mappings for inclusion within curricula.

The critical review of the Australian curriculum content of current nursing undergraduate programs identified preparation to clinical practice gaps in areas noted as being national priorities (Ralph, Birks, Chapman, & Francis, 2014). Of the nine National Health Priority Areas identified by the AIHW (2013a) within its national chronic disease strategy, 17 of the Australian nursing programs did not feature seven of these areas within their subject titles, synopses or learning outcomes (Ralph et al., 2014). Notably these areas include arthritis, dementia, cancer, cardiovascular disease, asthma, and diabetes as well as obesity. Ralph et al. (2014) noted that the current options were to continue, increase student intake, or redefine the role of nursing to become an even more highly specialised profession that focuses on those deficiencies by provision of post-graduate qualifications.

The NSW Pain Management Taskforce (2012) noted that specialised training and education for nurses in relation to pain management occurred primarily within the hospital environment from a pain clinical nurse consultant (CNC). The taskforce noted that any pain-specific training for nurses was not guaranteed within undergraduate programs and when pain education was present it was limited within the curriculum. In response to those concerns about pain education levels, the NSW Ministry of Health (2012) proposed an aim to establish partnerships to develop and embed clinical training for the management of pain within nursing undergraduate and post-graduate programs. Regardless of these positive incentives, it is becoming increasingly clear that effective pain management for the older person within an acute care setting is a specialist area within nursing (Prowse, 2007).
It is apparent in the research literature that all nurses do not have a common baseline knowledge about pain assessment procedures and have varied experiences in pain management that depends, in part, on where they have previously worked (Micheals, Hubbartt, Carroll, & Hudson-Barr, 2007). Vaartio, Leino-Kilpi, Suominen, and Puukka (2009) identified that acts of advocacy by nurses during procedural pain are often applied in a haphazard manner that is dependent on the patient’s ability to express their interests and wishes. A lack of empowerment for nurses that resulted in limited influence over the planning for procedural pain was found to determine whether or not those nurses would enact or implement any advocacy (Vaartio et al., 2009). It has been suggested that nurses require more education in relation to how they can influence outcomes for management of procedural pain and use of nursing faculty education has been identified as a potential beginning point for addressing the lack of education issues (Vaartio et al., 2009; Wilson, 2014).

Of the current literature in relation to provision of nurse education regarding pain, the descriptive correlation study by Voshall et al. (2013) on nurse faculty members in one Midwestern USA region noted that less than one half identified that they had used specific pain management guidelines within their teaching. The study by Chiu, Trinca, Lim, and Tuazon (2003) who compared levels of knowledge from 81 Australian and 69 Filipino final year nursing students, identified a lack of knowledge from both countries and deficiencies were noted to be in areas of pain mechanisms, pharmacology, regional pain syndrome and central sensitisation. The New Zealand survey by Barton et al. (2004) on 600 nurses and midwives with a response rate of 48% (286) about their pain knowledge and attitudes identified that nurses who were unaware and had no direct contact with Acute Pain Service (APS) nurses had lower levels of pain knowledge and attitudes than those who did. In particular, Barton et al. (2004) identified that a
significant influence of contact with APS nurses was found to correlate positively on nurses’ and midwives’ choice of analgesia, specifically pharmacological and non-pharmacological interventions. A common finding of all research on levels of education for student nurses in relation to pain was that they consistently recommended curricular revisions to stem the insufficient and deficient levels of knowledge as well as addressing inappropriate attitudes regarding pain (Al-Khawaldeh et al., 2013; Chiu et al., 2003; Duke et al., 2013; Mackintosh-Franklin, 2014; Plaisance & Logan, 2006).

**Barriers and facilitators to pain care: a critical review of the literature**

This section of the literature review chapter will discuss the barriers and facilitators relating to the assessment and management of pain in older people by focusing on the findings of a systematic search and a critical review of the literature. The findings are presented thematically by using the organisational framework by Schien (1992, 2010).

The aim of this critical review is to explore the current literature to gain insight not only into the impact of nursing culture on the clinical practice of nurses when providing pain care, but the patients’ perception of receiving that pain care in the acute care setting. Included are those articles that are published as well as the grey literature available for the nurses in this study to refer to on the ward by either computer or hardcopy.

The organisational framework developed by Schien (1992, 2010) asserts a culture within an institution is learnt by experience that is based on socialisation, and leads to a proscribed way in which its members will act, find meaning and get along with others within that setting. While this is not dependant on any one individual’s action, the rules will be learnt, perpetuated and replicated by the interaction of individuals within the climate of the subculture as a whole (Glaeser, 2005; Murchison, 2010). Exploration of these values and beliefs can aid understanding or explanation of their impacts on an
individual and why or how they will respond to a defined situation in that manner (Schein, 2010). Developing understanding about care delivery by nurses within acute care can help anticipate these behaviours, not only in that group of nurses but also within other areas of nursing specialisations as well (Gobo, 2008; Leininger, 1991).

**Critical review findings.**

From the previous systematic search of the literature as outlined

Appendix 2 Table 13 List of search terms page 374, a critical review was undertaken on those primary research articles that focused on pain in the older person and nursing care within acute care. In total 34 articles were found as shown by Table 3 Search strategy for critical review of the literature below on page 69. Within these 34 articles as presented in summary within Table 4 Summary table of the 34 articles on page 70 and 17 were inclusive of the older person. A full presentation of all the 34 articles critiqued by use of the McMaster critique form (Letts et al., 2007) is presented within Appendix 4 Table 15 Articles critiqued in literature review on page 379.

A search of the grey literature encompassed an online search within the area health that this study is located in and a manual search of each of the wards (described in more detail within Chapter four: Description of the setting, research design and methods on page 101). The results of the grey literature search was a lack and distinct paucity of specific guidelines as well as policies and procedures available for nurses to refer to within their clinical practices for the assessment and management of pain in the older hospitalised person. The absence of the presence of this grey literature on the wards in an accessible format has meant that they are not critiqued alongside the findings of this critical review. The importance of easily accessible guidelines, policies and procedures
was presented within chapter one; the impact of their absence is evident within the findings chapters of this study and this is discussed in more detail within the concluding chapter.
Table 3: Search strategy for critical review of the literature

Number of databases searched = 4
Number of articles retrieved = 14,888

Items acquired = 2211

Initially perceived as relevant = 597
Not in English = 8

Fully evaluated = 133
Not located in acute care = 11

Not relevant = 84
(Not specific for the older person, and/or not about nursing)
Not research (literature reviews) = 10
Double up = 7

Total in review = 34
Table 4 Summary table of the 34 articles critiqued within this review

<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Specific for the older person</th>
<th>Older persons are included by interview</th>
<th>Older persons are included within observations</th>
<th>Their family was included</th>
<th>Those with a cognitive impairment are included</th>
<th>Nurses are included by interview</th>
<th>Nurses are included within observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Manias, 2012)</td>
<td>Complexities of pain assessment and management in hospitalised older people: A qualitative observation and interview study</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>(Albarran, Clarke, &amp; Crawford, 2007)</td>
<td>It was not chest pain really, I can’t explain it!’ An exploratory study on the nature of symptoms experienced by women during their myocardial infarction</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
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<tr>
<td>(Bowman, 1997)</td>
<td>Sleep satisfaction, perceived pain and acute confusion in elderly clients undergoing orthopaedic procedures</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
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<tr>
<td>(Rankin, 2015)</td>
<td>The rhetoric of patient and family centred care: an institutional ethnography into what actually happens</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>(Dihle et al., 2006)</td>
<td>The gap between saying and doing in postoperative pain management</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
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<tr>
<td>(Idvall, Bergqvist, Silverhjelm, &amp; Unosson, 2008)</td>
<td>Perspectives of Swedish patients on postoperative pain management</td>
<td>N</td>
<td>Y</td>
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<tr>
<td>(Kim et al., 2005)</td>
<td>Strategies of pain assessment used by nurses on surgical units</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>(Klopper, Andersson, Minkkinen, Ohlsson, &amp; Sjöström, 2006)</td>
<td>Strategies in assessing post-operative pain – A South African study</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>(Manias &amp; Williams, 2007)</td>
<td>Communication between patients with chronic kidney disease and nurses about managing pain in the acute hospital setting</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>(Manias et al., 2005)</td>
<td>Nurses’ strategies for managing pain in the postoperative setting</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>(Manias, Botti, &amp; Bucknall, 2006)</td>
<td>Patients’ decision-making strategies for managing postoperative pain</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>(Söderhamn &amp; Idvall, 2003)</td>
<td>Nurses’ influence on quality of care in postoperative pain management: A phenomenological study</td>
<td>N</td>
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<td>(Willson, 2000)</td>
<td>Factors affecting the administration of analgesia to patients following repair of a fractured hip</td>
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<td>(Clabo, 2008)</td>
<td>An ethnography of pain assessment and the role of social context on two postoperative units</td>
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<td>(Rejeh &amp; Vaismoradi, 2010)</td>
<td>Perspectives and experiences of elective surgery patients regarding pain management</td>
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<td>(Rushton, Eggett, &amp; Sutherland, 2003)</td>
<td>Knowledge and attitudes about cancer pain management: a comparison of oncology and non-oncology nurses</td>
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<td>(Spilsbury et al., 2007)</td>
<td>Pressure ulcers and their treatment and effects on quality of life: hospital inpatient perspectives</td>
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<tr>
<td>(Coker et al., 2008)</td>
<td>Pain Management Practices: Older Adults on Acute Medical Units</td>
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<td>(Eriksson et al., 2014)</td>
<td>Numeric rating scale: patients' perceptions of its use in postoperative pain assessments</td>
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<td>(Tutton, 2005)</td>
<td>Patient participation on a ward for frail older people</td>
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<td>(De Silva &amp; Rolls, 2010)</td>
<td>Health-care system and nursing in Sri Lanka: An ethnography study</td>
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<td>(De Silva &amp; Rolls, 2011)</td>
<td>Attitudes, beliefs, and practices of Sri Lankan nurses toward cancer pain management: An ethnographic study</td>
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<td>(Penney &amp; Wellard, 2007)</td>
<td>Hearing what older consumers say about participation in their care</td>
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<td>(Tutton &amp; Seers, 2004)</td>
<td>Comfort on a ward for older people</td>
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<td>(Cowdell, 2010)</td>
<td>Care of older people with dementia in an acute hospital setting</td>
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<td>(Costello, 2001)</td>
<td>Nursing older dying patients: findings from an ethnographic study of death and dying in elderly care wards</td>
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<td>(Brown &amp; McCormack, 2006)</td>
<td>Determining factors that have an impact upon effective evidence-based pain management with older people, following colorectal surgery: an ethnographic study</td>
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<td>(Closs &amp; Briggs, 2002)</td>
<td>Patients' verbal descriptions of pain and discomfort following orthopaedic surgery</td>
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<td>(Wikström et al., 2014)</td>
<td>Healthcare Professionals' Perceptions of the Use of Pain Scales in Postoperative Pain Assessments</td>
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<tr>
<td>(Joelsson et al., 2010)</td>
<td>Patients' experience of pain and pain relief following hip replacement surgery</td>
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<td>Reference</td>
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<tr>
<td>(Anderson, Burman, &amp; Skar, 2011)</td>
<td>Experiences of care time during hospitalisation in a medical ward: Older patients’ perspective</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
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<tr>
<td>(Tadd et al., 2011)</td>
<td>Right place – wrong person: dignity in the acute care of older people</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>(Coker et al., 2008)</td>
<td>Pain Management Practices: Older Adults on Acute Medical Units</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
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<td>Y</td>
<td>N</td>
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<tr>
<td>(Neville, 2008)</td>
<td>Older people with delirium: Worthless and childlike</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
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</tbody>
</table>
Of the 35 primary research articles found as shown in Table 4 Summary table of the 34 articles on page 70, 17 are specific for the older person.

Within the studies found, the most prolific researcher was noted to be Manias, with a total of five articles included within the review (Manias, 2012; Manias, Botti, & Bucknall, 2002; Manias et al., 2006; Manias et al., 2005; Manias & Williams, 2007). The research design used by Manias is described as being from observational design (Manias et al., 2002), to naturalistic observational design (Manias, 2012) and single group non-comparative design (Manias & Williams, 2007). All the studies by Manias lack in-depth description of the methodological approach used and appear to have a particularistic and positivist as opposed to a naturalistic approach that is more inclusive of the context in which it occurs. The studies by Spilsbury et al. (2007) and Cowdell (2010) were the only articles that both undertook a systematic search of the literature and outlined a process of critique within their literature reviews.

**Grey literature.**

A review is provided of a systematic search of the grey literature that the registered nurses in this study can access from within their ward location, either by the computers located at the nurses stations and/or in hardcopy that have been provided by the organisation such as mandated guidelines, policies and procedures. McAuley, Pham, Tugwell, and Moher (2000) assert that grey literature needs to be included within any systematic review process as when omitted an exaggeration may result of any estimation about the effectiveness of an intervention. Therefore, the inclusion of the online and manual search of grey literature located within the context of this study is to explore if any linking had occurred between the current EBP literature and research for use within clinical practice.
Grey literature is defined for the purpose of this review as online National, State, Area, and Local health policies as well as procedures or guidelines that are available to be accessed within the context by the nurses in this study. The manual search was undertaken within each of the eight acute care wards for documents that are available for the nurses to access to guide their pain care provision actions and a search of the APS website which covers the area health that the study is located in. The results of the grey literature search are as shown in Appendix 4 Grey literature search strategies and results pages 385 to 388

The search terms for the grey literature online search are as outlined in Appendix 4 Table 16 Search terms for the National health policy directives and guidelines database on page 385. Once a National search was conducted, then an individual NSW statewide search was undertaken as shown in Appendix 4 Table 17 NSW policies and procedures reviewed for guidance for pain care provision on page 386.

The NSW state wide search did not find the national seminal guideline for person centred pain care provision within acute care by Katz and Gibson (2012) located within the Victorian Department of Health (2012) guideline entitled ‘Best care for older people everywhere – The toolkit’. A singular document, the NSW Department of Health (2013) ‘Handbook for the Assessment and Management of people with behavioural and psychological symptoms of dementia for NSW health clinicians’ does refer and provide links to the Victorian Department of Health (2012) guideline. However, it is noted that the state wide website for the South Australian Department of Health (2012), not only has the Victorian Department of Health (2012) ‘Best care for older people everywhere – The toolkit’ document, but also has provided links for adaptation within the context of that state. Despite an extensive online search, no other Australian state or Territory had this guideline listed or links to it on their websites.
The result of the grey literature search was that no specific policies as well as procedures or guidelines were identified for pain assessment and management of the older person. The exceptions were a statewide cardiac chest pain policy and a summary of the Goucke et al. (2005) residential aged care guideline. A policy was located within Appendix 4, Table 17 NSW policies and procedures reviewed for guidance for pain care provision on page 386 that outlined that senior ED nurses are able to nurse initiate IV morphine for provision of breakthrough pain relief in ED.

**Nurses’ values for providing pain care.**

The ability of a nurse to provide culturally congruent pain care as previously defined in chapter one in the section titled Pain care provision and evidence based practice on page 15 will be in part dependant on the values in operation and placed within that context for reaching a goal that leads towards the development of health and well-being (Leininger, 1988, 2002, 2006; Wikberg & Eriksson, 2008). A value is an attribute that is placed by an individual towards themselves, and applied to another person, or placed on an object or idea (Mullen, Brown, & Smith, 1992; Schein, 1992, 2010). Values that are held by a person tend to be located within a simple belief that is very specific about what is desired or preferable which is a standard for what is acceptable personally or socially and this will influence or guide their behaviour (Schein, 1992, 2010). Values, by their nature, tend to be more stable and less changeable than an attitude or a belief – hence this makes a value more difficult to change (Schein, 1992, 2010). The values that a person holds or adheres to will involve a higher set or level of consciousness than a basic assumption.

Values are often spoken of, for example, they can be best described as what a person will say what they will do rather than what is actually done in a situation when the espoused values should be operating (Carspecken, 1996; Schein, 1992, 2010). The
phenomenological study by Söderhamn and Idvall (2003) used vignettes and interviews to identify that the nurses in their study spoke of placing a high value on relieving patients from suffering by using their professional skills as part of a creative problem solving process. Similarly, the descriptive correlational survey study by Ware, Bruckenthal, Davis, and O’Conner-Von (2011) also confirmed that nurses perceived themselves as strong advocates for patients’ pain management. Conversely, the study by Dihle et al. (2006) identified a gap between what the nurses’ say they do and what they were actually doing in clinical practice. Dihle et al. (2006) indicated a discrepancy between the nurses’ own perceptions on how they dealt with post-operative pain and the incongruence with the actions actually undertaken by them. Likewise, the studies of Clabo (2008); Kim et al. (2005); Klopper et al. (2006); Manias (2012); Manias et al. (2002); Wikström et al. (2014) and Willson (2000) noted that nurses were assessing pain by referring to the patients as having a heterogeneous typology of pain and placing their own values in relation to the intensity of that pain experience.

This is in contrast to the values held by the older person when they are an inpatient in acute care. Within the studies by Anderson et al. (2011) and Penney and Wellard (2007) they identified that high values are placed by the older person onto participating in their care delivery and their importance on developing relationships with health care professionals as being equated with independence. Similarly Rejeh and Vaismoradi (2010) and Rustoen, Gaardsrud, Leegaard, and Wahl (2009) acknowledged the significance placed by the older person on gaining and sharing information about their pain, and this resulted in a stated increased of those patients’ confidence in the nurses’ ability to know or detect their pain. Manias et al. (2006) refuted this within their research by asserting that the adult patients were observed to be passive recipients for pain relief. Conversely, the older persons in the Spilsbury et al. (2007) study were not
passive and they spoke of nurses not listening to them. Furthermore, those older patients also spoke of having to put up with painful wound care which they stated was caused by the nurses’ negative attitudes towards them (Spilsbury et al., 2007).

The findings in the Spilsbury et al. (2007) study were not an isolated instance, with studies by Costello (2001); Cowdell (2010); Rankin (2015); Tutton and Seers (2004) and Willson (2000) all citing examples of patients speaking of receiving care that was at a nurse’s convenience and of not being able to participate in the provision of their care. Situations in which patients spoke of having to wait and endure their pain were identified within the studies by Dihle et al. (2006); Idvall et al. (2008) and Manias et al. (2002) who indicated a noticeable delay from when the patient requested analgesia to when they received it. Likewise the aspect of waiting was noted as a subtheme within in the Anderson et al. (2011, p. 648) qualitative study by the older patients who commented that they had to ‘adapt to wait for everything’. Penney and Wellard (2007) identified in their study that patients expressed frustration and spoke of a desire to manage their own medications for pain like they already did at home.

The amount of time a nurse allocates to providing pain care is indicative of the value placed on the act of conducting a pain assessment and determination of management efficacy (Ware et al., 2011). Ware et al. (2011) cited nurses stating that the main factor acting as a barrier to the management of pain was a lack of time. A lack of time has also been noted by nurses as a barrier to the management of pain by nurses in clinical practice in many studies, including Dihle et al. (2006); Idvall et al. (2008); Manias et al. (2002) and Manias et al. (2005). However, when Manias et al. (2005) and Manias et al. (2002) explored this aspect more closely, they found that the delay was due to interruptions, mainly by other nurses, and the nurses’ prioritisation of functional task completion. Certainly Anderson et al. (2011); Costello (2001); Cowdell (2010);
Spilsbury et al. (2007) and Tutton and Seers (2004) all noted that aspects such as fluid balance charting, the time of day, administering antibiotics, pressure area care and conducting rounds, impacted significantly on time availability for pain care provision. What these studies highlighted is not only that a lower value is placed on the time allocated for completion of pain care, but also that other unrelated functional tasks have a higher value and this was perpetuated by the nurses themselves.

Within the Tutton (2005) action research project it was noted that nurses were unaware of the potentials for facilitation and opportunities for the older person to participate within the provision of their care. Tutton (2005) attempted to encourage the nurses to engage in cycles of reflection in relation to their daily care provision and spoke of this as facilitating increased understanding and awareness by the nurses. Values about pain can also be influenced by a prevailing national culture held by its members and the ability of a national culture as an influence on an individual has been extensively studied by Hofstede (1983) who identified that a person’s thinking can be partly conditioned by national cultural factors and this is influenced by their early life experiences. Klopper et al. (2006) found an example of this within their South African phenomenography study on nurses’ assessment and management of post-operative pain. It was established that the nurses would typify the ability of patients to withstand pain based on a typology of the patients’ race (Klopper et al., 2006). Albarran et al. (2007) noted a difference between sexes in their study on women’s descriptions of a myocardial infarct. When the women recalled their experiences of their cardiac event, their symptoms were found to be inconsistent with that of the prevailing evidence which originated from research findings that were predominately male based (Albarran et al., 2007). The women spoke of their distress at not knowing that they were experiencing a
myocardial infarct and they had delayed their presentation to hospital (Albarran et al., 2007).

**Beliefs held about pain.**

Beliefs can be elicited when a researcher asks a participant to explain more about an aspect of the observed behaviour and use of artefacts or tools that have been noted as being puzzling, unusual or inconsistent (Schein, 1992, 2010). Basically, beliefs are entrenched within the values held by a person and can be considered as the ‘rules for action’ (Mullen et al., 1992; Schein, 1992, 2010). A belief is more than an attitude or a value ascribed towards a person or object and it is a standard held to guide and determine action (Schein, 1992, 2010).

The main belief held by nurses and evident within numerous studies was the belief that they can determine the actual level and amount of pain, based on how a patient looks along with a typology of the procedure that they underwent (Clabo, 2008; Dihle et al., 2006; Kim et al., 2005; Klopper et al., 2006; Manias, 2012; Manias et al., 2002; Söderhamn & Idvall, 2003; Wikström et al., 2014). Also reported within numerous studies are the difficulties a patient will face when their pain does not follow or conform to a subjective interpretation held by nurses (Albarran et al., 2007; Eriksson et al., 2014; Idvall et al., 2008; Joelsson et al., 2010). This has led to the identification by patients in the Spilsbury et al. (2007) and Cowdell (2010) studies that nurses lacked empathy. Patients in the Brown and McCormack (2006), Rustoen et al. (2009) and Rejeh and Vaismoradi (2010) studies were unable to articulate the roles that a nurse will hold in relation to the management of pain.

The ethnographic study in acute care by Willson (2000) does provide some insight into the contextual aspects that provide insight into the impact of nurses’ beliefs within clinical practice. It was noted that the way in which the delivery of care was organised
had an effect on the continuity and individualisation of how nurses made clinical decisions regarding pain assessment and management (Willson, 2000). In particular, the way in which analgesia was administered was the result of professional socialisation that had been determined by a set of social rules, rather than implementation of EBP (Willson, 2000).

The presence of social rules was identified by Willson (2000) who found that the acute care nurses had devised their own model for pain assessment and analgesia administration that operated solely within their convenience. The study noted that the more senior nurses acting as role models to the junior nurses perpetuated this and that rules of application of analgesia administration appeared to be learnt this way (Willson, 2000). For example, there was no written protocol in the study hospital regarding ceasing of opioid analgesia; however nurses held an attitude that opioids were not to be given after 24 hours post-operatively (Willson, 2000). Furthermore Willson (2000) noted that the nurses would collude together, that they questioned and openly doubted the credibility of patients who requested more analgesia.

**Assumptions/ attitudes.**

Assumptions are often invisible or implicit; they are what is used by a cultural group to guide the behaviour of the group and will inform them on how to perceive, think, or act (Schein, 1992, 2010). Attitudes are essentially three components being values, beliefs, and their evaluation, which emerges as behaviour (Mullen et al., 1992; Schein, 1992, 2010). The attitudes that acute care nurses hold about older people can range from ageist stereotyping, to marginalisation or outright oppression, and to that of respect and compassion (Brown & McCormack, 2006; Coker et al., 2008; Cowdell, 2010; Gallagher, Bennett, & Halford, 2006; Lovell, 2006; Neville, 2008). A nurse’s basic assumption about how to gain resolution or relief for a patient who is experiencing a
pain crisis situation will be based on their ability to conduct conflict resolution (Lovell, 2006). The ethnographic study by Brown and McCormack (2006) noted that nursing staff did have proficiency in completion of a series of tasks to ensure safe practice for management of pain. Equally Manias et al. (2005) noted a reliance on a series of completion of functional tasks by nurses to deliver pain management. However, Brown and McCormack (2006), Manias et al. (2005) and Joelsson et al. (2010) noted that the nursing staff did not have an array of strategies available to cope with situations of patients having uncontrollable, severe or problematic pain. Likewise other studies that have focused on the patients’ perceptions of pain in the first few days post-op, have found that this is the time when the patients’ descriptions of their pain are the most graphic and intense (Idvall et al., 2008; Joelsson et al., 2010). Manias et al. (2005) identified that when nurses are confronted with a patient in uncontrollable pain they were reactive in their responses before engaging in collaboration with the patient, other nurses, doctors and anaesthetists. Alternatively, Rejeh and Vaismoradi (2010) asserted that patients wanted nurses to be more proactive and pre-empt their pain.

**Use of artefacts by nurses.**

Artefacts involve all the phenomena that one can see and hear a culture using within their context, and include aspects such as the use of policies, procedures and guidelines (Schein, 1992, 2010). Artefacts can also range from the physical layout of a ward, visible traditions, symbols and the types of technology used as well as relate to modes of communication and language used (Schein, 1992, 2010). How nurses will speak to patients when assessing their pain and how the patients respond was the subject of the study by Closs and Briggs (2002) that compared congruence of patients’ description with the McGill pain questionnaire.
Closs and Briggs (2002) found that patients used verbal descriptors and analogies in order to describe their pain or its intensity. Patients rely on an array of sensory vocabulary for a description of the pain intensity as well as use of analogies, and conversely will characterise discomfort by describing the cause, rather than the nature of the discomfort (Closs & Briggs, 2002). Studies have shown that the language used by nurses was dissimilar to that used by the patients, for instance Manias et al. (2006) and Manias (2012) noted the nurses used direct questioning involving statements like ‘how is your pain’ or ‘do you need anything for your pain’.

Studies have identified that proficient communication (Brown & McCormack, 2006) involves providing opportunities (Tutton & Seers, 2004) and letting the patients speak for themselves (Albarran et al., 2007) when describing their pain. Patients often have difficulties in describing their pain. Eriksson et al. (2014) noted that patients found it difficult to describe their pain when asked to represent pain as a numerical value. The inconsistent use of a numerical rating score by nurses was noted by Wikström et al. (2014) who noted that the nurses expressed their uncertainties of using a numerical score. Furthermore the nurses in the Wikström et al. (2014) study suggested that pain scoring need not be carried out after a couple of days had passed after a patient had surgery and at that point they then relied on visual cues. Tutton (2005) noted that nurses need to facilitate communication by understanding the patient and this can only be gained by developing a caring connection with them.

**Nursing routine and rituals.**

The process of care delivery in acute care can become ritualised and routine from being based on functional task completion. The main example of a ritual within acute care is the round with a medication trolley, which numerous studies have identified as a prioritised event (Brown & McCormack, 2006; Davidson, 2011; Dihle et al., 2006;
Higgins et al., 2007). The studies by Cowdell (2010), Manias et al. (2002), Manias (2012) and Willson (2000) have all noted that a major constraining factor of administration of analgesia was the formal set times of the drug round, and this was the time when pain relief was administered. Of interest is the time difference between these studies, as over a period of 15 years the constraining aspects of the clinical practice of administering analgesia has consistently not changed in acute care.

The increased use of technology has allowed the development of pain assessment documentation to be located or placed within functional task completion. However, Rankin (2015) noted that the increased use of technology to standardise documentation of care to streamline processes has impacted adversely on the ability of nurses to provide patient and family centred care. The nurses identified that they were unable to provide input or contribute their professional knowledge into the electronic system (Rankin, 2015). The result was the obscuring of care that was removed from the patient and centred within the confines of a computer program that did not allow the documentation of the individualisation undertaken for patient centred care (Rankin, 2015).

**Review and summary**

This literature review clearly indicates the presence of culturally mediated barriers regarding the conduct of pain assessment and management within acute care. The most common reason for unrelieved pain is the failure of health care providers to systematically assess and treat it (Herr et al., 2006). What is not understood are the reasons why this occurs despite the evidence. This literature review has offered a novel approach for looking at the problem from a different perspective by use of thematic mapping based on the framework devised by Schein (1992, 2010). It is noted that the main criticism of using Schein’s (2010, 1992) organisational framework in this manner
is that professional behaviour exhibited by an individual is being viewed from an etic or outsiders’ view (being a perspective of institutional interactionism), rather than a true insiders’ or emic view (Bloor, 2001; Pollner & Emerson, 2001).

The following chapter presents the conceptual framework and methodology that was used to explore, gain insight and understanding in the experiences of the nurses and the older person in relation to pain care provision. In the following chapter, discussion of the application of Leininger’s culture care theory (1988) for guidance when using a focused ethnographic approach is presented.
Chapter three: Conceptual framework and methodology

Chapter Introduction

In this chapter, I outline the conceptual framework and methodology used in this study. This chapter comprises two sections. The first section provides an introduction to the conceptual framework adopted that is based on Leininger’s culture care theory (1988). The second section introduces ethnography and outlines how the use of focused ethnography has informed this study.

To begin with the first section titled Conceptual framework provides an outline of how Leininger’s culture care theory (1988) has underpinned and guided this study. Although used extensively in other contexts and applications, the use of an adaptation of Leininger’s culture care theory (1988) is a novel application for exploration of pain care provision by nurses for the older hospitalised person and has allowed recognition of the data to be gained by its use as an internal structure. The use of Leininger’s culture care theory (1988) has allowed capturing of those aspects such as how nurses will use their knowledge of the acute care system to provide culturally congruent pain care for the older person.

The second section titled Ethnography begins with an exploration of ethnography as a research methodology. Discussion occurs on the differing types of ethnography. Focused Ethnography is detailed and defined in light of its historical origins. The challenges of using a focused ethnographic approach are acknowledged, and a rationale for the use of this approach in this study is provided.
The conceptual framework

The conceptual framework that underpins this focused ethnographic study is Leininger’s culture care theory (1988). It provides a structure to not only organise and support the purpose of this study. It also allowed flexibility during the study whilst still providing coherence (Leshem & Trafford, 2007). The reason for the application of theory at this point and embedding it within the methodology is to ensure that prejudgement and forcing of impetration of the research into a mould will not ensue (Hammersley & Atkinson, 2007).

Leininger’s culture care theory (1988).

To date, Leininger’s culture care theory (1988) has been used extensively. Examples include its use by nurse educators to provide a model for teaching nursing students to develop culturally congruent care (Mixer, McFarland, Andrews, & Strang, 2013), for provision of nursing care for Muslim patients in the USA (Wehbe-Alamah, 2008), for community nursing within rural areas of the Dominican Republic (Schumacher, 2010), for Nigerian immigrants’ eating and physical activity levels in the USA (Turk, Fapohunda, & Zoucha, 2015) and for inclusion in models of care (Jasovsky, Morrow, Clementi, & Hindle, 2010) to name a few. The use of Leininger’s culture care theory (1988) for determination of culturally congruent pain care provision for the older person in acute care is a novel application of this theory. With this in mind an adaptation as shown in

Figure 1 Adaptation of Leininger’s culture care theory (1988) on page 88 was used as the basis for this study.
A *skeletal framework*, based on both Spradley (1980) and Leininger (1988) used in conjunction with Schein (1992, 2010) as well as long term and ongoing immersion in the field (Brewer, 2000; Hammersley & Atkinson, 2007) has allowed recognition of what data was to be gained through an internal structure. This *skeletal framework* is used as a bridge between the practice of undertaking the study and the explanation of the issues and functions. It provides a map that gives meaning to the relationships that will emerge for provision of insight and understanding (Leshem & Trafford, 2007). When a paucity of knowledge exists it is noted by Morse and Mitcham (2002) that the use of a skeletal framework will ensure all necessary data will be available not only to guide inquiry for data collection, but to allow exploration and inclusion of the context in which it is located.

For instance the use of

Figure 1 Adaptation of Leininger’s culture care theory (1988) has allowed inclusion of categories such as technological, economic and education factors, as well as social and philosophical factors to be collected for exploration of how they influence nursing care patterns (Morse & Mitcham, 2002). The worldview of the provision of nursing care within the acute care setting is based on patient centred care as defined by the ACSQHC (2011b) which is holistic and respectful as well as responsive to the preferences of the person who is receiving it. Moreover, the inclusion of the work of Schein (1992, 2010) allows exploration of how the beliefs held by a nurse within an acute care can be transformed into the collective beliefs held by other nurses within that ward.
Worldview of acute care provision of pain assessment and management by nurses for the older person

Values, beliefs, motivations, artefacts, rituals and routines

Pain care expressions, patterns and practices

The older person

Pain care provision

Professional care-cure practices

Inclusion of the older person, translation and implementation of EBP

Pain care provision that provides preservation or maintenance, and accommodation or negotiation as well as re-patterning and restructuring

Explicit use of individualised pain care provision that is individualised, person centred, provides benefit and meaning by nurses within the context of acute care in an organisational climate.

Figure 1 Adaptation of Leininger’s culture care theory (1988)
The aspects of pain care delivery that require the older person to adapt to the hospital setting and/or require negotiation by a nurse to provide pain care provision can then be explored in depth and in detail (Leininger, 1988, 2002, 2006). How a nurse will provide safe and effective pain care that promotes the health, well-being and the ability of the older person to deal with the nature of their pain in conjunction with their illnesses or experiences can be captured (Leininger, 1988, 2002, 2006). Any aspects of nursing pain care re-patterning, or whether any restructuring is required that the nurse will undertake in the provision of assistance and support for pain care provision can be identified (Leininger, 1988, 2002, 2006). Additionally, aspects that require facilitation or that act as a barrier towards professional nursing pain care provision, such as translation of EBP actions and implementation of mutual decisions made between nurses and the older person within the acute care system of person centred care, can also be acknowledged.

Validity is provided by ensuring that the conceptual framework is as complete and comprehensive as possible, and also to ensure that premature closure does not occur (Morse & Mitcham, 2002). This is a risk that is covered in more detail later in this chapter, due to the researcher being overly familiar with the setting and topic (Pereira de Melo, Sevilha Stofel, Rosa Gualda, & Antunes de Campos, 2014). The application of Leininger’s culture care theory (1988) for the conceptual framework was to gain completeness and to not pre-judge or force the data into a mould, and was used as a resource in order to provide assistance to help to make sense of the data (Hammersley & Atkinson, 2007).
Ethnography evolved from cultural anthropology and often focused on the small scale cultural patterns of tribal or village life (Morse & Field, 1995). Ethnography is a research methodology that involves the researcher directly interacting with the participants of a particular cultural group or sub group within a society in order to explore and describe the cultural beliefs held by the group (Hughes, 1992; Madden, 2011; Morse & Field, 1995; Murchison, 2010). A defining characteristic of ethnography is a description of the behaviours of individuals and groups of people from a holistic perspective. This involves outlining the social framework of meaning held by members of that group and the social rules and norms of the group (Roper & Shapira, 2000). In a practical sense, ethnography is used to collect, describe, and analyse the ways that people categorise not only their meaning of their world, but also how they use this knowledge to interpret an experience and mould their behaviour within a culturally constituted environment (Aamodt, 1991).

Underpinning an ethnographic approach is the premise that culture is a system of knowledge used to interpret experience and generate behaviour and that the linguistic expressions, behaviours, and use of tools/artefacts by people during social interactions are the structural blocks for constructing these systems of cultural knowledge (Aamodt, 2001). Culture, as Raymond Williams in 1958 famously articulated, is ordinary and as cited in Higgins (2001, p. 11). Culture exists when the aim of the members within a society not only try to find a common meaning and direction, but when they also bring this forward by applying, as well as imparting within it, their own meaning. Culture can then be expressed as the values that will suffuse the beliefs and behaviours within those of a group and are expressed as a system of structures and rules that are applied by them
to not only frame, but understand, situations that arise within a context (DiMaggio, 1997).

All ethnographers hold a clear consensus, this being an overriding priority on gaining the insiders’ viewpoint of the culture of the particular group or community in which the insider works or lives. Ethnography is grounded in the concept of culture, and seeks to understand the *emic*, which is the insider’s viewpoint of the socio-cultural world in which they live their lives (Aamodt, 1991; Brewer, 2000). For example, how a nurse interprets an event will differ from a patient’s interpretation as they each reflect their own culture and it is this world view that will influence their reactions or behaviour (Carspecken, 1996; Finkler et al., 2008; Spradley, 1980).

A culturally defined reaction will be communicated with ease and revealed during interview conversations, however, what a person will say that they will do is often different to what is actually done (Carspecken, 1996). Gaining the culturally created tacit meaning that is guiding behaviour for reactions that are outside of one’s awareness are harder to define, but are often gained by observing what a person did do and what objects they used, whilst also capturing the seemingly casual comments made at the time (Spradley, 1980). This can be achieved by exploring, observing, and describing behaviour in order to understand the context and the application of knowledge and how the culture present uses it to guide behaviour when applied, transmitted, and received in a particular manner (Morse, 2007; Murchison, 2010; Roper & Shapira, 2000).

**Types of ethnography.**

There are many different types of ethnography, differing in relation to the style and form of their research approaches. Werner and Schoepfle (1987, p. 45) developed a taxonomy to classify the styles of ethnographic research. Werner and Schoepfle (1987)
classified ethnographies undertaken on people by the term *processual* to refer to those approaches that explored aspects involving social processes and the apparent synchronisation of events as well as the development of language over time. Werner and Schoepfle (1987) subdivided processual ethnographies into a taxonomy of seven subtypes being particulistic, sketch, ethnohistorical, structuralist, ecological, cross-sectional, and auto ethnographies.

This study uses the processual ethnographic style as a particularistic subtype that is similar to a traditional approach. However, instead of applying this to the entire community of the hospital, a particularistic approach was applied to the social unit or the cross section of acute care nurses and the older person (Werner & Schoepfle, 1987). Although a narrower focus is then applied, in this study, the approach is still described holistically within the contextual setting of acute care as opposed to a cross sectional ethnographic approach which will not take into account the interactions of the nurses within that context (Boyle, 1994). This approach is therefore topic orientated (Leininger, 1985), is about small groups (McFeat, 1974) and uses focused methods (Morse, 1994). With this approach, the application is of a focus on undertaking an:

*Ethnographic holistic approach to any social unit or isolatable human group.*

(Boyle, 1994, p. 172)

This style of ethnography is now more commonly referred to as *focused ethnography* (Knoblauch, 2005; Morse, 1994; Roper & Shapira, 2000; Wall, 2015; Werner & Schoepfle, 1987).
Focused ethnography.

Focused ethnography is a style of processual ethnography that is situated within a subtype of a holistic particularistic perspective that draws on aspects from within each discipline (Savage, 2006; Wall, 2015; Werner & Schoepfle, 1987). The distinguishing features of focused ethnography are a particularistic approach that describes a subculture which is presented as a thesis, using reporting by use of thick description of the social organisation of people within an institution (Werner & Schoepfle, 1987). The focused ethnographic approach used in this study has produced multi levels of data, which are then written and presented with the use of theory as a lens (Werner & Schoepfle, 1987). The unit of analysis is exploration of the knowledge expressed within a cultural domain of a cross sectional representation of a small group within a geographically based subculture and the timing of the field work is based on interactions as they unfold during a working shift (Werner & Schoepfle, 1987). Focused ethnography is a practical and applied form of research.

As Polit and Beck (2010, p. 265) noted that focused ethnographies are:

...exhaustive and fine grained studies of small units within a group or culture.

Roper and Shapira (2000, p. 7) concur by stating that:

Most nursing ethnographies today focus on a distinct problem within a specific context among a small group of people.

The use of a focused ethnographic enquiry towards small groups was initially termed micro-ethnography for groups that comprised fewer than 15 members and has its roots in classical holistic anthropological ethnography (Wall, 2015; Werner & Schoepfle, 1987). When a focused ethnographic approach is used in research about nursing, a sociological approach is more commonly used (Morse, 1991). Focused micro-ethnography is the term for a small group of up to two or five persons being used for a
sociological approach called *small group cultures* (Ebright et al., 2003; McFeat, 1974). Leininger (1991) also used the term *mini-ethnography* to describe a narrow area of inquiry within a prevailing culture; however, that was based on a holistic traditional anthropological viewpoint that the prevailing culture as a whole had been or was already explored. The rationale for using a sociological approach is to capture the rules for culturally constituted behaviour within the context when it occurs and as it unfolds (Aamodt, 1991).

The actual term *focused ethnography* was originally proposed by Morse (1991, p. 18) for exclusive use in nursing research that is *topic-orientated ethnography*. A focus is placed on the exploration of culture within a small group (McFeat, 1974), of up to 2-5 people, to understand the cultural rules, norms, and values that are in place and that will influence how information is perceived and the behaviours enacted by a nurse when undertaking a set task within this group (Boyle, 1994; McFeat, 1974; Morse, 1994).

The research presented in this thesis extends the focused ethnography approach by including the older person who is in receipt of nursing care that is holistic and inclusive, focused, situational and occurring naturally (Knoblauch, 2005). Most importantly, the use of a focused ethnographic approach can answer some of the research questions that were formulated before going into the field so that the study can concentrate on very specific aspects or topics (Meeussen, Delvaux, & Phalet, 2013; Morse, 1991; Roper & Shapira, 2000; Wall, 2015).

In nursing research, a focused ethnographic methodology is normally applied to explore how a dynamic contemporary sub culture of nurses and patients within an organisation that is typically made up of differentiated, competing and fragmented cultures, experience a specific topic within that context (Meeussen et al., 2013; Wall, 2015).
focused ethnographic approach is a dynamic way that is used for exploration of specific cultural perspectives held by a sub culture within a context specific and problem based framework (Wall, 2015). Focused ethnography is an applied research approach that provides a focused and efficient approach for ways to understand a particular topic or issue as it is situated within the cultural perspectives, behaviour and social clinical context in which it occurs (Knoblauch, 2005; McElroy et al., 2011).

The undertaking of a focused ethnography study is an applied efficient approach that allows the capturing of data within nursing clinical specialities in order to explore the ways that nursing care and the processes involved in its delivery can be improved, for it provides knowledge about the participants by learning from them (Higginbottom, Pillay, & Boadu, 2013; Roper & Shapira, 2000; Wall, 2015). A focused ethnographic approach can identify when culture care conflict occurs, and when nursing care results in inadvertent distress or concern for the recipient as it fails to meet their cultural expectations, both possibly resulting in situations of tension fraught with problems for all concerned (Leininger, 2002). The use of a focused ethnographic approach also allows understanding of the organisational culture in which care is being provided (De Chesnay, 2014).

A focused ethnographic approach means that description is therefore required of the specific experiences of the nurses and the older person as they are in their natural state during pain care. For example, in the research reported regarding the nurses providing care to older people in pain who were patients on an acute care ward, the specific focus was on the assessment and management as well as the provision of pain care for the older person. A focused interaction can be understood in terms of how, when, and why it occurred in that manner observed (McFeat, 1974) and this provides insight into the meanings that each person has placed on that situation or event.
The research reported in this thesis also places considerable attention on the culture that surrounded the social circumstance that has given rise to the human experience of pain care provision being studied. Even though an interaction within a chance encounter between a nurse and an older patient appears to be transitory and casual, when they do occur they are not at all random (McFeat, 1974). Nurses work in a bounded social context, and this requires exploration in order that their meanings and those of the older persons that were developed by their sub-culture may be revealed within that environment (Brewer, 2000).

**Why a focused ethnographic approach is used in this study.**

The notion of cultural ethnography was ‘rediscovered’ for use by nurses who realised its utility in health care research in the late 1960s (Hughes, 1992; Morse & Field, 1995). Although if a set style or particular approach of ethnographic methodology is used that is based within one school of thought, the ability to explore any interconnected perspectives within the larger context will be missed (Hornsey, 2008). Blind adherence to the traditional teachings of qualitative methodologies in education, anthropology, cultural and sociology faculties do not help those undertaking research within nursing, as these disciplines have traditionally no knowledge of a nursing clinical context, nor do they prepare a researcher for what it is like to conduct research on those who are ill and dying (Morse, 2007). Certainly this is an issue, as nurses are exposed daily to aspects that are often un-representable and difficult to encapsulate within the wide array of human differences, diversities, and multitudes of human suffering (Cameron, 2006).

Focused ethnography is appropriate for exploring aspects of nursing practice as it helps to identify culturally mediated patterns of care delivery (Leininger, 1985, 1988, 1991, 2002, 2006) and it aids understanding of the perspectives held by nurses about human
conditions (Leininger, 1985, 1988, 1991, 2002, 2006). Nursing care practices are culturally mediated, in that they are reflective of professional factors which will influence the provision of care. However the meanings, expressions and patterning of nursing care will vary within different cultures (Leininger & McFarland, 2002). To be of benefit to the patient, nursing care has to be culturally congruent for either an individual or a group and this will only result when the culturally mediated care values, expressions and patterns are known and also used to provide appropriate, safe and meaningful care (Leininger & McFarland, 2002). Therefore, not only is it important to gain both the viewpoints of those who are providing the nursing care, but also of those who are receiving it (Leininger, 1985, 1988, 1991, 2002, 2006).

Focused ethnographic research is the work undertaken by a researcher to understand another way of life from a group and to understand the point of view of individuals within that group (Spradley, 1980). In particular, ethnography allows:

*A focus to be provided on a distinct problem within a specific context and among a small group of people.*

Roper and Shapira (2000, p. 7)

May (1994) argued that the situational application of pain comfort care by a nurse has no direct measurement, however it can be explored to understand the cultural influences on the behaviour of the nurse and the perceptions of the older person receiving that care whilst being located within the context that it occurs (Morse, 2012). An older person’s experience of pain and suffering is a personalised and subjective experience.

Pain and suffering are also reasons for a nurse to try to offer culturally congruent comfort and care that is meaningful for that person. How a nurse provides pain relief and care is reliant on the influences that are present within the context of care. It is the notion of culture that is present and that will be the ultimate deciding factor for how a
nurse will behave during situations of opposing and possibly disproportionate competing demands that are known to occur within acute care (Purkis & Bjornsdottir, 2006). It is of importance to understand what happens in the clinical context when caring for older people with pain to understand how a nurse will act when caring for an older patient with pain, and to get insight into how unpredictable situations are dealt with.

Focused ethnography allows probing to occur about the meanings behind care in relation to the actions, beliefs and values that guide the nurses’ clinical practices (Leininger, 1985, 1988, 1991, 2002, 2006). In particular, a focused approach allows that exploration to occur that is inclusive of both the nurse and the older person while taking into account the context in which it is being delivered. Gaining this understanding not only provides insight and new knowledge, but also can be used to shape care delivery programs. Getting this knowledge that is inclusive of both the older person and the nurses who care for them within the context of acute care may result in new knowledge for the provision of education that is also culturally congruent, sensitive, thoughtful and meaningful to those concerned (Leininger, 2002; Morse, 2012).

**Challenges of using focused ethnography.**

Focused ethnography is known to be challenging as the researcher is required to have an applied level of understanding of not only cultural anthropology, but also the meanings of what constitutes a social-cultural system and also the concepts utilised for this exploration (Cresswell, 2013). Focused ethnographies, by the nature of their circumscribed focus and intense nature of data gathering, place demands for prompt ongoing data analysis that directs the inquiry. This means that there is a potential for sensory, emotional and analytical overload as well as researcher exhaustion (Knoblauch,
2005; Lee & Gregory, 2008). In particular, when ethnography is undertaken with the researcher a member of that profession, studying in a known environment is an added difficulty of transforming what is familiar to the researcher into the unknown to allow future exploration of surprises to emerge (Pereira de Melo et al., 2014).

There is a need for nurses to be aware that their own experiences will affect their time in the field. Conversely Morse (2012) argues that undertaking ethnographic studies within hospital settings is imperative to contribute to knowledge and that this will require insider knowledge. A focused ethnographic researcher has the opposite issue from that of a scientific observer who tries to remain detached, as they need to free themselves of their ethnocentric background in order to study an exotic participant (Knoblauch, 2005). The elements of surprise can still occur when one is studying their own culture; in fact, it would be improbable for this researcher who is a registered nurse to refer to other nurses as being within a foreign exotic culture. But this does raise an issue that is singular to using focused ethnography, in that it can only be undertaken in conditions of common shared knowledge, rather than strangeness (Knoblauch, 2005). It should be noted that being a nurse and becoming overly immersed such as by going native on the ward, means that surprise may not be gained nor explored adequately if the researcher is not able to see and take into account the substructures that are in place and are perpetuating it (Heying, 1999).

**Review and summary**

This chapter highlighted how the use of Leininger’s culture care theory (1988) allowed exploration of how nurses will use a combination of their insider knowledge of the acute care setting with their professional knowhow to provide person centred pain care for the older person. The use of Leininger’s culture care theory (1988) in the study
provides a comprehensive framework for culturally mediated care delivery and by incorporating the works of Spradley (1980) and Schein (1992, 2010) provided focus to occur within the context without premature closure. The use of focused ethnography allowed specific exploration to occur within the small groups that form when a nurse interacts with an older person to provide pain care. The meanings behind the actions of care delivery can then be gained and understood within the contexts in which they occur as well as the perceptions of the older persons who are receiving it. In the next chapter, I provide a description of the setting as well as introducing the research design and methods.
Chapter four: Description of the setting, research design and methods

Chapter Introduction

In this chapter, I present a description of the setting, the research design, methods and data analysis as well as some of my own reflections on undertaking ethnographic methods within the acute care setting. This chapter is divided into five sections. The research questions are revisited as outlined previously in chapter one, and this is to recap and provide clarity for the reader.

The first section titled Description of setting provides a depiction of the study setting. The study site locations are described with an outline of the hospitals and the acute care wards. The contexts in which the study is undertaken are also provided.

The second section titled Research design describes the research design and outlines the methods used in this study to reveal how a focused ethnographic approach as described in the previous chapter has been used to explore the clinical practices of nurses when assessing and managing pain for the older hospitalised person. Provided in detail is how trustworthiness was established by outlining the reliability and validity strategies to ensure excellence in research was achieved. Aspects such as how entry was gained to the field are presented, how informed consent was gained and ethical considerations unique to this study are presented.

The third section titled Methods outlines how the fieldwork was undertaken. This section begins with an introduction of the older person and the RN participants. The processes of participant observation, semi-structured interviews and the document
review undertaken for fieldwork are provided. Presented is how the researcher gained reflexivity by the use of a calendar diary and maintaining three different journals: a document review, reflective and field notes journals.

The fourth section titled *Data analysis* outlines how a process was undertaken to move the study findings from a qualitative descriptive analysis to that of a thematic analysis. The cultural domain analysis based on Leininger’s culture care theory (1988) and informed by Spradley (1980) outlines the processes undertaken to develop a taxonomy and typology of the provision of pain care by nurses for the older person. The thematic analysis process is then explored, detailing the separate content analysis undertaken of the interview transcripts and observation data before outlining the coding and categorising that was undertaken for the themes to emerge along with the provision of an audit trail.

The final section of this chapter titled *Reflection* provides a personalised account of the researchers’ experiences of using ethnographic methods within this study. Provided is an account of how entry and immersion into the field was gained. The role of the researcher is discussed along with the first hand experiences of unexpected gatekeepers and how the impact of a Hawthorn effect was reduced.

**Description of the setting**

The study was conducted in two hospitals located on the east coast of Australia based within the same area health service. The wards that were approached for inclusion in this study are presented. The acute care wards are located at two separate public hospital sites on the east coast of Australia.
Hospitals.

The hospitals included are referred to as Hospital A and Hospital B. None of the nurses or older person participants are described with an identifier of which hospital, being A or B, they are located within, and this is to provide de-identification, confidentiality, and anonymity for all. Hospital A as noted below in Table 5 Hospital A services, is designated as a public district hospital, that provides both inpatient and outpatient services. The number of beds in this hospital varies from 50-99. The services provided are:

Table 5 Hospital A services

<table>
<thead>
<tr>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and drug unit</td>
</tr>
<tr>
<td>Coronary care unit</td>
</tr>
<tr>
<td>Domiciliary care unit</td>
</tr>
<tr>
<td>Emergency department</td>
</tr>
<tr>
<td>Geriatric assessment unit</td>
</tr>
<tr>
<td>Nursing home care unit</td>
</tr>
<tr>
<td>Obstetric services</td>
</tr>
<tr>
<td>Rehabilitation unit</td>
</tr>
</tbody>
</table>

Hospital B is designated as a public tertiary referral hospital and bed numbers vary from 100-199. Hospital B provides a comprehensive range of services as listed below in Table 6 Hospital B services:

Table 6 Hospital B services

<table>
<thead>
<tr>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and drug unit</td>
</tr>
<tr>
<td>Bone marrow transplantation unit</td>
</tr>
<tr>
<td>Coronary care unit</td>
</tr>
<tr>
<td>Emergency department</td>
</tr>
<tr>
<td>Hospice care unit</td>
</tr>
<tr>
<td>Intensive care unit</td>
</tr>
<tr>
<td>Oncology unit</td>
</tr>
</tbody>
</table>
Acute care wards.

The eight acute care ward types included in this study were oncology, surgical, medical and subacute wards as shown below in Table 7 Hospital sites and ward types. Each ward has 30 beds.

Table 7 Hospital sites and ward types

<table>
<thead>
<tr>
<th>Hospital A</th>
<th>Hospital B</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Medical ward</td>
<td>● Medical ward</td>
</tr>
<tr>
<td>● Medical ward</td>
<td>● Medical ward</td>
</tr>
<tr>
<td>● Surgical ward</td>
<td>● Surgical ward</td>
</tr>
<tr>
<td>● Subacute ward</td>
<td>● Oncology ward</td>
</tr>
</tbody>
</table>

All of the wards had a philosophic approach to care being based on person centred care as per the standards set out in the report by the ACSQHC (2011b). Furthermore the seven basic rights of patients are detailed within a national Australian charter of health care rights which covers areas in relation to access to health care, safety, respect, communication, participation and privacy as well as the ability to comment on their care (Leary, Cottrell, & Phillips, 2001).

Research design

A qualitative research design to incorporate an ethnographic approach was used in this study to answer the research questions as previously outlined in chapter one. The study was designed to ensure trustworthiness was gained by using the criteria of Lincoln and Guba (1985) that is reflective of the nature of qualitative research, as opposed to formulaic rules commonly found in quantitative research to demonstrate rigor. The area health research Ethics Committee has approved this research as part of the pilot study and the approval number is HNEHREC Reference No:12/09/19/4.03 University of Newcastle HREC/12/HNE/313 (see Appendix 5 : Ethical approval form on page 389. Full details such as information sheets, posters and semi-structured interview guides in
Reliability and validity strategies.

This study was guided by the criteria of Lincoln and Guba (1985) who identified the processes of credibility, transferability, and dependability as well as confirmability. Morse (2015) asserts that use of the criteria by Lincoln and Guba (1985) is only of benefit when integrated into the design and undertaken during the course of the study as opposed to being applied retrospectively. The processes engaged in within this study to provide reliability and validity have been undertaken during the study by ensuring that the findings are reflective of the experiences of the participants by remaining authentic to their emic perspectives (Morse, Barrett, Mayan, Olson, & Spiers, 2002; Whittemore, Chase, & Mandle, 2001).

Verification occurred as a cyclical iterative process between the design and the methods that incorporated the methodology as well as the conceptual framework to ensure congruence was maintained (Morse et al., 2002). The techniques undertaken to demonstrate validity are outlined by the explicit detail within the method and methodology as well as the research design sections of this thesis for how decisions, interpretations and researchers’ bias are addressed (Whittemore et al., 2001). Furthermore, those aspects in relation to creativity, thoroughness, congruence and sensitivity are also provided in more detail within this chapter (Whittemore et al., 2001).

Sampling strategy

Qualitative sampling strategies allow selection of the most appropriate group of people within the situation being studied (Llewellyn, Sullivan, & Minichiello, 2004). This
The study used a combination of purposive and opportunistic approaches (Domholdt, 2005; Higginbottom, 2004; Holloway & Wheeler, 2002; Llewellyn et al., 2004; Whittemore & Grey, 2007). Purposive sampling allowed targeting of RNs within acute care wards; and opportunistic sampling resulted from invitation for the RN participants within the wards to participate. Positive action was taken to ensure that the participants did not feel obliged or coerced to participate in the study. The recruitment process provided eligible nurses the opportunity to elect whether or not he/she wished to participate in the study (Cerit & Dinç, 2013). An independent third party person approached the older person participant or the designated proxy consent person to invite participation into the study. The selection criteria for the nurses were that they are a registered nurse and currently employed within a clinical ward for more than three months. An older person was defined as those aged over 65.

How contact was made with the wards.

The initial contact of the RN participants began with a meeting of each Director of Nursing for each hospital who then approached the Nursing Unit Managers (NUMs) of each acute care ward to inform them of the study. Those NUMs who indicated that their ward was interested in participating in the study were then contacted and asked to provide an avenue of access see Appendix 6 for the placement of a poster Figure 6 Poster inviting participants to the study on page 392 which provided a statement about the research. An information letter as noted in Appendix 6 on page 393 to invite RNs for participation on the staff notice board. The NUM then organised information sessions for the staff to be able to attend to hear about the study.
Recruitment of the registered nurses.

Informed consent was obtained through the delivery of an information statement and a consent form (see Appendix 6 Poster inviting participants to the study, the Registered nurses information sheet and Semi-structured interview guide for registered nurses as well as the Consent form for registered nurses on page 392 to 400) on page 400 that was written in plain language and outlined the purpose of the study. The information statement clearly stated how the establishment of ongoing informed consent will be reaffirmed throughout each process of interaction (Haber, 2006). The principles of beneficence (Wilkes & Beale, 2005) were applied by informing all participants that they may withdraw, both themselves and any data gained from them, from the study at any time by either confirmation to the researcher or by an email address to another person (Crane, Cody, & McSweeney, 2004). For those older persons with a cognitive impairment the NUM, acting NUM, CNC or designated in charge nurse or family/relative/carer or significant other could withdraw consent on that person’s behalf.

Older person participant contact.

The older person participants were informed that the researcher was present only to observe care being provided to them by the consenting nurse participant, and that the researcher would not be providing any nursing care to them. The older person was also informed that they were not required to experience pain or invasive procedures, and intimate moments such as being washed or using the bathroom were not included within the observation period (Cubit, 2010). This was verbalised by the researcher as well as written on the information and consent form (see Appendix 6 Older person information sheet Older person consent form, Proxy consent form and Semi-structured interview
guide for older cognitively intact inpatients pages 402 to 415) in order to ensure that the older person knew what it was that they were consenting to (Miller & Bell, 2012).

The NUM, acting NUM, CNC or designated in charge nurse initially approached the older person to gain verbal permission for the observation of the RN participant whilst care was being attended to them and this verbal permission was documented in the patient’s medical notes. When the older inpatient had a cognitive impairment, the family/relative/carer or significant other was approached at the discretion of the independent third party who were either the NUM, Acting NUM or CNC to provide consent by proxy for the observation of the RN participant whilst care was being attended to them (Crane et al., 2004; Hellstrom, Nolan, Nordenfelt, & Lundh, 2007; Sherratt, Soteriou, & Evans, 2007). A letter of consent and a reply self-addressed envelope were also provided with all information letters. The letter of consent was returned to the researcher for the study either by mail, the placement within a locked box located in a public area of the ward, or by a third party person. The researcher then contacted the person to arrange an information session to brief the participant and to determine their availability (Lingler, Jablonski, Bourbonniere, & Kolanowski, 2009).

When the older person was identified as culturally and linguistically diverse (CALD) the multicultural health liaison officer was contacted for assistance with the NUM, acting NUM, CNC or designated in charge nurse for communicating with those patients for permission for observation of the RN participant whilst care was being attended (Qureshi & Johri, 2008; Sherratt et al., 2007). When the older person chose to identify himself or herself as being of Aboriginal or Torres Strait islander descent then the Aboriginal health liaison officer was also contacted for their input and support for those older persons.
Informed consent

Maintaining informed consent when using ethnographic techniques has been known to result in potential issues because of the requirement for a continued interaction between the researcher and the participants (Russell, 2004). All participants were encouraged to take time to consider their participation, or their non-participation, in this study (Cerit & Dinç, 2013). Informed consent was facilitated by the use of information statements, written in plain language, that outlined the purpose of the study to the patients and participants or the designated next of kin or contact person for those who have a cognitive impairment (Cutcliffe & Ramcharan, 2002; Kerridge, Lowe, & McPhee, 2005; Minichiello, Madison, Hays, & Parmenter, 2004). They were provided with an information letter that outlined the contact details of the researcher in case any potential participant or their family member wished to ask questions about the study (see Appendix 6 page 392).

There were two different information letters (see Appendix 6 Registered nurses information sheet on page 393 and Older person information sheet on page 402), with the information letter for the older person being written in plain English and a larger print than that used for the RN participant (Boxall & Ralph, 2011; Crane et al., 2004; Jefferson et al., 2008; Wong, Clare, Holland, Watson, & Gunn, 2000). Determination of evidence of coercion in participants’ willingness to participate was ascertained by the researcher asking if they had any sense of coercion, enforced compliance with the study, and/ or if they felt compromised in any way (Suhonen, Stolt, Launis, & Leino-Kilpi, 2010). Avoidance of coercion was also facilitated by not providing a financial incentive to participants. If a participant indicated a sense of obligation or coercion, then any data gained from that participant was not used. All of the participants were informed both
verbally and in writing that if I saw or if it came to my attention that anything illegal, immoral or criminal was occurring during the observation period that it would be reported to the appropriate channels within the institution.

**Anonymity and confidentiality.**

Anonymity of the names of wards involved, RN participants, patients, the integrated pain service, and the hospitals as well as the area health service was achieved by referring to each by an individual pseudonym. The RN participants will not be listed by individual tags in a table with demographic characteristics, as this can lead to identification of the participants, threaten anonymity and in particular when linked to pseudonyms or quotes threaten confidentiality (Morse, 2008b). The older person participants have also had any identifiable attributes removed from this study that may lead to their identification.

Care was taken to ensure that the hospitals and wards could not be identified by reference to the particular area health service in which it resides. As data collected by audio recording can identify a participant, they were listened to for transcribing by the researcher only (Carpenter, 2007; Curtis, 2009; Parsons & Oates, 2004). Similarly any other data gained is stored on a password protected USB in a secure cabinet within a locked room and the USB will be destroyed after seven years. Confidentiality is then assured, for not only the duration of the study but on completion and subsequent publication. Consideration was also given to elements of the interview that may identify the participant. Omitted are specific descriptions of a situation or type of procedure observed that may allow identification of that RN, ward or person/s. For example any reference or descriptor to the specific type of nursing specialist care being delivered to a
patient are be de-identified (As all the wards covered in the fieldwork have areas of
speciality and as a result have specific nursing care regimes).

**Processes involved for undertaking interviews.**

The semi-structured interview with the RN and older person participants took place
after the participant observation periods and on the same day to gain insight into
triggers as well as the actions undertaken and the rationale for these. The timing of the
semi-structured interview was at a predetermined location and setting convenient to the
participants and in an area that is private.

Options were provided for the interview to occur at the bedside or in a private room that
had been purposely booked. If any of the older person participants indicated during their
interviews that they had the presence of pain and expressed the wish for an intervention
then the RN assigned to their care was informed immediately.

**Ethical considerations**

The use of focused ethnography methods require the formation of prolonged
relationships with participants that is gained by immersion and length of time that the
researcher spends in the field (Bennan & Cousins, 2007; Cutcliffe & Ramcharan, 2002;
Dickson-Swift, James, Kippen, & Liampittong, 2006; Goodwin, Pope, Mort, & Smith,
2003; Johnstone, 2000; Wilkes & Beale, 2005). A researcher has little or no control
over illegal, unethical or emergency situations (Bennan & Cousins, 2007; Cutcliffe &
Ramcharan, 2002; Dickson-Swift et al., 2006; Goodwin et al., 2003; Johnstone, 2000;
Wilkes & Beale, 2005). At the outset for this study was the placement of a contingency
plan for relational ethical issues should they arise and this was devised in conjunction
with the management within the hospitals and ward settings (Borbasi, Jackson, &
Wilkes, 2005). It was an agreement that I would follow policy and procedures that are in place for instance if a patient became unwell; that I would call for help and then stand back. Furthermore, that I would inform the NUM that if I saw anything illegal, immoral or criminal during the observation period and that I would report it by the appropriate channels within the institution. Not only was this written in the information statement, but I also reiterated this verbally to the RN and older person participants.

**Proxy consent.**

The principle applied for this study was to be as inclusionary of all older persons as ethically possible (Cubit, 2010; Sherratt et al., 2007). The use of proxy consent relies on the belief that the proxy will base their decision on their best interests, and take into account a consideration of that persons’ past desires and values when known (McKeown, Clarke, Ingleton, & Repper, 2010). It is noted that often the proxy will be a relative or a close carer (McKeown et al., 2010) and in this study this was extended to include the guardianship board, or significant other. The NUM, Acting NUM, CNC or designated in-charge RN identified and approached those who were the identified proxy consent provider for determination of interest for inclusion in this study. Those with a cognitive impairment were not invited to participate in the semi-structured interviews.

**Process consent.**

After proxy consent had been gained for those older persons with a cognitive impairment, a method known as process consent was then undertaken (Dewing, 2007; McKeown et al., 2010; Norman, 2006). Process consent acknowledges that capacity is situational and can be present for a person to be able to understand and appreciate the purpose, risks and benefits of a low risk study even after the usual legal threshold of
consent had been crossed (Cacchione, 2011; Dewing, 2007). That is, a persons’ capacity is placed along a continuum and can vary from day to day (Cacchione, 2011).

Process consent required matching with capacity and this was not overly complex (Sherratt et al., 2007). The NUM, Acting NUM, CNC or designated in-charge RN undertook a personalised and individualised check before each observation period began on the cognitively impaired older person to see how they were, and liaised with their allocated nurse from the previous shift. This increased the opportunities available for the older person with a cognitive impairment to participate or indicate otherwise by an independent third party before the observation period commenced.

Methods

Introduced within this section are the older person and RN participants. The methods employed within the fieldwork included participant observation, semi-structured interviews and a document review. The processes undertaken to facilitate reflexivity during the fieldwork by keeping journals are outlined.

Introduction to the participants.

In this section, I outline the participants in the study. Presented is a description of the RN participants, followed by the older person inpatients. For both participant groups pseudonyms are used to ensure anonymity and confidentially. Any data that had the potential to identify them was removed. For instance the RN participants are not identified by which ward they worked on and aspects for the older person such as rare or uncommon diagnoses or ward type or site that they are located on are not presented.
Registered Nurse participants.

Originally 11 RNs consented to participate in this study, with one RN being lost to the study and another withdrawing due to a change of circumstances. Of the nine RNs in this study, a total of 24 observation periods were undertaken and 23 interviews. The observations and interviews were undertaken in a flexible manner within the six month field work period. One interview was lost due to the season (it was Easter). Table 8 Length of RN observation and interview times provides in more detail the length of time taken for each interview and observation period per registered nurse participant.

Table 8 Length of RN observation and interview times

<table>
<thead>
<tr>
<th>Hospital and ward</th>
<th>Participant</th>
<th>period 1</th>
<th>period 2</th>
<th>period 3</th>
<th>period 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital B ward 1</td>
<td>A Observation</td>
<td>3hrs 30 min</td>
<td>2hrs 10 min</td>
<td></td>
<td></td>
<td>5hrs 40 mins</td>
</tr>
<tr>
<td></td>
<td>A Interview</td>
<td>25 min</td>
<td>15 min</td>
<td></td>
<td></td>
<td>40 mins</td>
</tr>
<tr>
<td>Hospital A ward 1</td>
<td>B Observation</td>
<td>3hrs</td>
<td>1 hr</td>
<td>3hrs 45 min</td>
<td></td>
<td>7hrs 45 mins</td>
</tr>
<tr>
<td></td>
<td>B Interview</td>
<td>20 min</td>
<td>28 min</td>
<td>23 min</td>
<td>35 min</td>
<td>1hr 45 mins</td>
</tr>
<tr>
<td>Hospital A ward 2</td>
<td>C Observation</td>
<td>2hrs 30 min</td>
<td></td>
<td></td>
<td></td>
<td>2hrs 30 mins</td>
</tr>
<tr>
<td></td>
<td>C Interview</td>
<td>29 min</td>
<td></td>
<td></td>
<td></td>
<td>29 mins</td>
</tr>
<tr>
<td>Hospital A ward 3</td>
<td>D Observation</td>
<td>2hrs</td>
<td>2hrs 5 min</td>
<td>3hrs 30 min</td>
<td>3hrs</td>
<td>10hrs 35 mins</td>
</tr>
<tr>
<td></td>
<td>D Interview</td>
<td>28 min</td>
<td>20 min</td>
<td>no</td>
<td>37 min</td>
<td>1hr 25 mins</td>
</tr>
<tr>
<td>Hospital A ward 4</td>
<td>E Observation</td>
<td>1hr</td>
<td>4hrs 5 min</td>
<td>2hrs 10 min</td>
<td>1hr 40 min</td>
<td>9hrs 35 mins</td>
</tr>
<tr>
<td></td>
<td>E Interview</td>
<td>29 min</td>
<td>30 min</td>
<td>28 min</td>
<td>28 min</td>
<td>1hr 55 mins</td>
</tr>
<tr>
<td>Hospital B ward 2</td>
<td>F Observation</td>
<td>3hrs 15 min</td>
<td>3hrs</td>
<td>4hrs</td>
<td></td>
<td>10hrs 35 mins</td>
</tr>
<tr>
<td></td>
<td>F Interview</td>
<td>23 min</td>
<td>28 min</td>
<td>33 min</td>
<td></td>
<td>1hr 40</td>
</tr>
<tr>
<td>Hospital A ward 5</td>
<td>G Observation</td>
<td>4 hrs</td>
<td>5 hrs</td>
<td>5 hrs</td>
<td></td>
<td>14 hrs</td>
</tr>
<tr>
<td></td>
<td>G Interview</td>
<td>41 min</td>
<td>47 min</td>
<td>24 min</td>
<td></td>
<td>2hrs 5 mins</td>
</tr>
<tr>
<td>Hospital B ward 3</td>
<td>H Observation</td>
<td>5hrs</td>
<td></td>
<td></td>
<td></td>
<td>5hrs</td>
</tr>
<tr>
<td></td>
<td>H Interview</td>
<td>36 min</td>
<td></td>
<td></td>
<td></td>
<td>36 mins</td>
</tr>
<tr>
<td>Hospital B ward 4</td>
<td>I Observation</td>
<td>4hrs 30 min</td>
<td>3 hrs</td>
<td></td>
<td></td>
<td>7hrs 30 min</td>
</tr>
<tr>
<td></td>
<td>I Interview</td>
<td>49 min</td>
<td>59 min</td>
<td></td>
<td></td>
<td>1hr 48</td>
</tr>
<tr>
<td>Total observation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>73 hours</td>
</tr>
<tr>
<td>hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total interview</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12hrs 38 min</td>
</tr>
</tbody>
</table>

With RNs A (Ann), G (Georgina), and H (Hermione) further contact was lost as these nurses changed job roles and no longer had direct patient care responsibilities. With the RNs C (Clare), F (Fran) and I (Iona) contact and follow up ceased as they went on holiday for extended periods.
Nurses’ perceptions of themselves.

A short overview is provided of how the nurses spoke of perceiving themselves and this is presented below in Table 9 The nurses’ responses when asked to describe themselves. This is to provide understanding of how the RNs placed themselves within the group identity of their ward. In the semi-structured interviews (as shown in Appendix 6 Semi-structured interview guide for registered nurses on page 400), the nurse participants in this study were asked: How, in your own words would you describe yourself as a nurse. They responded by describing themselves within or part of a group affiliation as shown below:
Table 9 The nurses’ responses when asked to describe themselves

<table>
<thead>
<tr>
<th>RN</th>
<th>Comment when asked to describe themselves as a nurse</th>
<th>Nursing qualification</th>
<th>Undertaken postgraduate studies</th>
<th>More than five years of experience nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ann</td>
<td>An acute care, medical nurse, yes - a medical nurse</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Barbara</td>
<td>I like that term ‘specialist generalist’ [nurse]</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Clare</td>
<td>I am a problem solving nurse, as in the patients’ problems and I get the job done</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Danielle</td>
<td>Committed, conscientious, passionate, I love nursing otherwise I wouldn’t be doing it, I really love nursing people</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Elise</td>
<td>Now I really think of myself as more of a rehab nurse</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Fran</td>
<td>I like surgical nursing, I don’t like medical nursing</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Georgina</td>
<td>I like it here, it’s different nursing than acute care nursing</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Hermione</td>
<td>I was in Aged Care and I’ve always liked the palliative side of it</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Iona</td>
<td>I am a trusted person, I am honest with my patients, but if it is cancer I won’t tell them - that’s not my job. I am motivated to learn</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>
All of the nurse participants in this study identified themselves as being a senior nurse, except one nurse participant, RN Iona. RN Iona asserted that she was not a senior nurse in number of clinical years (being more than eight), nor did she talk of fulfilling senior management positions such as NUM or acting NUM, however, she did not consider herself as a junior nurse either. For instance, RN Iona was required to be in charge of the ward when allocated.

**Older participants.**

In total 42 older persons consented to the study. Thirty agreed to being observed, and 12 agreed to being interviewed and observed. In this study 13 older persons had a documented disability ranging from congenital, developmental, and due to a disease process as well as communication impairments and severe mobility limitations. In total, seven older persons had a documented diagnosis of dementia with a further two being provided with a provisional diagnosis of dementia to be confirmed later. Only two older persons in this study had a documented diagnosis of delirium. Patients who were under the care of the community palliative care providers totalled seven and three of these patients passed away during the course of this study. Six older persons chose to be identified as having culturally acquired language diversity (CALD). Three older persons declined to be included in the study citing that they were too tired.

Basic demographic data about the older person participants in this study are as presented below in Table 10 Basic demographic data for the patients in the study. For more detailed information about those older persons in this study, the reader is referred to Appendix 7 Table 22 The older person participants in this study on page 417 for the list. The Prologue to the findings chapters provides a description of the 18 older
participants whose findings are included. This provided an individualised introduction to those older persons which presents their story in more detail to provide background and context for their presentations to hospital.

Table 10 Basic demographic data for the patients in the study

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Age range (years)</th>
<th>Average age (years)</th>
<th>Total number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>19</td>
<td>28</td>
<td>65-94</td>
<td>80</td>
<td>42</td>
</tr>
</tbody>
</table>

The reasons why the older person in this study initially presented to hospital were gained from the document review of admission notes. These reasons were then added up and expressed as a percentage of the whole and are presented below in Figure 2 Reason for presentation to the emergency department.

Importantly for the older persons in this study, pain is most often noted to be a reason or a contributor for admission into acute care. The previous medical histories of the older persons on admission were a list of more than one diagnosis, as shown in Figure 3 Previous medical history of the older person participants on page 120. The only exception was one older male patient Barry (86) who on admission had not seen a doctor for 30 years and had only one provisional medical diagnosis. However, for the rest of the older patients osteoarthritis or rheumatoid arthritis was the second most common diagnosis. Also of interest is the inclusion within the previous medical histories of previous falls, back pain, and fractures.
Figure 2 Reason for presentation to the emergency department

Total number of patients = 42
Figure 3 Previous medical history of the older person participants
Field work

The period of time spent in the field was 2 months to gain entry and 6 months (1040 hours) in the field. RNs typically work a variety of shifts within a 24 hour period, therefore observation was timed to be conducted within their normal roster at their convenience. Participant observations were undertaken during day, evening and night shifts at both hospitals. The interviews were all conducted on the hospital site.

Participant observations.

Participant observation was similar to Twycross et al. (2013) with field notes being taken in real time whilst observing the nurses and their interactions with the older patients while listening Forsey (2010) to their conversations. These field notes served as a prompt for the semi-structured interviews. For example, they were also referred to as required to inform or clarify the notes in my reflective journal. I also reflected on what I had written in my field notes, such as instead of writing the nurse is taking observations, written was the direction that the nurse took, description of the environment, how the older person patient was approached and aspects such as silence or looks were noted (Field, 1991). When I thought that repetition of what I was observing was occurring I ensured that I wrote even more detailed notes, to be sure that what I thought was repetition were actually repetitious actions of the nurses or my own cultural viewpoint.

Interviews.

Semi structured interviewing is an important aspect as this facilitates the formation of prolonged relationships for follow up and discussion of sensitive issues relating to the research topic (Crawley, 2010). The topics for conversational questioning, as outlined in Appendix 6 Semi-structured interview guide for registered nurses on page 400 and
Semi-structured interview guide for older cognitively intact inpatients on page 415 were formulated based on the previous observational period and the reflective journal as well as field notes.

The nursing PhD by Crawley (2010) on African American adults with chronic pain who attended an urban primary care unit, noted that flexibility is required in the location and timing of interviews in hospital settings. For this study significant negotiation was undertaken regarding the timing and location of all interviewing. For all the participants, a discussion was entered into at the beginning of the observation period in relation to timing and location for the ensuing interview (Bergh, Jakobsson, Sjöström, & Steen, 2005). A separate room off the ward was booked for the use of both the RN and older person participants if they chose.

For the older participants the timing of the unstructured interviews was kept deliberately short in recognition that they were ill and in hospital for a reason (Bergh et al., 2005). It was not the researcher’s wish to unduly be a source of fatigue for them. Guidance was taken from the phenomenological study by Lindberg et al. (2013), on the inclusion of the older person’s participation in team meetings for monitoring of overt signs of fatigue, such as tiredness or yawning. Although the older persons who were part of this study were also offered a private space and separate room for their interviews some chose to have their interviews conducted at the bedside. This issue was also experienced by Bergh et al. (2005) in their interview study of older patients’ expression of pain after a hip operation.

Bergh et al. (2005) expressed the view that when conducting interviews within a four bed room on the hospitalised older person they were often interrupted by nurses and the presence of other patients. This meant that some participants themselves may have
restricted the information that they were providing (Bergh et al., 2005). However, they countered this by commenting that the way that the older person participants spoke to them was in the same situation as they spoke to the health care providers and that their study was not an artificial experimental study conducted in a sterile setting (Bergh et al., 2005). For this study, every attempt was made to reduce interruptions by liaison with the older person and the nurse caring for them, curtains were drawn to provide a semblance of privacy and for single rooms the door was shut.

**Document review.**

The document review (Appendix 6 Document review schedule on page 416) was a written account that included the results of the manual search of the ward for grey literature¹ and a summary of any general information about each older person patient in the study. The information gathered about the older person related to reasons for admission, previous medical history, plans of nursing care in relation to pain, the pain medications administrated or charted and documentation of pain scores. This information was collected on the day of observation from the older person’s medical notes.

**Reflexivity**

Reflexivity is a critical self-reflection about preconceived biases, preferences and preconceptions that a researcher may have that has the possibility to influence a situation or interpretation of an observed event or interview (Borbasi et al., 2005; Polit & Beck, 2010). In essence, reflexivity exerts a check on the threat of the researcher having a potential to influence a situation or interpretation (Clarke, 2006; Dowling, 2006).

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¹ As defined previously within Chapter two: Literature review within the section titled Grey literature on page 74 as: online National, State, Area, and Local health policies as well as procedures or guidelines that are available to be accessed within the clinical context by the nurses in this study.
2006; Mantzoukas, 2004; Whittemore et al., 2001). Critical reflection is required by the researcher on how they may influence the data; from being in the setting, the power relations that may be in place and the nature of the social interaction that is occurring between them and the participants (Brewer, 2000). Scott, Estabrooks, Allen, and Pollock (2008) assert that documentation of personal bias and expectations before entering, and during the fieldwork is required when undertaking ethnographic studies.

The researcher for this study undertook written documentations for reflection, which is shown in 424Appendix 8: A reflective statement by the researcher on page 424 written before the study began and another reflective account during the beginning of the field work in this study titled Walking onto the wards on page 425.

Reflexivity was also gained in this study by the use of journaling to allow documentation of critical thinking and facilitate reflection (Borbasi et al., 2005). This was to reduce the impact of the researcher as an instrument within the collection, analysis and interpretation of the data (Borbasi et al., 2005). Journaling when undertaking research is defined as the documentation of field notes and comprises several aspects, such as notes taken before, during and after an observation event (Dewar & Mackay, 2010). Journals provide prompts and serve as question guides for semi-structured interviewing as well as peer review recommendations or input from meetings with supervisors during the data collection period (Dowling, 2006). The journals created an account and audit trail that outlined the progress and journey through the data collection period (Dowling, 2006). For this study a diary book was kept separate to the three journals; the document review journal already mentioned as well as a field notes journal.
**Calendar diary.**

The diary book was used solely for its calendar purposes. This calendar diary was used to document the participant nurses’ rosters and shift times along with periods when they knew that they were going to be absent such as holidays. The diary functioned as a personal assistant, in that upcoming meetings with NUMs, ward education days etc. could be documented and planned for, along with notification of hospital or ward education days.

**Document review journal.**

A journal was kept for the document review of the older persons’ medical notes and bedside charts information. A separate entry was kept for each ward and written within were the results of the individual searches of that wards’ policies and procedures in place as well as any other pertinent information such as who the NUM was etc. Within this journal the results of the grey literature search of the online policies and procedures as well as guidelines accessibility were noted.

**Reflective journal.**

The reflective journal was used to document experiences, fears, problems and general activities involved surrounding the episodes in the field (Spradley, 1980). This reflective journal was kept separate to the fieldwork, diary, and document review journals. In this journal, I wrote about my experiences of what happened in the field as well as reflection on the interviews, the wards/hospitals, and document review. I also entered into this journal my reflections from the supervision meetings undertaken during the fieldwork period.
Field notes journal.

The type of field notes kept during the non-participant observation period was as noted by Dewar and Mackay (2010) as being transcription field notes. The notes were jotted down in the field as events occurred and aimed to record as much as possible as exactly as possible. This produced a textual and visual account (Dewar & Mackay, 2010). A descriptive account was placed at the beginning of the observation account that helped form a comprehensible account of what was being observed (Dewar & Mackay, 2010). I also placed within the field notes memos to myself. The use of memory notes are termed inscriptions by Le Compte and Presissle (1993) and really they are a memo of key aspects during the observation period that provide focus and identify aspects occurring that may have related to another previous observation period or interview.

Data analysis

This section provides an outline of the data analysis processes undertaken in this study. The analysis of data required the researcher to engage in an iterative, cyclic and self-reflective process that was undertaken throughout the data collection period (Higginbottom et al., 2013; Wall, 2015). A sequential series of steps were in place to counter analytical overload due to the multiple and extensive amount of data collected (Knoblauch, 2005; Lee & Gregory, 2008). For instance, the software program ‘Nvivo’ was used to assist with management of data (Bazeley & Jackson, 2013).

Qualitative descriptive analysis

The following processes outline how the data was able to be organised into manageable units (Brewer, 2000). Although the steps were performed from adherence to Spradley
(1980), it is noted that this does not provide completeness but it is a part of a process of qualitative descriptive analysis (Brewer, 2000) before thematic analysis.

**Cultural domain analysis.**

A cultural domain analysis was initially undertaken of the processes that the nurses undertook when assessing and managing pain (Grbich, 2007; Leininger, 1988; Spradley, 1980). Worth noting is that a cultural domain comprises categories of meaning which are not only inclusive of smaller categories (Spradley, 1980), but also broadened by the use of a *skeletal framework*, as previously discussed in chapter three within the conceptual framework. The cultural domain analysis was guided by Spradley (1980) and Leininger’s culture care theory (1988) and was used in conjunction with Schein (1992, 2010) as well as long term and ongoing immersion in the field (Brewer, 2000; Hammersley & Atkinson, 2007).

A description of the cultural domain of the acute care setting was gained by use of the language, to uncover the terms and semantic relationships used by both nurses and the older person. Insight was gained into the purposes of placing meaning and definition of the objects and events as well as activities being observed (Spradley, 1980). This allowed the researcher to become more familiar not only with the emic (or folk) terminology being used, but also allowed the use of that folk terminology within the development of cultural domains and thus staying close to the data (Leininger, 1988; Spradley, 1980). This identification was gained by immersion in the field and by a thick rich descriptive account (Spradley, 1980) of the processes that the nurses undertook when assessing or managing pain. Then the nine major dimensions of social situations as outlined below in Table 11 Development of a cultural domain analysis (Spradley, 1980) were identified. The use of Spradley (1980) was the starting point for the
exploration of the domains of data that included the structures and rituals undertaken by nurses during these processes, as well as inclusion of the older person (Grbich, 2007; Leininger, 1988).

Table 11 Development of a cultural domain analysis (Spradley, 1980)

<table>
<thead>
<tr>
<th>Dimensions of social situations</th>
<th>Cultural domain development for pain comfort care provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Space: the physical space</td>
<td>1. The ward layout</td>
</tr>
<tr>
<td>2. Actor: the people involved</td>
<td>2. The nurses and the older person</td>
</tr>
<tr>
<td>3. Activity: sets of related acts that people do</td>
<td>3. What did the nurses and the older person do</td>
</tr>
<tr>
<td>4. Objects: the physical things that are present</td>
<td>4. The chair position and location of the older person, the posters on the walls, the blood pressure monitor, medication charts</td>
</tr>
<tr>
<td>5. Act: single actions that a person does</td>
<td>5. What are the acts that nurses and the older person undertake</td>
</tr>
<tr>
<td>7. Time: the sequencing or patterning of events over time</td>
<td>7. Is there patterning of the timing of these events</td>
</tr>
<tr>
<td>8. Goal: the things that people were attempting to accomplish</td>
<td>8. What are the goals of these events</td>
</tr>
<tr>
<td>9. Feeling: the emotions that were felt and expressed</td>
<td>9. How did the nurses and the older person feel about participating in these events</td>
</tr>
</tbody>
</table>

Focused observations were then guided by Leininger’s culture care theory (1988) to explore the development of the cultural domain in relation to processes, practices and procedures undertaken by the nurses and which were also based around the undertaking of structured questions of the data (Leininger, 1988). For example the domain analysis of undertaking a round of vital signs examined the stages involved, the roles assumed by the nurse, the ways in which they moved through the room and also how they approached the older person (Spradley, 1980). Use of Leininger’s culture care theory (1988) meant that other aspects were also able to emerge from the data by looking for answers to the structural questions with the goal in mind to not be finding a single answer, but a multitude of answers (Spradley, 1980). It is in this way that the focused observation data was used to explore and discover the categories that make up a cultural domain (Leininger, 1988; Spradley, 1980).
**Taxonomy.**

The next step in the data analysis was construction of a taxonomy by asking structural questions of semantic relationships within the grouping of the cultural domains (Spradley, 1980). This was to show the relationships among all the included terms within the domain in order to identify groups or sets of data and hierarchies (Grbich, 2007; Spradley, 1980). The taxonomy then provided an approximation of the cultural patterns observed and provided by the participants to provide depth of the data.

**Typology.**

Within each taxonomy a typology was also undertaken for classification and grouping of information gained from each taxonomic set (Grbich, 2007). This was the collation of all data gained in relation to the taxonomies undertaken in order to identify all the variations, layers and dimensions within before classifying them into types and subgroups (Grbich, 2007). This was to ensure completeness of the data gained and also to identify disconfirming or outlying instances of data that are not included within the taxonomy (Grbich, 2007). The typologies allowed identification of areas that may not logically be uncovered within the data collection process, but to provide sensitising concepts to guide further exploration (Marshall & Rossman, 2011).

**Thematic analysis process**

Although some ethnography can remain at this descriptive level, this study involved further analysis for the development of explanations and theories (Hammersley & Atkinson, 2007). The process of thematic analysis began with a content analysis. An iterative process began of coding and formation of categories before emergence of themes in order to complete the thematic analysis.
Content analysis.

A content analysis of the words used by the nurses and the older person about pain within the interview and observation data was undertaken by systematic coding and categorising to determine trends and patterns (Grbich, 2007). This was then compared back to the observational data to provide insight for any relationships that existed between what was being said and the actual observed events (Grbich, 2007). The content analysis halted any de-contextualisation of the interview data and was used to highlight spoken intentions, attitudes, and prevailing emotions (Grbich, 2007).

Coding.

In qualitative research, the term code is applied most often to a word or a phrase that has a symbolic attribute for a portion of language or visual based data; it also can be an idea, phenomenon, an issue, action or theme as well as line or sentence in the data (Germain, 2001; Mullen et al., 1992; Murchison, 2010). The initial process of coding involved the reading and constant re-reading of the data while asking questions of it (Brewer, 2000). This was as an iterative process, from a line by line analysis undertaken on the observations, reflective journals, interviews, and document review (Morse, 1994). This allowed the development of codes that emerged from within the data but also stayed close to the data. A set of codes was also devised by the use of theory as a lens, known as theory generated codes (Marshall & Rossman, 2011) which stemmed from Leininger’s culture care theory (1988). As the codes were developed, checking and comparison occurred with the main supervisor of this study.

This dual process of coding was undertaken by generating concepts based on patterning that is evident across the continuum of the data generated and was a recurrent process of developing categories (Hammersley & Atkinson, 2007). Importantly the codes
generated were not only succinct but reflective of the raw data itself and inclusive of the conceptual framework (Germain, 2001). The iterative process required that the transcripts of coded textual data be explored for highlighting of categories within the thick descriptive content for comprehension of knowledge to develop the recurrent ideas (DeWalt & DeWalt, 2011; Morse, 1994). This was undertaken by questioning the data, writing notes in the margins, cutting and pasting as well as reflective passages which were then placed into separate summary sheets and also the use of NVIVO as an organiser (Bazeley & Jackson, 2013; Cresswell, 2013; Marshall & Rossman, 2011; Murchison, 2010). A process of checking and constant re-checking was followed while staying close to the context (Germain, 2001) before the codes were then checked, compared and then grouped into categories.

Categories.

Categories are identified and worked out by a careful mental process of logical analysis of content from all the data sources gained by coding (Germain, 2001). These categories are then further compared back to the raw data and clustered together for review for emergent concepts, typification, themes and patterns (Germain, 2001). A category is defined by Morse (2008a) as being merely a collection of coded data that is similar to that which has been arranged into a collection for a description of its characteristics.

Themes

Thematic analysis is the process by which a development of explanations and theories is used in order to provide not only a narrowing of focus but also a process of abstraction (Hammersley & Atkinson, 2007). This allows the working out of the relationships formed as well as the significance of these that allows the development of theoretical conceptions and statements (Bazeley, 2013). It is noted by Guest, MacQueen, and
Nemy (2012) that thematic analysis requires more input from the researcher beyond the counting of words and phrases. A focus was applied on identifying as well as describing the implicit and explicit ideas within the data and these are known as themes (Guest et al., 2012).

The themes as shown in Figure 4 Thematic analysis findings on page 134 emerged from the constant iterative questioning, movement back and forth of the categories, by reviewing them line by line and paragraph by paragraph while still immersing them within the original thick descriptive account in order to stay close to the data context (Morse, 1994, 2008a). Emphasis occurred of key words and phrases within the text which were noted separately and then examined together as a whole. It is in this way that the data was moved away as a part of the original whole, but was always placed back against the whole in order to ensure that it stayed close to the context in which it originated (Morse, 1994, 2008a).

The themes remained a meaningful personification which existed through the data and were ever present either overtly in the foreground, in the background or even in parallel with the other sub-themes (Morse, 2008b). The result allowed the keeping of the individual within the textual representation of that theme while maintaining a contextualised description with meaning (Morse, 2008b). It is in this way, from a process of constant reiteration and writing that the themes emerged from the data.

**Audit trail.**

An audit trail is as shown in Table 12 Steps involved in the analysis of the data (O'Leary, 2010) on page 135. This contains an outline of the progress of the field work journey all the way through the data collection period (Richards, 2010). This is an
essential aspect for contributing towards validity and reliability for the study (Bazeley, 2013; Richards, 2010).
Figure 4: Thematic analysis findings

Nurses clinical practices

- Pain Care, Tension and Disjunction
  - The constantly transferred: pain care for the dying
  - Pain care and cognitve impairment
  - PRN opioids not given by IV for breakthrough pain relief; it's too risky
  - Special occasions for PRN IV opioids as pain relief
  - Assessing pain for those with a cognitive impairment: Having dementia and being in pain. Pantomime and pain
  - The complaint that was not believed: pain words and statements, gestures and sounds of pain, the sameness and constancy of pain

- Older persons’ experiences of pain and comfort care
  - When pain was not believed: pain words and statements, gestures and sounds of pain, the sameness and constancy of pain, Inflicted pain, anticipating pain and avoiding embarrassment, pain management plans

- Providing pain care
  - Not being heard
  - Pain care assessment
  - Being audited and the black mark
  - Pain charts: nobody reads them, we don’t use them, bedside clinical handover

- Nurses’ problem solving pain care
  - The ward round and pain assessment
  - Lost pain stories
  - The pain enquiry, have you got pain, can you give me a score, understanding the pain scale and conflicting accounts, rating multiple sites and types of pain

- Tension and Disjunction
  - Unpopular patients
  - Being a leader, problem solving pain care
  - The ward round and pain assessment
  - The pain enquiry, have you got pain, can you give me a score, understanding the pain scale and conflicting accounts, rating multiple sites and types of pain

- Pain Care, Tension and Disjunction
  - Pain care and cognitve impairment
  - PRN opioids not given by IV for breakthrough pain relief; it's too risky
  - Special occasions for PRN IV opioids as pain relief
  - Assessing pain for those with a cognitive impairment: Having dementia and being in pain. Pantomime and pain

- Older persons’ experiences of pain and comfort care
  - When pain was not believed: pain words and statements, gestures and sounds of pain, the sameness and constancy of pain, Inflicted pain, anticipating pain and avoiding embarrassment, pain management plans
Table 12 Steps involved in the analysis of the data (O’Leary, 2010)

<table>
<thead>
<tr>
<th>Step</th>
<th>Process</th>
<th>Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Familiarisation with appropriate software</td>
<td>Nvivo</td>
<td>Workshop on how to use Nvivo</td>
</tr>
<tr>
<td>Logging the data during field work</td>
<td>Files created noting the source of the data as it was collected.</td>
<td>The data collection procedures, collection dates are all placed into the journals, field diaries</td>
</tr>
<tr>
<td>Organisation of data sources</td>
<td>Grouping of like sources being observational data and interviews from registered nurses as well as older person interviews. This was the earliest screening process.</td>
<td>Potential problems not picked up in honours pilot study are noted here as being timing of the interviews for the registered nurses and for the older person. Issues surrounding gatekeepers became more prominent</td>
</tr>
<tr>
<td>Read through and make overarching notes</td>
<td>Reading and re-reading as well as taking notes in the reflective journal.</td>
<td>Sorting and categorising data begins as it is coming in</td>
</tr>
<tr>
<td>Preparation for transcriptions/analysis</td>
<td>The data sources being interviews and field notes are all prepared for transcription by the researcher.</td>
<td>Transcription begins as text</td>
</tr>
<tr>
<td>Entering of data</td>
<td>Data was entered into Nvivo for management.</td>
<td>Analysis begins before all the data has been collected and entered</td>
</tr>
<tr>
<td>Analysis of data</td>
<td>Writing of margin notes in the field notes, memos, development of cultural domains, undertaking a taxonomy and grouping into typologies. The undertaking of a content analysis with constant comparison between thick description, mapping of the space by drawing.</td>
<td>Reflective passages also written in the margins of the notes, reflective journal also consulted</td>
</tr>
<tr>
<td>Identification of process for coding</td>
<td>A draft summary sheet on each set of margin notes is made.</td>
<td>These are read back with the whole original text for placement in context</td>
</tr>
<tr>
<td>Relating the process for category development</td>
<td>The codes are explored for identification of patterned similarities.</td>
<td>Reflection against the original thick descriptive textual sources</td>
</tr>
<tr>
<td>The processes undertaken for thematic analysis</td>
<td>The themes are mapped and built by exploration for patterning and then are verified by use of theory as a lens.</td>
<td>Constant comparison between the thick rich descriptive textual sources, codes and categories</td>
</tr>
</tbody>
</table>
Reflection

In this study, I was mindful of how I presented myself. Being aware of social positioning was outlined in the critical ethnographic study within long term care by Baumbusch (2011) who found in their study that wearing formal casual clothes during observation periods had the care attendants associating her with the clothes worn by management and nurse educator who gave in-services at the facility. For this study, I wore smart casual clothes and not a nursing uniform. I used a photo identification badge stating in large print at chest height ‘I am a university nursing research student’. I found that this strategy was effective as the NUM, CNC, CNE, CNS and medical staff were obliged to wear a distinct uniform and as such I was not confused with them.

On gaining entry to the field and immersion.

Gaining entry took a total period of two months. This began by extensive face to face meetings being held with each hospital director of nursing, followed by both individual and group meetings with the NUM and acting NUMs of each ward. Information sessions were held for the nurses as requested by the NUM. Highly visual posters explaining the study were placed around the wards.

I maintained a continuous presence, to explain and answer any questions about the study not only during the working days of the week, but I was also present on the weekends and during night shift. This period of gaining entry began early November into December, and a suggested reason for why observations did not begin until January came from the participants themselves who often stated you will want to start after Christmas then. Despite my assertion to the contrary, this showed that the participants themselves were focused on Christmas time and the associated festivities.
For each ward before any observation and interviewing occurred, extensive negotiation and liaison occurred that began the day before. I found acute care is an extremely busy and dynamic setting. The day before any formal aspects of the fieldwork were undertaken I went and spoke to the morning in-charge nurse and the afternoon in-charge nurse, who are only present together in the afternoon and the NUM.

This was how I could determine who was most likely to be in-charge the next day. This meant that the evening in-charge nurse could review the patient allocation book for the next day and identify eligible older patients who are allocated to the consenting nurse participant. Once the potential older person patients were identified, as previously identified in the ethics section, an independent third party person determined their level of cognition. If the independent third party identified that the patient had a diagnosis of cognitive impairment then at their discretion they approached the appropriate parties (if known) for provision of proxy consent, but otherwise those patients were not included.

The process of proxy consent resulted in a loss of potentially five older persons who were actively dying. Proxy consent was not able to occur, as the family were either uncontactable or simply not known. If at any time I thought that my presence created an undue level of disruption for those cognitively impaired older persons then I removed myself from the setting and did not include the data gained from the study.

When eligibility for participation had been determined then the independent third party person approached either the older person or their proxy consent provider in the afternoon or evening when the ward. This actually worked well for the acute care wards and was devised in close conference and consultation with them.

This approach was required as the independent third party persons identified a concern they expressed to me that they were too busy in the morning right up until lunchtime.
with the running of an acute care ward, and gaining consent was an extra burden as well as not being a priority for them. They talked of worrying about how they came across to the older person patients. I agreed and the devised system worked really well. Furthermore, I undertook a follow up with the members of the independent third party to gain feedback about the process that they had undertaken. They then spoke about how relaxed they were in speaking to the patients and that they had more time to engage with them. Another important aspect was they spoke of having increased ownership from more involvement. Therefore, this approach was used consistently throughout the study.

**My role as a researcher.**

Each of the wards required the enactment of differing researcher roles. I created two main roles. One was a social role when I mainly walked about, and chatted to staff about the research. The other role was when collecting data. De Laine (2000) noted the need to have informal and formal roles. A formal role was assumed when undertaking the actual fieldwork and the informal role was to maintain a presence and recruit participants (Börjesson, 2014; De Laine, 2001).

**Gatekeepers.**

Gatekeepers are individuals within a setting that may inadvertently or intentionally block a researcher’s access to potential participants (Belousov et al., 2007; Berwick et al., 2003). It is noted by Berwick et al. (2003) that to turn a gatekeeper into a supporter requires identification, networking and direct communication. Identification of potential gatekeepers within each ward was a significant determining aspect if the research was to go ahead on a given day (Belousov et al., 2007; Berwick et al., 2003). I found the
allocation of staff on every ward was different, but all were very busy due to the hectic nature of acute care ward activities. First thing in the morning is particularly busy due to staff changeovers and doctors’ rounds. To ensure the staff on the wards was supportive, I liaised the day before any fieldwork was to take place. This approach assisted key contact people to support and facilitate the study, instead of placing them offside into a gatekeeper role.

The original plan was for up to four observation and interview periods per RN participant but this did not always work out. The nurse participant duties changed, and day by day they were often working in other roles. For instance, it was common for cancellation of the formal observation periods due to the nurse participant not having a patient load, despite the intention on the previous day to determine what their role was going to be. The nurse participants were required to collect quality improvement data, and undertake clinical case management, or be in-charge of the ward with no patient load as well as provision of education sessions for other nurses. Placement into a role occurred at a moment’s notice if another colleague had called in sick for instance.

The RN participants in this study viewed their changing roles as normal and common. In addition, the RN participants themselves often did not work full time and a lot of negotiation was required to fit in with their rosters, which took into account leave for holidays, mandatory education attendance and their provision of education to other nurses. The implication for the study was that less formal observations occurred than was planned.

**Hawthorn effect.**

The *Hawthorn effect* was originally noted as a possible source for bias (Curry, Nembhard, & Bradley, 2009; Nedick, 2000; Speziale, 2007; Whittemore & Grey, 2007).
The Hawthorn effect is when either the participant or the patient alters the way in which they would normally behave, directly due to their awareness of the researcher’s presence, or of the situation being scrutinised (Curry et al., 2009; Nedick, 2000; Speziale, 2007; Whittemore & Grey, 2007). The researcher found in this study, similar to the observational study by Bloomer, Cross, Endacott, O’Connor, and Moss (2012) on end of life care within the clinical setting, that the reality was that the nurse participants were too busy to alter their practice. The researcher also did not offer any opinion on the RN’s participants’ practice whilst observing, and during the semi-structured interview (Clarke, 2006; Dowling, 2006; Etherington, 2007).

When the researcher spoke to the RN participants about the observation periods, they stated that it was normal for them to be watched by others, particularly by student nurses on their first practical placements who did not participate nor speak much in nursing care provision when they first initially came onto the ward. Therefore, the RN participants accorded me a position of a student nurse with no knowledge of nursing. Within the interviews, none of the older person participants spoke of their allocated nurses as having changed the way that they provided their care, and they did not state that the nurses were acting differently. As a result, within this study the Hawthorn effect was nullified.

**Review and summary**

In this chapter I provided a description of the setting with an outline of the research design. I described how the methods of observation, semi-structured interviewing and a document review were formulated to answer the research question. Particular detail is provided to the processes involved for the data analysis undertaken. Reflection is provided on the real life challenges and unanticipated difficulties encountered when
using ethnographic methods within the complexities of a clinical context. The following chapter is a prologue to the findings chapters. Titled *Prologue: introducing the older person participants*, the aim of the next chapter is to introduce in more detail those older persons included within the following and concurrent findings chapters.
Chapter five: Prologue: Introducing the older person participants

Chapter Introduction

This chapter introduces each of the older person participants who are presented in the following findings chapters. Although in total there were 42 older person participants and a summary table to introduce them is provided in the Appendix 7 Table 22, the older person participants in this study on page 417, only the 18 who are present in the findings chapter are introduced here. This section presents an account using the words of the participants (for those who were able to be interviewed) with excerpts from medical notes, reflective journals and observation periods as well as interviews. The aim of this prologue is to give the reader some background and contextualise the older person to provide rich information about their life and provide context for the findings chapter.

Martha had multiple fractured ribs from a fall.

Martha was 90 years old and came into ED by ambulance due to having a fall in her garden one Friday afternoon after returning from a three and half hour drive\(^2\) to visit her family:

\begin{quote}
I fell up the steps. I was coming home and I was just going to unlock the door. I got up to the front step, (...) and next thing I knew I was going over backwards and I fell into the garden. My ribs---I fell on them when I went over [and] I landed on my back.
\end{quote}

[Martha interview]

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\(^2\) In Australian rural towns, distance is often measured by how many hours it takes to get to a location. A couple of hours is an approximate distance of 200 km (or 125 miles) more or less.
Martha had a permanent pacemaker from ischemic heart disease and has a history of having polymyalgia rheumatica as well as asthma. Her admission ED noted;

*Chest X-Ray shows fractured right ribs 4th and 5th, with fractured left ribs inclusive [from] 1st to 6th (No heamo/pneumothorax or flail)* discussion with surgical register. Plan-for admission and PCA over night with review in manae of same.

[Martha medical notes]

She did not receive a PCA and there was no documented reason as to why this was not given. Her plan was to not develop pneumonia as a complication:

*The doctors said that I could get all these things, if you do not cough it could develop into a bronchitis thing in your chest---pneumonia. That’s what, I hope to keep me lungs open and I’m trying to take big breaths to stop me from getting that---because they said that it can be very dangerous when you get that (...) I was right as rain until I fell over.*

[Martha interview]

Martha wanted to be discharged home quickly so that she could go up the coast and help her granddaughter who had a new baby.

**Belinda got a new diagnosis: Polymyalgia rheumatica.**

Belinda was 78, lived 3.5 hours away on a rural property and presented to the ED by ambulance; her pain was severe and on review in ED Belinda was given a new diagnosis:

*Decreased mobility- unable to walk, acute pain, numbness bi-l lat fingers 2/52 pain in joints, states pain 8-9/10 Polymyalgia rheumatic, Musculoskeletal, Very tender joints to palpate with or without active or passive moment –Pt c/o burning tingling joint pains in MCP, elbows, shoulders and hip R>L. Pain worse on movement and when trying to grasp objects (squeezing).*

[Belinda medical notes]
Belinda spoke of her pain getting worse and her mobility decreasing over a period of two weeks, which involved repeated presentations to her GP and the local ED, until she was unable to get off her bed one night, at which point her husband called an ambulance:

> So I remember that I finally managed to get back into the doctor (...) oh and then he sent me to Koala Base hospital, with a letter (...), so I went and I had to wait four and a half hours (...) [sobs] oh--- shocking. Because I---[sobs] and then I---the pain [blows nose] the waiting---the whole lot it was just getting to me and [the ED Dr] he said he’d done the same as what my doctor had done (...). When I got home again (...) everything just seemed to be---gripping me---locking me---jamming if you can understand and poor Oliver [husband] was helping me to move around, helping me to stand up whenever I wanted to go to the toilet---he had to lift me up more or less---but he’s a sick man himself. It was so severe the pain, [that] one night at home that I lay on the bed and I couldn’t get up again, [and] that was when we thought we’d better, part of the reason for coming in [and ] I ended up coming in here.

[Belinda interview]

Belinda’s plan was to go home and drive the tractor to slash the grass in the paddocks. She also wanted to be discharged before an upcoming court case against her son-in-law, whom she had an AVO\(^3\) out against.

**Suzanne had increased seizure activity with incomplete partial paralysis.**

Suzanne was 65 and reminisced about the days leading up to when she was diagnosed and had the first of her brain cancer (a glioblastoma) operations:

> Do you remember that stinking hot Friday, the week before the long weekend? I do, I was walking around in Sydney. And then the following Saturday I was in hospital and that Sunday I was operated on---it just happened that quick, very quick.

[Suzanne interview]

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\(^3\) Apprehended violence order
That was three months ago. Now Suzanne has had two craniotomies, a course of chemotherapy and radiotherapy as well as a spontaneous left ankle fracture when she went to a rehabilitation centre. Suzanne spoke about losing track of time since this admission, and that she kept a daily diary:

*Why am [I] in hospital? What happened this time?* (…) *I have been in there a few times lately* (…) *since they found the brain tumour, apart from when I was operated on* (…). *Thursday or the next day I was in here, or it might have been a week later---I can’t. Time is nothing at these, at this moment. I have lost, I just have lost track of time, ---and I just have to stop and think to keep track of dates. I have them written down in a book here* (…) *it is just a note book where I keep everything* (…) [to herself while she opens up a small pocket book] *here we go--- I remember now, I felt lazy and I had a fit, a seizure. No warning, I just tried to walk, I couldn’t walk- I could go forward and I couldn’t go back.*

[Suzanne interview]

Suzanne previously was the carer for her husband and grandchildren. She talked of how her increasing seizure activity had left her with progressively incremental left sided incomplete and partial paralysis. Now she was worried about how her daughter was going to cope while she was in hospital.

**Brianna experienced an exacerbation of her asthma.**

Brianna was 69. The reason for this admission was a respiratory infection, which had exacerbated her asthma. Her life had changed when she was 58. After working for 30 years she had to stop work, when on riding her pushbike home from work, she fell off, broke her leg, and developed chronic pain.

*I dare say that I am more frightened of the asthma than the pain.\nMind you the pain is not easy to deal with either. But I have my good days and my bad.*

[Brianna interview]
Brianna referred to being frightened a lot in her interview and spoke of feeling unsafe during this admission. On gentle prompting about being frightened, she spoke of her experience of a medication error by the nurses the previous day:

*It’s in my head I know [silence 5 seconds] but like before with the medication mistake yesterday, I worry that they will miss me, the nurses. I think that they will not get to me quick enough, I don’t know—- I am just panicky that the nurses will not get to me quick enough.*

[Brianna interview]

Brianna had received instant release oral 16mg of hydromorphone instead of her usual 16mg slow release. Brianna spoke of previous negative experience during an opioid medication rotation that sounded like a period of psychosis, which required her being transferred into a hospital that specialised in providing mental health interventions. She was worried that the same thing would happen again and she had refused to be discharged home.

**Allison had a fall at home.**

Aged 85, Allison was a volunteer, until three months ago when an onsite accident left her with a fractured pubic rami and she was discharged home 12 weeks ago. Now after a fall at home and fracturing her ankle, Allison was upset and angry with herself:

*I felt a fool, silly old girl, anyhow---I did not tell Jean [daughter in law] but oh, I am that cranky with myself to think that I have done this to myself.*

[Allison interview]

Allison spoke of being limited in her mobility and not being able to go down the steps of her house that her husband built for her. Allison’s home care package had just ended and she had no more home help. She talked of not being able to leave her house to go
shopping and mentioned that she had been told that she now required placement into a low care facility.

**Bridget required emergency surgery for advanced bowel cancer.**

Bridget was 84 and lived at home alone. She has been experiencing increased incontinence and frequency of watery blood stained stools five to ten times a day. In her interview, Bridget spoke of experiencing this condition for more than six months. She said her daughter had finally taken her to the doctors, who diagnosed her with bowel cancer and admitted her immediately into hospital for a surgical intervention:

> So I stayed home. My daughter would or my son does a bit of shopping for me... and they did that for ages for me [about] 6 months I suppose. It was my own fault. The doctor wanted to give me an examination, but no I would not have it. I did not like him to be looking at my bottom, you see he’s a male doctor.  

[Bridget interview]

Bridget had a colostomy bag. However, she developed a pressure area on her heel which was painful for her:

> Now it’s different--- a different ball game altogether with this bag [taps the colostomy bag] with this bag- the colostomy bag, now things will be different--- when I leave here I will be able to go out. Mind you actually at the moment the only thing that is giving me pain at the movement is my heel- that hurts now. Oh I have a big ulcer, not a big ulcer---a big pressure area. I would call it a big blister actually. It’s about that big [makes a movement with her hands of a size of an apple] it’s a big one [nods head] yes about 10cm. I didn’t have it when I came in--- it’s from lying in bed. I keep on pushing myself up with my heels in bed and that’s how I got it- I keep using that leg you see.  

[Bridget interview]

Bridget did not have the pressure area on her heel before going into hospital and was now finding it difficult to walk down the corridor to the bathroom to empty her colostomy bag because of the pain when she put her foot down.
Molly was waiting for a hip replacement.

Molly was 73 and had been a widow now for five years; she had placed a recent AVO out against her son, who was until then her carer; now her neighbours keep an eye on her. Molly had been on the public waiting list for a total hip and separate knee replacement for more than 18 months. She was due to have an upcoming total hip replacement; however, this was cancelled due to a pre-op check-up identifying that she required a pacemaker insertion. Molly had been home now for three weeks and had experienced two separate falls after having her cardiac surgery. Molly spoke of how she had experienced a pain crisis at home and had exhausted all avenues of help:

After I came out of hospital for my heart operation a couple of weeks ago (…) I was supposed to have my hip done you know, well you know what? They put me onto having a cortisone injection in my hip. The [expletive] thing didn’t work! I waited but it didn’t get any better, I waited seven days and I thought ohhhhh the pain so I rang my GP\(^4\) up and she issued me with some patches\(^5\) that went for seven days. And then it just wasn’t getting any better. So I rang her again and she issued me with some patches that go for three days.

[Molly interview]

Molly also spoke of ringing up and attempting to speak to the orthopaedic surgeon in order to discuss options for her cancelled hip operation. Molly informed me that these efforts were counterproductive, as what resulted was that both joint replacement operations had been summarily cancelled and that the receptionist had put her at the end of the list.

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\(^4\) General practitioner – a person’s family /local doctor

\(^5\) Fentanyl patches
Ninnette had a course of chemotherapy and experienced shingles.

Ninnette was 66 and had receiving her second round of chemotherapy as an outpatient in an acute care ward. She was staying in charity provided accommodation as she lived in a remote rural area five hours travel away. This meant that she can have the chemotherapy treatment daily for a month in a treatment lounge that was located on the haematology acute care ward.

Ninnette talked about her attempts over a period of days to draw the nurses’ attention to her pain in the haematology ward, about her increasing shortness of breath and the pain in the base of her shoulders. She commented that she was made to feel like a hypochondriac until, after being ignored once again, she became proactive, marching up to the nurses’ station while the doctor was there and lifting her gown to expose her back:

Well I can truthfully say, those girls in the day unit must have thought that they were dealing with a total hypochondriac. I couldn’t understand what was going on [silence] (...) the nurse, he must have been busy because he didn’t even look at me, I said to my husband Ned “oh for heaven’s sake will you scratch my back?” And he said “oh no I won’t there is a big clump of sores on it”. [Silence] So that is when I (...) followed up on it. I walked up to the [nursing] desk with Ned and I said “I am pretty sure that I have got shingles”. I lifted my gown and as soon as they saw it, they knew that that was what it was. [Ninnette interview]

Ninnette reflected on having a sequence of side effects before that eventful day:

I felt that the nurses couldn’t be blamed in the end for the fluid that I developed. I sat in the chair for three hours each day for my therapy so they didn’t see me moving and on exertion and stuff- so they did not see my breathlessness that I was having or we would have all got onto it sooner. I had so many different side effects presenting and every day it was different, but I was not well. [Ninnette interview]
Rhonda experienced a spontaneous rupture of a baker’s cyst at home.

Rhonda was 92 years old. She talked of being struck down by the terrible pain due to a spontaneous rupture of a baker’s cyst behind her knee, that left her unable to walk and almost fainting with pain at home:

_I was only walking around at home, and all of a sudden I got a terrible pain in my knee. I could not even walk, it struck me down, and I had---oh my gosh---But the pain just got worse and worse and worse. To the stage when--- I got---I really thought that I was fainting with the pain._

[Rhonda interview]

When asked to describe her pain in more detail Rhonda began talking about how the doctor in ED asked her to describe her pain:

_The pain was absolutely atrocious; the doctor in ED asked me if it was worse than childbirth. I said well childbirth is bad, but you get rid of the pain quickly---but this was a terrible pain and I couldn’t explain it-- just a terrible pain---and [silence 10 seconds] I was shivering and the whole bed was shaking._

[Rhonda interview]

The day after her admission into ED, Rhonda went into the OT and had 20ml of fluid from the cyst behind her knee drained under a general anaesthetic.

Peter had pneumonia from a recent thoracotomy at another hospital.

Peter was 73 and has been admitted into a medical ward for management of pneumonia. He also suffers from rheumatoid arthritis (RA) and metastatic cancer. He has a very complex and chronic history:

*Herpes (L) eye, NIDDM, Melanoma, HTN, Hepatic thrombocytopenia, RA- Plaquenil 200mg and prednisone 5mg.*
Prostate Ca, GI METS, Hodgkins Lymphoma (chemo &
recession) since 2010, Recent ? thoracotomy and R/O ribs\textsuperscript{6},
Recurrent pseudomonas RLL, R) hemicolectiminy 2010

[Peter medical notes]

Peter had a recent hospital admission six weeks ago at another hospital for a
thoracotomy and removal of ribs. When referring to his pain he comments that:

\textit{I have a great tolerance for pain; I have had eleven cancers
and nine operations. I am always in self-control with my pain,
but I have always controlled everything pretty well. I found that
if you take Panadol\textsuperscript{7} regularly, you eliminate a lot of pain.}

[Peter interview]

Peter’s pain was part of his story, which is about controlling it in order that he can have
quality of life and function. Peter regarded his pain within his previous experiences, and
he emphasised having a relationship with his pain that had no individual attributes, and
as a result he did not objectify his pain into separate locations or numerical values.

\textbf{Simon admitted for management of ascites.}

Simon was 65 and he referred to his pain as overriding his ability to attend to his family
by listening and being present. In particular, to listen to the stories they were telling
him, it was notable that Simon had a very strong cultural connection with family and
was CALD. His pain had affected him in a major way by infringing on his sense of
identity as a person and within his family role. No longer able to work because of the
pain and swelling from his cellulitis in his leg meaning he was unable to put his shoes
on anymore:

\textsuperscript{6} Not documented what side or which ribs, Peter informs me that it was his left side and this was 6 weeks
ago.

\textsuperscript{7} Paracetamol (Acetaminophen) provides analgesia and antipyretic activities but does not provide anti-
inflammatory properties and is used to provide relief from mild to moderate pain and reduces fever, when
given orally it provides a peak plasma onset from 10 to 60 minutes (Monthly Index of Medical
When it did first happen, it was four times bigger than that---it were massive, it were swollen from there [points to top of knee] all the way down to the toes (...). And then one morning, because I didn’t want to lose my job- I had to force my feet into my shoes---to go to work, not because I wanted to be there--- but I wanted to prove it to them---cause they think that I am making stories so the manager went off at me and told me that I shouldn’t be there! Go back home, now I can’t wear any shoes---the blood---I can feel the blood like it’s flashing and it’s so painful.

[Simon interview]

Janet has had recent surgery.

Janet was 68 and day two post-op from her gynecological surgical procedure. She was in good spirits because after having her catheter removed she was able to urinate. Janet found sitting out of bed in a chair to be comfortable:

After a pain assessment by her nurse RN Clare, Janet makes a comment about her lack of comfort from chair that she is sitting on. She looks down on the chair she is sitting on, frowns and comments that:

“The chairs are good here, but no good for my tailbone”

[Reflective journal entry 35]

When RN Clare walked out to get her some Endone³, Janet stood up slowly and reached across the bed to get a pillow that she slid under her bottom and then sat down slowly.

Marcus and terminal care.

Marcus was 89 and he was originally admitted into hospital for management of end stage liver cancer, CCF and exacerbation of APO which then developed into multi organ failure. After discharge out of CCU he was transferred to the Eucalypt medical, before being transferred into the Acacia medical ward and then transferred into the Red Gum sub-acute ward in the same hospital. He then deteriorated rapidly and was

³ Endone is a narcotic analgesic which is similar to that of morphine, it is an opioid agonist that produces analgesia with some sedation with an onset between 10 to 15 minutes and reaches a peak in 30 to 60 minutes which may persist for up to three or six hours (MIMS 2015a)
transferred back into the Eucalypt medical ward in the middle of the night before being made palliative the next day. Marcus was day 14 of his admission and had a marked decreased level of consciousness as he was in the terminal stages of dying.

**Sally had a fall and a circumferential skin tear.**

Sally was 86 and lived at home alone. Sally indicated that she wished to be interviewed for this study, but when the researcher went to interview her she then declined, as she had gathered up her belongings, and was waiting for the wardsperson to take her to the front door as she had been discharged. Sally spoke of having had a fall or accident at home when walking out to put the washing out when she talked of slipping on the stairs and cutting her leg. She then said she tried to deal with this wound at home for a couple of days by *wrapping it with a tea towel* until when on removing her dressing and attempting to wash her wound it began to bleed a copious amount and she rang for an ambulance. During her 10 day admission, Sally’s pain increased to the point on her second day of admission when she began to refuse to weight bear or mobilise on that left leg and she became functionally incontinent.

**Donna had no advanced care directive.**

Donna was 84, and lived at home independently. She was brought in by ambulance after being found naked in a pool of blood on the floor of her home by her neighbour. Donna had a very complex and chronic history which is summarised within the reflective journal:

> BIBA Implications, Mechanical fall/ Rectal prolapse/ Hyponatraemia/ R Fungating popliteal fossa lesion 7cm by 3cm, foul smelling lesion which bleeds ++++, long standing

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When Sally removed the tea towels that she was using as a dressing at home it appears that maybe she inadvertently contributed to her wound by possibly making it worse.
malodorous fungating sarcoma removed 20XX & 20XX, Rectal prolapse longstanding and previously refused for surgical management. Donna states it used to be easily reducible. Decided surgical issues are secondary due to context of presentation. Medical issues AF- rate controlled. On warfarin, Malnourishment- recent weight loss and chronic rectal bleed, Anaemia secondary to rectal bleed that has underlying malignancy of unknown source – to be investigated. Acute kidney injury, Right leg cellulitis. Decreased capacity to cope at home, lives alone, recent widow, No advanced care directive. CALD.

[Reflective journal entry 25]

Donna, during her two week admission, was initially transferred into a medical ward, then into a surgical ward before being transferred into a different medical ward and then ending up in the sub-acute ward. When Donna deteriorated and developed an ischemic bowel, she was then transferred back into one of the medical wards before she passed away. During her journey through these five acute care wards there was no summary provided of her journey and no advance care directive but constant documentation outlining planning for her to maybe be discharged into a hostel.

**Astrid had dementia and is in pain.**

Astrid was 79, and she had been diagnosed with dementia now for six years. She lived in a granny flat next to her daughter’s house; she is a very slight and petite person who weighs 43kg. Astrid was initially brought into hospital by ambulance for management of her chest pain after being discharged from the study site hospital one week ago. On examination in ED, she was transferred to another hospital for an ultrasound of her gallbladder that showed multiple small calculi and she then returned to the study site hospital and was admitted into a medical ward, before transfer into the sub-acute ward. In her notes, it was documented that she was experiencing pleuritic chest pain, not colic pain but also she was being investigated for pneumonia and that the cardiologist had reviewed her and had ruled out a cardiac source.
Terry can’t talk.

Terry was 85 and lived at home alone. He was being cared for by palliative care in the community. He had multiple cancer sites being prostate, liver, bone and after an SCC was removed from his neck he had a laryngectomy 38 years ago. He was hearing impaired and used an electro-larynx to speak. Terry had a fall at home and activated his vital call. During this admission, more investigations had been undertaken and he has been provided with a new diagnosis of cancer with colon, sacrum, and rectum metastasis. On his admission into the medical ward Terry’s bottle of liquid Ordine was removed from him and it was charted PRN. It was now the eighth day of his admission and he has received PRN every night between 19:30 to 20:10 of 2.5mg of liquid Ordine. He has no charting of paracetamol regularly or PRN. There is no documented plan for Terry nor is there any documentation from palliative care coming to see him whilst he was hospitalised.

Jack falls at home and again in hospital.

Jack was a 94 year old gentleman who was legally blind and also had profound hearing loss in both ears. He lived in a hostel in the community and came into hospital after being found on the ground after a fall with an arterial bleed from a laceration to his head. It was documented in his notes on admission that he is unsteady on his feet and that he uses a four wheelie walker to ambulate. His plan by the ED admitting doctor was for investigations of causes of declining function beginning with ruling out sepsis and/or a urinary tract infection.

Jack was transferred from the ED ward into a medical ward late in the evening before being transferred again at 07.30 am into the sub-acute ward. This early morning transfer
meant that Jack almost missed out on his breakfast, but the sub-acute nurses quickly identified that he had not eaten and provided him with some breakfast.

On the third day of his admission, Jack had an unwitnessed fall. The following are from my reflective journal about the event:

I am in the nurses’ station, waiting for RN Elise who is speaking to one of the physiotherapists. All of a sudden, we all hear this all mighty sound of a crashing coming from down the hallway. RN Elise and the physiotherapist run towards the scene. The other nurses call for assistance from the doctors who are down the opposite end of the hallway. I go and look into the room and I see Jack lying on the floor bleeding from a cut lip.

[Reflective journal entry 36]

The treating team decided to begin exploration for delirium. His nurse RN Elise reported the incident as per policy and procedure by the computer system, rang up his daughter and informed the NUM. Despite having a busy shift she ensured that she made some time to not only get him a cup of tea and chocolate biscuit, but she also sat down next to him and chatted while writing up her nursing documentation for that day, instead of sitting at the nursing station.

**Review and summary.**

A common theme amongst the older people was their decision to come into hospital because of the presence of pain. Evident as a common thread was how they attempted to manage their pain not only before admission but also during their admission in acute care as an inpatient. The 18 older persons who are introduced within this prologue chapter are all represented within the findings chapters. The aim of this chapter was to facilitate input from these older persons in order to provide their viewpoints. This was to ensure conveyance of some of their story to the reader. This provides another layer of perspective in relation to not only the observations of their interactions with the nurses,
but also provides a balance when the nurses are speaking of them as well as insight into the thoughts of those older persons who were interviewed.

The following three chapters are an arrangement of the findings.
Chapter six: Nurses’ experiences of providing pain care for the older person

Chapter Introduction

The theme *Nurses’ experiences of providing pain care for the older person* depicts the experiences of the nurses in this study when providing pain care for the comfort of the older persons in this study. Provided are insights that reveal not only their understanding of pain in older people but also the constraints within the acute care environment experienced when delivering care for comfort and relief of pain for the older person. The theme *Nurses’ experiences of providing pain care for the older hospitalised person* comprises four subthemes: Being a leader: problem solving pain issues and concerns; Nurses’ pain stories; The ward round and pain assessment and Being audited, and the ‘black mark’.

The first sub theme; *Being a leader, problem solving pain issues and concerns* highlights the study nurses’ leadership, how they provided education about pain, and mentoring as well as role modelling behaviour for the processes involved for assessment and management of pain for the older person. It outlines the study nurses’ attempts to integrate their perceptions of what is best practice in pain management to ensure pain relief and comfort while being a role model for appropriate behaviour in relation to pain assessment and management. The nurses in this study talked about how important they felt it was to be a mentor for other newly transitioned nurses into their wards. They spoke about the importance they placed upon being approachable and available to other nurses to answer any questions in relation to pain care provision for
the older person. They talked about how they provided education to their colleagues about assessment and management of acute pain. The nurses in this study also outlined how they questioned the junior transitional nurses about their understandings of how they had undertaken pain care practices and checking on the comfort of older persons in their care.

The second subtheme; Tales of success provides insight into the provision of pain care for the older person by the nurses in this study. It captures the situations when the study nurses attempted to solve the issues and concerns about an older patient’s pain, however, absent from within their stories of problem solving was input from the older persons themselves. Although the nurses listened, they believed that the older person would not tell them when they were in pain. The study nurses’ perceptions of pain in the older person was that it was real and genuine, that they often relied on visual cues, such as wincing or grimacing, to confirm the presence of pain. The nurses also spoke of their distress when knowing pain was present and unresolved. Described are the reactions of nurses when providing comfort for older patients in pain. Being able to provide comfort for pain for the older person was a positive experience for the nurses in this study.

The third sub theme; The ward round and pain assessment captures the experiences of the nurses in this study when undertaking the processes of pain assessment during a ward round. It captures the complexities of assessing pain during ward rounds. Outlined are the ways in which the nurses inquired about the presence of pain by asking the older person to provide a single score out of ten for their pain and the nurses understanding of the score provided. This sub theme reveals how the nurses in this study taught the older person how to use a pain score for their pain. Highlighted is the complexity involved when the older person expressed that they had multiple sites and differing types of pain.
to the nurses, and captured are the reactions of the nurses when those instances occurred.

The final subtheme; Being audited, and the ‘black mark’, provides understanding of the provision of pain relief and comfort in acute care when full compliance is mandated and how the nurses attempted to provide this within a climate of surveillance and auditing. It highlights the attempts made by the study nurses to avoid the ward receiving a ‘black mark’ or ‘practice noncompliance’ for incomplete pain documentation during auditing for quality assurance purposes. The nurses’ efforts to provide continuity of pain assessment during the bedside clinical handover are also described.

**Being a leader: Problem solving pain issues and concerns.**

As noted previously, the sub theme Being a leader for problem solving pain issues and concerns outlines how the nurses in this study perceived themselves as a clinical leader for problem solving the older persons’ pain issues and concerns. Nurses spoke candidly about their experiences of being a role model for other nurses, providing education for the ward staff and shared their success stories on what it is like when they had a positive outcome, in terms of reducing pain for the older person.

However, all of the study nurses believed they were good at problem solving situations for providing relief from pain for their older patients. As RN Clare said:

[I am] Efficient! [Laughs] (...) I’m very much [a] problem solving [nurse], and I’ll get it sorted out (...) as in the patients’ problems, so if they are uncomfortable, their pain, [nods] that sort of thing.

[RN Clare interview 1]
Mentoring nurses.

The registered nurses Fran, Hermione, Elise, Ann, and Georgina all commented that being a team leader was being a resource person and a mentor for staff which for them meant they were always teaching other nurses about pain assessment and management. When RN Barbara was asked to clarify what it felt like to be in this situation in relation to caring for older people with pain she described it as:

*It is being a ward champion and a mentor at the same time [and] you know, you find your brain being pulled around some days.*

[RN Barbara interview 1]

These roles\(^{10}\) were interchangeable with RN Clare, Hermione, Ann, and Georgina speaking about them occurring simultaneously in time constrained or pressured situations where they were keeping eyes and ears open. RN Barbara talked about the difficulties of being the only RN eight on\(^{11}\) and teaching on your feet while being in-charge of the ward at the same time:

*You do that teaching on your feet and it’s [in these] time constrained (...) situation[s] when that team leader role comes in, you got to keep your eyes and ears open (...) I am the only RN eight on, I’ve got [counts on her fingers] one, two, three, EEN eights\(^{12}\), (...) and the rest are only RN two and three\(^{13}\).*

[RN Barbara interview 2]

Being a mentor was spoken of by RNs Danielle, Ann, Georgina and Barbara as being very important and a serious undertaking. When asked what the duties of a mentor were, RN Danielle spoke of being available for answering any questions no matter how

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\(^{10}\) See methods for definitions of what are the roles of a ward champion, team leader, in-charge, resource person, mentor and teacher.

\(^{11}\) In Australia ‘senior nurses’ are deemed nurses who have more than eight continuous years of clinical practice. These nurses are known by the pay award as being eight years and thereafter and receive the maximum amount of pay per hour for a ward nurse.

\(^{12}\) EEN eights are endorsed enrolled nurses with a minimum of eight years’ experience as an EEN nurse.

\(^{13}\) RN Barbara makes a distinction between the EENs being more senior because they have more than eight years’ experience and the RNs who have less years of clinical experience.
stupid and also to inform the mentee nurse that this is what you do here. RN Danielle talked about this when asked to speak about her role as a mentor:

I am Leo’s mentor and I treat it as really, seriously, absolutely very important (...) because sometimes you don’t realise what somebody doesn’t know (...) I can tell him “This is what you do here--- it’s this, and this, and this, not that” (...). If they go “What is that?” You know--- you just think “Oh thank goodness you asked, because I wasn’t going to tell you” (...) part of being a mentor [is] you got to make sure that you don’t assume what they know or don’t know or whatever hmmm [nods head] I am happy, happy for them to ask whatever.

[RN Danielle interview 2]

RN Iona talked about her experiences as a junior nurse, and how important she felt it was to have a mentor who could understand and be approachable in order to ask those stupid questions to them:

I went to The Mallee Point Hospital (...) I really liked my mentor there. Because in my first rotation, I had no mentor at all. None. I will never forget that [first] ward, I felt so left alone (...) I hated it [whispers] like you start at one o’clock and finish at ten, and you hand over at nine thirty. After your handover you are meant to go home, but I never did. I was always back until 11o’clock and no-body cared (...) So [big breath in] when I went to The Mallee Point it was all different, and my mentor was really nice and approachable. If I needed help they would be there for me and they understood you are going to ask them stupid questions (...)Yeah it was great, so nice (...) to be asked “how are you, do you want to learn something new?”

[RN Iona interview 2]

Absent from the conversations by the nurses in this study about mentoring was any reference to mentoring provided to themselves or formal direction and support when being a mentor.

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14 In Australia newly graduated nurses can undertake a graduate rotation program where they gain experience of different speciality wards over a year within some of the larger acute hospitals.
Providing education about pain for nursing staff.

Three of the nurses in this study spoke about how they provided formal education sessions about pain assessment and management to other nurses on the ward. For instance, RN Barbara talked about her attempts to provide education to the ward:

*Really what we need to do is have an in-service on pain, which I would like to give---we do have sessions that are allotted---my [last] allotted time (…) I was all ready and prepared (…) and it was cancelled! (…) due to---insufficient staffing or the ward was too busy.*

[RN Barbara interview 3]

When RN Hermione asked if she provided education about pain or older person care, she spoke of *constantly educating* for not only registered nurses but also the nursing students who come through the ward by a formal session termed an *in-service*:

*I mean we are constantly educating, and I mean I educate the students when they come through, in [about] palliative care and death, (…) [and] so I educate the nurses here as well, but I’m always going off to run some in-services, this week I’ve got falls [prevention], next week I’ve got gynaecological and there is a tracheostomy day on Friday --- almost half of the ward is going to [come] to that.*

[RN Hermione interview 1]

Two nurses spoke about undertaking clinical supervision workshops and that they wanted to implement it within their wards. They spoke about wanting to use clinical reflection to improve the junior nurses’ abilities to manage pain, with the benefits RNs Barbara and Georgina spoke of as being that the junior nurses will *incorporate that into their practice*. RN Barbara spoke about knowing that the junior nurses picked up their learning from others and that they needed to be able to *put forward* their *concerns rationally* to solve what she called *simple problems*:

*Now that’s our third incident on the ward this afternoon of pain and I got it resolved fairly easily. It was very frustrating as it*
was a simple problem, so that’s another aspect I’d like to address, you need to have a pain management plan but [you have got to] put forward your concerns rationally (…) instead of just going “He needs pain relief because I think he does” (…) I don’t know what the new graduate nurses are learning in so far as pain goes, I think it’s been learnt as they go along, but they need to talk to the team leader (…) who will go “Why--- What’s he crying out in pain for? Tell me the story?”, and then you have a session with them and go “well reflect back to me what you think about that?” That’s why we should have clinical supervision in clinical practice. I want to encourage them to do that, because they will incorporate that into their practice too, [and] when they do their in-charges [role] as well.

[RN Barbara interview 2]

When RN Barbara was asked to talk about this more, and if she found it difficult to educate her colleagues, she talked of wanting to become a clinical supervision trainer so that then you put yourself on a list and people actually come and speak to you, so they can reflect on their clinical practice:

We really need to have clinical supervision in clinical practice, like with mental health (…) they have clinical supervision, and you can go along and I want to [do it and] become a clinical supervision trainer and then you put yourself on a list and people actually come and speak to you so they can reflect on their clinical practice (…). It’s actually (…) that opportunity to just talk about something and reinforce basically that they are doing a good job or how can you handle this or that.

[RN Barbara interview 2]

RN Georgina had undertaken a clinical supervision course and spoke of her unsuccessful attempts to implement clinical supervision with the ward staff. She found out it was just not the done thing on her ward; that the NUMs haven’t heard of it before and they withdrew their support:

I just did the clinical supervision [course] and it has really helped me here. I tried to get it put in here, but I just can’t (…) I have spoken about it to people, but they just don’t want to do it, it’s just not the done thing, people just don’t want to do it. Well [5 second pause] it’s just, it’s this hospital as a whole (…) a lot of people haven’t heard of it before (…) “Oh wow. I have never heard of this, what is this clinical supervision?” (…) I have
spoken to the NUMs here and other staff as well (...) and they go “Yeah that is great, that’ll be good to do, Yes, yeah, nape, none, no, NO.”. [Sighs] I do mentoring and things here, [so] I guess I just got to be more proactive [shrugs].

[RN Georgina interview 1]

In this study three nurses spoke about providing pain assessment and management education sessions to other nurses within their wards, however, absent are references to current EBP nor was there any mention of conferring with other experts in the field.

**Questioning junior nurses about pain.**

When study nurses spoke of their leadership roles in relation to pain assessment and management for the older person, RNs Clare, Barbara, Fran and Georgina talked about how they *questioned* other nursing colleagues about their pain comfort care clinical practices. RN Barbara talked about the importance she placed on questioning her junior transitional nurse colleagues as part of engaging them in reflection on assessing pain in older people:

*You know, there are lots and lots of questions to ask them [junior colleagues] and I begin by looking for something to support that SAGO [numerical] pain score, look---is it time to get this reviewed or is there pain relief already charted? Is it only PRN (...) [thumps table] I question more to guide---to guide them because I don’t know what the new grads [junior transitional nurses] are learning in so far as pain in older people goes---I think that it has been learnt by them as they go along from us.*

[RN Barbara interview 2]

When RN Barbara was asked to elaborate about how she went about questioning her junior transitional nurse colleagues, she related an incident that had occurred during the observation period about an older person who was calling out in pain (but was not part of the study):
You know and that’s where people like myself (...) out there are going well to them [junior colleagues] “Why--- What’s he crying out for? Tell me the story?” And then you have a session with them and go “well reflect back to me what you think about that?” and that’s when I question them [her colleagues] “What do you perceive that pain as? As a five? Or a two?” (...) and I go “Ohh a two. That means they [the patient] will be nearly dead by the time they get to an eight you know-maybe you could increase it [the numerical value] a little and also find out when the pain is coming on, is it because they are moving and they don’t want to, you know is it because the patient is being stubborn, or being behavioural as opposed to something physical you know---because pain is so complex.

[RN Barbara interview 2]

The study nurses RN Clare, Barbara, Fran and Georgina also mentioned feeling unsure at times of the responses provided by the junior nurses when they queried them about their pain assessment practices. They spoke of asking these junior nurses for more information and they talked of checking on the patients themselves because as RN Clare commented you still have to be very careful. They were not confident of the junior transitional nurses’ responses to their questions relating to care and attempted to implement strategies to provide comfort for the older person as well as provide education for the junior transitional nurses.

RN Barbara was observed to ask the treating team to also chart regular pain relief while stating that the patient was not getting the PRN charted pain medication. Later in the follow up interview she was asked to discuss this. In her reply on being asked to describe the situation, she spoke about how one of her colleagues had come to her about a patient in pain, that after speaking to nurses involved she covertly observed their clinical practices:

I said to the RMO so we have got Endone and paracetamol charted PRN, [but] I said due to our skill mix and recent change of staff they very often are perceiving his pain as being part of his dementia and he’s not getting it. Because the next nurse came on, [and] they come up to me because, he’s screaming out
in pain yet on the pain scores it’s been a zero or two. I looked at this man’s pain score and [taps table] every four hours its zero or two or whatever (...) I am their mentor--- so I talked to the nurses, Angus and Patty the new grads\textsuperscript{15} who have been here now [for] two weeks (...) [is re-enacting conversation with staff] “he’s always screaming out, always screaming out when we turn him and do stuff” so I go “what pain meds did you get for him then” they say “umm arrghh” [snorts and thumps table with palm of hand to emphasis point] this is because ---at---that---time---when---they [Angus and Patty]---are---doing---the---obs and asking about pain [pause, points finger] he’s quiet, he’s not moving. [Silence]. I went and watched (...), they asked the patient if they had pain [mimics the older person] “yes love, oh it’s all right”- right then, they wrote zero [Taps table to emphasis point] No, it’s not all right and it’s not a zero.

[RN Barbara interview 2]

With reference to the use of opioids, RN Clare talked about how the nursing staff on the surgical ward were pretty good with the pain relief, and that other nurses might be more scared of dishing it [opioids] out. She said the nurses on her surgical ward were used to giving out [administering] morphine many times a day in contrast to those nurses who came from medical wards. In addition, she talked of nurses from other non-surgical wards often requiring reassurance from the surgical nurses because these other nurses are scared of giving out [opioids]. RN Clare also spoke about being unsure when junior transitional nurses came to the ward as part of their clinical rotations and were unable to articulate a reason for giving the patient morphine. She talked about checking on both the nurse and the patient.

I think that no matter what, you still have to be very careful. So if a junior nurse comes to me and says, “Can I give them some morphine?” I will say to them “What’s wrong with the patient, what have they had done\textsuperscript{16} blah blah blah (...) what’s their OBS?” to see if everything is ok and if I am still a little bit unsure, I will go there myself to the patient and go what are the numbers? I will make sure that they [the patient] are all right.

[RN Clare interview 1]

\textsuperscript{15} Junior transitional nurses
\textsuperscript{16} She is referring to what surgical procedure the patient has had
When asked why some study nurses felt that they had to question junior nurses often and check on them, RN Ann responded by stating a need to maintain high standards within a tough ward. RN Ann further noted it is important to be seen to meet these high standards which were set by the senior nurses; however, she also noted that at times the standards for pain may not be met:

We, well the more experienced nurses, we like to (...) keep things going well. We have high standards, they are difficult to maintain but we do a pretty good job, we do a damn good job actually but I think with pain we slip a bit sometimes, but no we are a tough ward with high standards and it’s important that we are seen to meet them.  

[RN Ann interview 1]

Whilst the nurses saw themselves as attentive to the pain of their patients and asserted their clinical leadership capacities there were older patients whose pain issues and concerns were not heard.

**Tales of success**

When speaking of their efforts of being an advocate for the older person in pain, the nurses in this study often told success stories that involved nurses having to ‘repeat’ themselves, be persistent, and advocate for their patients for attention for their pain. These pain success stories revolved around nurses asking different members of the treating team, other nurses and doctors, over time and sometimes repeatedly, to provide input by charting medications or changing the dosage or timing of these medications for management of their patients’ pain. Sometimes this lack of attention paid by the medical team to charting pain relief delayed the patients’ discharge home. RN Georgina recollected the experiences of the nurses on her ward having to repeat themselves over and over again.
A few weeks ago we had a lady (…) with fractured pubic rami and all she was on was PRN Endone and she was in agony [5 second pause]. And all I can remember is that we kept on saying to the doctors [slaps hand down hard on table] “Look she needs something else---she needs something to kick in” and then one of the weekend doctors went “Oh she needs regular Oxycontin\(^1\), I’ll give her five”. So we went “yes” [pumps fist in air] so that’s what we did, we gave her the regular five of Oxycontin and then the regular PRN Endone and then still, the physios\(^1\) went (…) It’s not under control [the pain]. So we relayed that to [our] other [weekday] doctors (…) and reinforced what the physio had said and then they (…) upped it to 15 BD. By the time we had finished, we were at 20 BD. She [the patient] didn’t need the Endone anymore, only needed the Panadol, she could get up and mobilise on her 20 of Oxycontin and went home on that.

[RN Georgina interview 3]

RN Fran advocated for Martha (90), who had been admitted into a surgical ward on the weekend and whose pain was a result of multiple fractured ribs from a fall. RN Fran paged the weekend (W/E) resident medical officer (RMO) to undertake a medical assessment to review Martha however; when the RMO arrived to do the assessment Martha was excluded from the discussions which took place in the corridor away from her. In my journal I noted:

RN Fran and the ward physiotherapist held a brief consultation in the hallway with the W/E RMO. The physiotherapist commented to the RMO that Martha is unable to deep breath and cough due to pain. RN Fran confirmed this and stated she had although she had given the patient Endone that was under 3 hours ago and she still had pain.

[Reflective journal entry 57]

“That lady in bed 12 [Martha] with the fractured ribs is in a lot of pain and unable to deep breathe and cough.”

[A brief discussion ensues between them all about whether to provide Martha with a PCA or not. RN Fran then states the following]

\(^{17}\) To “Kick in” is to start or initiate an event
\(^{18}\) Oxycontin (oxycodone hydrochloride SR) is similar to Endone (see footnote \(^8\) on page 153), excepting that it is provided in a slow release format that will have a maximal onset after an hour or an hour and a half which will last for up to 12 hours (MIMS 2015b).
\(^{19}\) “Physio” is physiotherapist
“No PCA, she is ninety odd, and I think that we could give her some Oxycontin slow release or something, a little bit. So she has a background infusion going”

[The RMO concurs and goes into the room alone to review Martha before charting her a stat dose of 5mg SR Oxycontin and changing the PRN timing from TDS to 2nd hourly of the IR 5mg oxycodone.]

Martha was in severe pain. RN Fran intervened and succeeded in getting the weekend resident doctor covering the surgical ward to chart a combination of slow and instant release pain relief. RN Fran spoke of being an advocate for Martha and attempting to educate her about the importance of deep breathing and coughing. As she said:

Well, I guess (…), you just have to be their advocate and you’ve got to be (…) I just ask for a review by a doctor and I encourage them [the patients] to have their pain relief (…) I really explain to them why they need to have their pain relief, obviously (…) if they don’t get adequate pain relief, if they can’t breathe deeply you try and explain about the possible chest infection, pneumonia, and in the worst possible scenario, if it really gets bad you can sometimes die of it (…) you have to be an advocate.

[RN Fran interview 3]

Notably absent from the nurses’ pain stories was any input from the older person themselves, and this was due in part to the beliefs that the nurses held about pain in the older hospitalised person.

**Older people who deny having pain.**

When asked about pain in the older person a common response from all the nurses in this study was that many older people denied or ignored their pain and that they will not tell the nurses that they have pain like RN Elise did below:

You know, some of these older people ignore pain, they deny it or whatever. They won’t tell you.

[RN Elise interview 1]
Furthermore, as RN Clare commented below, that when in pain the older person will grin and bear it:

*I believe that a lot of them [older people] just grin and bear it.*

[RN Clare interview 1]

The overwhelming response from nurses in their conversations regarding pain in the older person was as expressed by RN Iona:

*They are very reluctant, to say that they are in pain. Most of them are; they are really!* [Nods head]

[RN Iona interview 2]

**Pain: Real and genuine.**

Four of the nurses in this study spoke about pain in the older person as real and genuine. For instance RN Fran said:

*Well, I think in a majority of older people the pain is real. Most old people have a high pain tolerance, so if there is pain, something’s got to be triggering it, because most of them walk around in pain anyway, so if they are yelling out in pain, nine times out of ten it’s a genuine pain.*

[RN Fran interview 3]

As opposed to RN Fran who spoke of the older person as having a high pain tolerance, therefore when *yelling out in pain* it was a genuine pain, the RN study nurses Georgina, Elsie and Danielle suggested older people had different thresholds for pain.

The RN study nurses Georgina, Elsie, and Danielle referred to patients with high thresholds as having genuine pain. When speaking of older people with intermittent pain or fluctuating pain, however, it was suggestive to this group of nurses that this was not genuine pain, and they did not perceive the presence of pain. RN Georgina came across as being unsure and spoke about intermittently having to *treat it like it is pain* and provide pain relief medications. RN Georgina made this point when making a
comparison of patients with different pain thresholds by comparing Hilda (78) who was complaining of neuropathic pain that came on at night in her feet as being like the boy crying wolf with Fleur (92) who had genuine pain from her fractured pubic rami. With reference to Hilda’s pain, RN Georgina inferred that it was not genuine:

> How Hilda handles her pain compared to what is wrong with her [pause 5 seconds] she goes “Oh I’ve got pain” then she moans and groans all night, on and off, all night but, [pause 10 seconds] it’s like the boy crying wolf sometimes, but you have to treat it like it is pain--- [be]cause sometimes it is and sometimes it isn’t---it’s really hard--- I don’t know. Especially when the lady in the bed next to her [Fleur] has a fractured pubic rami and she (...) genuinely did have a lot of pain when she was moving around the bed (...) but that’s two different people with two different pain thresholds. They are so different in their pain and in their pain thresholds.

[RN Georgina interview 3]

When asked to clarify more about the use of the term pain thresholds RN Elise spoke of knowing that the patients were hurting because they were rolling around in pain and agony but:

> Pain it’s like subjective, you know you have people who will be in pain with a low pain threshold and they will be rolling around in pain and agony. And yes, they hurt---but their pain might be minimal.

[RN Elise interview 2]

When RN Danielle was asked to describe patients with a low pain threshold, she spoke of older people as not being used to being in pain, so that for them the pain was unbearable. In her answer RN Danielle talked about a patient who had recently arrived on the ward:

> She’s [the patient] had a fall and fractured her [pubic] rami--- but you see for her, she’s got like, a low threshold, it’s like an unbearable pain and it’s not something that she is used to, and we are still not on top of her pain.

[RN Danielle interview 1]

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Reference to a 6th Century BC fable by Aesop about drawing attention to something that is not there only for it to actually turn up and kill you while nobody takes any notice (Aesop., 280 BCE/2002).
While the study nurses were adamant in their statements that pain was real and genuine, they used the term *threshold* to refer to the patient’s visual behaviours and ability to tolerate pain when in pain.

**Looking for wincing or grimacing as a sign of pain.**

The nurses in the study talked of relying on patients’ facial expressions as an indicator for the presence of pain. When asked to describe how she assessed pain RN Elise spoke of facial cues as being a *give-away*:

[Sighs] *how do you assess pain, what’s your biggest give-away, it’s your face!*

[RN Elise interview 3]

A reliance on facial cues, or the absence of these, was spoken about more so for those patients who had cognitive impairment or were unable to verbalise as well as for those who were dying. RN Barbara referred to *wincing or grimacing*\(^21\) when talking about Marcus (89) who had just been recommended for palliative care when she was attempting to interact or *rouse* him before providing pressure area care:

*So certainly this afternoon when I went and had a look at him [Marcus], I thought well your peripherals are warm, you are actually looking quite pink, perfused, you’re comfortable and he wasn’t wincing or grimacing when I was trying to rouse him, so I thought he was pain free.*

[RN Barbara interview 4]

The following exemplar shows how RN Barbara undertook a pain assessment on Marcus before turning him to provide pressure area care:

In this study one patient, Marcus (89) had indicated to his family that he wished to be included in the study before he deteriorated, but he became palliative in the middle of the night and was

\(^21\) Facial expressions
transferred to another ward (which is also part of the study). His family expressed his wish to be included.

[Reflective journal entry 20]

[RN Barbara picks up Marcus’ left hand and rubs his lower arm gently]
“Marcus, Marcus? Hmmm”
[Marcus’s hand is flaccid and he is unresponsive. He is breathing deeply and irregularly. RN Barbara then walks around to the other side of the bed and picks up his other hand, bends over and raises her voice. Marcus is still unresponsive.]
“How are you feeling Marcus? Look, can you squeeze my hand? You’re a little bit unresponsive”
[RN Barbara then pulls back the sheets and looks at his legs, they are swollen and bandaged. She leaves them exposed whilst saying]
“I’m going to have to roll you over, what do you reckon? We’ll do it as gentle as possible”
[Marcus has not responded. RN Barbara starts to put sheet under Marcus whilst the ward’s person gently turns Marcus a little bit on his back, his face is towards them and away from RN Barbara. Marcus makes a grunting noise of expelled air on being turned.]
RN Barbara then says
“I think he’s had a good effect from the morphine just pop your hands up here”
[To Marcus while she places them up on his chest]
“I think we can do it without morphine”
[She nods to ward’s person as they swap sides and then they roll Marcus fully on his other side]
“Over you go Marcus, not even a grimace he’s pretty good”

[RN Barbara observation period 4]

In the follow up interview RN Barbara was asked to talk about how she undertook a pain assessment on Marcus, given that he was no longer having his vital signs monitored. RN Barbara spoke about using observation on Marcus’s responses to her intervention. She inferred that nine times out of ten that it’s better to just finish the procedure and then give pain relief afterwards and as there was no pain assessment tool involved she inferred that it was all based on intuition:

Oh well it is observation [four second pause] you look for (...) if he [Marcus] is fidgety, looking bad or whatever [speaks softly] to see if they are as comfortable as the last time (...) hmm [nods head] and just make it a determination on their response to your
intervention. First you [are] looking (...) at how they respond to you once you have started your intervention. If it looks like they are experiencing any discomfort or pain, some people think that--- well it’s better to just finish the procedure, whatever it is (...) and then give pain relief afterwards, certainly nine times out of ten that is what would happen, but there is no tool involved, it’s all that intuitive stuff.

[RN Barbara interview 4]

The nurses in this study were observed to not use any formal pain assessment tool for those older persons who were unable to communicate or verbalise their pain. Although RN Barbara stated her responses to the presence of pain were often reactive, typically as shown by her gentleness in holding Marcus’s hand and rubbing his arm, nurses always provided touch for comfort.

**Pain comfort and care.**

Nurses offered comfort to the older patients with pain by simple gestures like touch and standing close by to those patients who they knew were distressed with pain. These intimate moments were poignant, brief, and typically used while talking to these patients as the nurses leant in towards them, as if to be physically closer as the following shows:

Belinda has polymyalgia rheumatica, a painful disease that restricts mobility. It is the morning on a medical ward and RN Ann has walked into Belinda’s room to give her medication. They begin talking. Belinda talks about a small improvement in her mobility with a decrease in her pain.

[Reflective journal entry 21]

[Belinda to RN Ann who is standing next to her]
“\textit{I was able to roll over on my side---on my own last night}”
“\textit{That will keep getting better Belinda, that's why we have to get you up and going}”

[RN begins to move away but comes back when Belinda starts talking again]
“I don’t know why I let myself get so bad”
“Well you don’t know about these things do you? [She leans in and rubs Belinda on her back and then strokes the back of her hand] Are you good then?”
“Yes”
“Ok, I’m here you know?”
“Thank you”

[RN Ann observation period 1]

The acute care wards are very busy; the nurses still often went out of their way to provide comfort through simple measures. RN Elise, despite doing an evening round of medications for all patients on the ward, still found time to get Jack a cup of tea and some biscuits before sitting down with him for a follow up assessment after he had a fall on ward:

No, no, no pain at all. It’s all good, it’s all wonderful, Jack sat up and ate his evening Tim Tams²², happy to have his cup of tea I got him.

[RN Elise interview 4]

The nurses in this study used a variety of means to provide comfort for the older person. They transformed common everyday items into non-pharmacological interventions for provision of comfort. Often with some ingenuity as RN Fran did for Ronald who had had abdominal surgery, she was observed to place a rolled up towel on his lap before asking him to hold it against his stomach before doing a deep breath and cough. During the follow up interview, she was asked to discuss this and she mentioned that her reasons were:

The rolled towel, it gives extra support, so they hold their hands on the towel and when they cough or take a deep breath, it helps to give support to the stiches and the abdominal wound, so when they cough they are using those muscles and it reduces the pain from those muscles twanging.

[RN Fran interview 1]

²² A type of Australian biscuit
RN Iona begin talking about how when the older person came out of the operating theatre that sometimes they just wanted a hot pack, but her ward was not allowed to have them, then she outlined how they made their own hot packs:

We don’t have heated packs because it has happened that we have heated it up too much and then it is not comfort for the patient it gives them a burn, well it doesn’t burn but it’s too hot and over time it burns, but we do [pause 8 seconds] make our own heat pack (...) you get a towel, wet it and put it in the microwave. The warm blankets cannot stay warm for that long, sometimes all they need [the older person] is a bit of heat pack somewhere along their body to an area when they come out of the operating theatre, so we make that for them.

[RN Iona interview 2]

Nurses in this study were observed to provide comfort by touch and being close to the older person to make a connection, and by transforming common everyday items into non-pharmacological interventions for provision of comfort. Later in their interviews the nurses referred to this as being part of the more positive and rewarding aspects of nursing.

Positive nursing care.

RN Danielle said that positive nursing care of older people meant the nurses could discharge patients and send them back home:

I really like the concept that somebody comes in\textsuperscript{23} [here] because they can’t be discharged from hospital\textsuperscript{24}. We are able to send them back home how they were hopefully or just with services. That’s pretty good, rewarding [and] it’s really positive nursing.

[RN Danielle interview 2]

RN Barbara talked about the importance of gaining pain background information about their patients to compare and contrast:

\textsuperscript{23} To the Sub-acute ward
\textsuperscript{24} Are unable to be discharged from acute care to rehabilitation wards
You want to get a little bit of pain background on your oesteos, like what are you living with now. What’s it been before and how does that compare to now.

[RN Barbara interview 3]

Whereas RN Ann spoke about her goals for the patient’s pain as being important to be able to walk around and mobilise:

Well I’d like to be able to get on top of Belinda’s pain, but these people, the oesteos^

^25: well [they] have had their pain and the oesteo a long time. So they are never pain free. But to be able to move, walk around and get to the toilet that’s important.

[RN Ann interview 1]

When speaking about working in sub-acute RN Elise pointed to a picture cut out from the newspaper that they had pinned up on the wall:

Like this one lady that was here with a fractured pubic rami, her photo was in the paper [points to cut out of a newspaper article with picture on wall], she made it to one hundred years! It was, Oh! I saw her there [in the picture on the wall] and I went ‘Oh wow I looked after her [and] look at her now, she’s put on weight [a higher tone of voice and spoken fast] da da da dar and it was just wonderful, because I remember all she just wanted to do was--- [just] go out to the sailing club for her hundredth birthday (...) Oh it’s just wonderful---it’s just beautiful---we got her there [sighs] it’s really nice.

[RN Elise interview 1]

Having a connection and achieving goals of discharge home, maintaining dignity and using pictures of the older person completing milestones in the community was important and seen as positive aspects by the nurses in this study. How the nurses developed this connection in relation to pain began when they undertook an assessment within their ward rounds.

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^25: Those with osteoarthritic pain
The ward round and pain assessment

The main activity that nurses were observed to engage with in the acute care environment was the ward rounds. Doing a ward round was essential to good pain assessment and management. These rounds included medication administration, assessment of vital signs including pain and wound care. The types of events which interrupted a round and led to the nurses interrupting the round were situations or instances when other patients on the ward had deteriorated and required a rapid response call. Undertaking a clinical round influenced pain assessment and management, more so when there were rounds of vital sign assessment and monitoring, because this was the time that the nurses not only asked, but also documented the patients’ responses. Notably however, it was during a round of patients for vital signs recording and assessment that nurses asked for a pain score. RN Georgina talked about her pain assessment approach during a round of vital signs:

*I ask people every couple of hours when I do their OBS\(^\text{26}\) “and how is your pain at the moment and is it a zero?” That sort of thing being out of ten.*

[RN Georgina interview 1]

The nurses commented that the documentation on the SAGO\(^\text{27}\) chart and pain assessment was part of vital sign monitoring during ward rounds. With RN Elise noting:

*Well yeah here it’s your sixth vital sign or is [it the] fifth? [She begins counting off her fingers] Resps---sats---heart rate---temp, and blood pressure. Nope it’s your sixth.*

[RN Elise interview 2]

In this study, observations of nurses undertaking vital signs recording and monitoring at night meant that they had to disrupt the older person when sleeping. The following is an

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\(^{26}\) OBS meaning observations of vital sign monitoring

\(^{27}\) See glossary
excerpt from my reflective journal when an older person was observed to be woken for vital signs assessment and monitoring:

It is late, 22.30, and dark. RN Georgina is doing a round of OBS with a machine that makes a bustle of noise with its electronic beeps during use. When she moves it from patient to patient it emits a clatter from the rattling of the temperature probe and blood pressure cuff in its metal basket along with its wheels that squeak loudly. She has moved across from the four bed room of men and is now in a four bed room full of female patients, who all have their curtains drawn with their lights off. Astrid is the third patient to have her OBS done as RN Georgina is moving in a clockwise manner in the room. She pulls back the curtain and goes towards Astrid who is lying in bed, while trying to not shine her torch in her face she reaches over and turns on the night light. My eyes are dazzled yet again by the light and Astrid looks startled as she blinks sleepily in the light.

[Reflective journal entry 62]

The pain enquiry: a score out of ten.

The study nurses asked the patients, *can you give me your pain score out of ten*, with this question the same for all patients regardless of the ward setting and hospital. Furthermore this question was asked when the nurse was taking vital signs. It was rare for this question to be asked at other times. Typical approaches to an older patient were:

*Have you got any pain? Can you give me a score out of ten, if ten is the worst and zero is nothing? Can you give me a score?*

[RN Danielle observation period 1]

Or

*I need you to rate your pain from a zero being none to the other being ten for the worst.*

[RN Fran observation period 3]

And

*How’s your pain if ten is the worse pain you have ever had and zero is none?*

[RN Clare observation period 1]
The older patients were consistently asked to either ‘rate’ their pain, state ‘how’ their pain was or to provide a ‘score’ according to a numerical value between zero; ‘none’ or ‘nothing’ and ten being; ‘the worst’. The value attributed to the zero score by nurses was nothing or none. Interestingly the term applied to the score ‘ten’ was always noted as ‘the worst’.

Modifications in the way that patients were asked occurred rarely. These instances were times when the older person was asked to provide a numerical value for their pain that applied temporally within the ‘moment’, as opposed to an invitation for the patient to speak about pain felt previously:

So what’s it out of ten at the moment?

[RN Elise observation period 2]

The nurses used pain scores during the vital sign rounds for assessing the effectiveness of the medications given to manage pain. Such as when RN Ann asked Simon below about his pain after having given him some pain relief earlier when beginning her vital sign round:

How’s the pain now? If ten outta ten is the worst what would you rate it as now? You said that it was ten out of ten before, what’s it now?

[RN Ann observation period 1]

Importantly regardless of the manner in which it was undertaken, when an older person was asked to provide a numerical value for their pain they would not be given any education from the nurse in relation to what the value meant.
Understanding the pain scale.

The nurses all appeared to presume that the older person knew what they were talking about when they asked them to either rate or score their pain. I noted in my reflective journal that:

At no time have I seen any nurse show the patients what an actual pain scale looked like, nor have I heard it explained in any detail to them. Furthermore never was any other alternative pain scale tool used or offered by the nurses for the older person to use.

[Reflective journal entry 68]

So when the older person provided an answer that two of the nurses in this study felt was inconsistent, they spoke of the older person as not understanding the pain scale.

When RN Clare was asked what influenced her when asking for a pain score in her reply she referred to applying it for the older person who was able to understand the scale:

I think that the scale [numerical rating scale] is quite good for [assessing] pain, so long as they [the older person] can understand the scale.

[RN Clare interview 1]

RN Fran expressed her concerns about the older person as not understanding the scale and when asked to talk about this more she referred to Martha who had been admitted with multiple fractured ribs. In particular RN Fran inferred that Martha did not perceive her pain the same way that she (RN Fran) perceived her pain. As Martha was unable to deep breathe and cough which for RN Fran meant that a score of 8 out of 10 was required, not the 2 out of 10 voiced by Martha. RN Fran suggested that despite explaining to her this was due to Martha not understanding the scale:

I mean if you ask her [Martha] if she's in pain, how she perceives her pain and how I perceive her pain is two different
things. You ask her to rate her pain and she says 2 out of 10, yet she can’t deep breathe and she can’t cough. So to me that should be 8 out of 10, but no matter how hard I tried to explain to her, I couldn’t get her to understand the scale.

[RN Fran interview 3]

Despite the fact that RN Fran believed that Martha did not understand the pain scale and how it was used to rate pain, the following exemplar suggests otherwise:

RN Fran gets Martha to mobilise up the bed by standing up and taking three steps sideways to move up, then she sat down on the side of the bed and then lifted her legs across on top of the bed. This exertion has made Martha breathless, I can hear her increased rate of breathing and she becomes agitated. Martha is grimacing and calls out in pain.

[Reflective journal entry 57]

“Ohh! I don’t really like these [gestures towards the nasal prongs]. You’ll get cross at me I know. You won’t forget me!”
“You’re unforgettable love [dryly] I’ve been in here sorting you out for the past one or two hours”

[RN Fran then stands with her hand on Martha’s right shoulder next to her and puts the NP back on. She imitates taking a breath and Martha then attempts to copy her]

“Alright Martha, listen to me, I need you to rate your pain from a zero being none to the other being ten for the worst. Now take a deep breath for me”
“Ohhh a one!”
“Now breathe out and cough”
“Hem”

[Martha does a very slight cough, RN Fran replies by imitating a hearty cough]
“No. hrrupmph! A bigger cough- does it hurt?”
[Then Martha smiles]
“A little bit-a five”

[RN Fran does a big sigh]
“[Sigh], So how much is a little bit?”
“Five”

[But RN Fran turns away]
“Hmmm I don’t think that you really got the concept”
[While Martha looks towards me and she says]
“Well it’s a bit better; it doesn’t grab me as much”

[RN Fran then walks off with the OBS machine and checks on another patient]

[RN Fran observation period 3]
The above exemplar highlights the difficulties encountered when attempting to assess pain by use of a pain scale. The comment by RN Fran about Martha as *not getting the concept* was a term used by the nurses to refer to those older persons with a cognitive impairment as not understanding the concept of pain. This is discussed in more detail in findings Chapter eight: Pain care, tension, and disjunction within the section Pain care and cognitive impairment on page 267.

It is important to note that Martha does not have a cognitive impairment and her pain is multifaceted and complex. There is a sense of a lack of clarity on which pain is actually being assessed, as when Martha initially undertook a deep breath she rated that experience as a one out of ten as well as not coughing per se, but providing a score of five for when she did. This is suggestive that RN Fran who, despite her listening, is not hearing what Martha has to say. It also appears that Martha does understand the pain scale and its application, and to a certain extent it is suggestive that she is merely unsure about which pain to apply it to. This is because the older persons in this study found it difficult to provide a singular numerical value to rate multiple sites and types of pain.

**Rating multiple sites and types of pain.**

The nurses in this study spoke about relying on the pain score responses provided by the patients. For instance when RN Clare was asked if the type of surgical procedure undertaken influenced how she assessed pain she said:

*I think that it probably makes me empathise with them a bit more---but---at the end of the day everyone’s pain control, their threshold is a bit different (…) people’s perception of pain and their procedures are a bit different (…) you really have to go by what or how they really are expressing it.*

[RN Clare interview 1]
The following exemplar shows, however, how difficult it was for the older person to provide an answer when asked to rate multiple sites and types of pain. Janet (68) has had gynecological surgery and informs RN Clare that she has two separate sites of pain being the *front pain* from the incision site and *my other pain in tailbone*:

It is a busy morning on the surgical ward. RN Clare is doing a round of OBS. She asks briskly “How are you?” while reaching for Janet’s (68) arm to connect the BP cuff

[Reflective journal entry 35]

[Janet replies by saying]
“I’m ok I did a wee”
“Good. How’s your pain if 10 is the worse pain you have ever had and 0 is none?”
[Janet replies by indicating that she has two sites and types of pain]
“I’m saying that it’s really good, my pain is almost but not gone- but my other pain in tailbone is still there”
[RN Clare sounds perplexed]
“So I, your saying that- err you do have pain then?”
[Janet then points to the front of her abdomen then to her rear]
“That's the front pain, that is almost gone, but the other pain in my tailbone is still there, yeah”
[RN Clare then gives Janet a numerical value out of ten to represent her pain]
“So I will give you a half then, I have never given a patient a half before so do you have pain?”
[Janet frowns and comments that]
“It’s dicky”
“Dicky sore?”
[Janet then nods sagely]
“Sore”
[RN Clare then laughs and writes up the OBS]
“Right I will give you a one outta ten then”

[RN Clare observation period 1]

Despite apparently indicating that she had two separate sites of pain, Janet was given a single numerical score by RN Clare. When asked to talk about Janet, RN Clare began to talk about her having a *more complicated procedure* resulting in knowing *that she was probably having a bit more pain with that*:

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28 Janet has passed urine
29 RN Clare then left the room to get Janet 5mg per oral of Endone
Initially what Janet said to me was “No I’m not that sore” (...) but what they actually did for her procedure was[^30], (...) [and that has] given her a lot of her pain. So what she said to me was that “No the outside is not that sore, but inside” [and] well (...) I knew that was her main focus of pain.

[RN Clare interview 1]

Of note in the above exemplar is that commonly while the nurses in this study often spoke about what they would like to do in situations, being a reliance on the verbalisation of a pain score, in actual clinical practice often a numerical was provided by the nurses themselves. Regardless a singular numerical pain score would be documented with many of these actions however occurring within the context of quality assurance audits and the threat of the ward getting a black mark.

**Being audited and the ‘black mark’**

The subtheme *Being audited, and the ‘black mark’* outlines the nurses’ experiences of the mandated compliance with hospital policies and procedures for pain documentation. Both study hospitals used the Standard Adult General Observation chart (SAGO) as shown in Appendix 1 on page 373, which requires nurses to place a single numerical value to represent a patient’s pain or pain score. When speaking about pain score documentation, RN Barbara picked up a SAGO chart and opened it to show the location of the pain score section and whilst jabbing with her finger stated that it was the *only thing* for pain documentation:

*The only thing [form] that you have got for pain, if you ask any nurse, she’d actually go “That one” [opens up a SAGO chart]. Where is it? [Hand hovers briefly before pointing to the numerical pain score scale on SAGO chart] there [jabs finger].*[^30]

[RN Barbara interview 3]

[^30]: Surgical intervention for an anterior and posterior repair of sacrospinous plexy
The reasons provided by most nurses for recording pain scores on the SAGO chart was for when they do an audit. RN Fran said this meant not getting a black mark against the ward:

Well the fact is, if you are taught anything about the SAGO is that you must ask them [patients for a pain score], for the reality is, if you don’t fill it in---when they do an audit [4 second pause] the whole thing is wiped and it is naughty. Right. So when you do the SAGO, if you have not got the three stickers on the top [taps table to emphasis the point] if you haven’t got everything filled in (…) if any of that is not filled in, then that is a black mark---a black mark against the ward.

[RN Fran interview 1]

The onus on not getting the ward a black mark was placed onto the study nurses themselves, with RN Georgina talking of it being my pet thing to check on her colleagues for compliance in regards to having everything filled out on the SAGO chart:

I don’t think that it [the SAGO] gets filled out as good as what it could be and I do check it, it’s my pet thing having everything filled out (…) A lot of people were missing the pain score--- like it wasn’t being filled out [and] you know what? Then people just wrote zero out of ten, zero out of ten, zero out of ten, zero out of ten (sighs and groans) (…) now I think “Duh!” someone has just put in that score so as to fill it in, just filling out the numbers, they haven’t really asked if they have pain, they have just done it--- scribbled it in and done it to say that the paperwork has been done.

[RN Georgina interview 1]

One nurse, RN Barbara, questioned the notion of a good audit and she said:

Ok we may get 100% in our audits but is that really a good audit? You know, are you [Jabs table with forefinger] addressing it on your feet? That [pain score numerical value] means nothing to me, apart from “Have you got pain?” I mean what kind of pain is it, where is it--- what does it do? Where did it go---what’d [you have to do] about it?

[RN Barbara interview 3]

31 The hospital based quality improvement section does random audits of patient notes and documents along with assigned CNC or CNS nurses whose position role requires them to undertake spot checks on the ward for compliance. This information is then delivered back to the NUM of the ward.
When talking about the benefits of using the SAGO chart, RN Fran spoke of her personal *empowerment* to use the chart as a prompt to ask patients and its use as proof that she had asked her patient about his/her pain:

*I like the SAGO charts because it really gives you a little bit more empowerment. I also see that a good part of it is [Taps table with forefinger to emphasis point] “Well why didn’t you check their pain?” [and that is] because it is written in there as proof, but also when a patient says “Oh I have been lying in bed all day no-one checked on my pain, and no-one asked me!” They can say “Well yes that nurse did--- look [taps table] see, it’s signed there”.*  

[RN Fran interview 1]

The comments by RN Fran however, suggest that some patients may not be aware that their pain has been assessed.

**Pain charts: nobody reads them, we don’t use them.**

Although the study settings in both hospitals used different forms for recording comprehensive pain assessments and the nurses said *we don’t use them* because *nobody reads them*. RN Ann spoke about not using the comprehensive pain assessment tools:

*Oh those pain charts, they are so---nobody reads them---we don’t use them and we don’t fill them in and really, they are not ours. They are hospital wide, but a new one is coming and we won’t be using that one any more thankfully.*  

[RN Ann interview 1]

Similarly when RN Elise was asked if she used a pain chart for documentation of a patient’s pain her response was:

*No we haven’t got one. We have it on our SAGO chart and that’s where we write it on there---that’s what it is used for.*  

[RN Elise interview 2]

It is important to note that the SAGO chart is not a chart that provides comprehensive pain assessment, but it allows placement of the documentation of a singular pain score
and has no facilities for any further input in relation to a pain history and or onset of pain etc.

**Bedside clinical handover picks up pain.**

Newly introduced into both hospitals was the notion of the ‘clinical handover’ which required nurses to walk to the patient’s bedside during their change of shift to sight the patient and handover or exchange relevant patient information. As RN Danielle noted:

*We haven’t got to the bedside yet, but we have moved closer to the doorway.*

[RN Danielle interview 3]

Whereas RN Clare spoke of the bedside clinical handover as being an awful chore, that people [staff nurses] took it a bit personal as their care was being checked but at the end of the day it’s not a blame game. However, she noted that there were benefits in picking up aspects like patients being in pain:

*We are beginning to see the benefits of it, just takes a bit more time (...), you pick up things, like about their pain and how it has been managed, particularly if they are not going to come forward to you and not say that they are sore, so if you actually ask them, then they will answer you, and other things (...) like is the suction is working, absolutely everything is getting checked, every shift and it is a form of accountability, and people can feel a little bit “oh I didn’t do that because”, and they can be a bit personal with it if you are checking up on their work. But really at the end of the day it’s not a blame game, it’s a let’s see if we got it done, if you haven’t, don’t worry, I’ll do it.*

[RN Clare interview 1]

Having a bedside clinical handover had advantages when it was undertaken. RN Fran spoke about the nurse from the previous shift verbally handing over to her that Martha (90) was pain free. However, on walking into the room she found that the situation was otherwise, that Martha was slumped in the bed and unable to take a deep breath and cough:
Well at handover, the person handing over [nurse] thought she had adequate pain relief on board, that Martha was fine [and] set up all day for deep breathing and coughing. Well, I walked in [to Martha’s room] and said “Will you take a big deep breath for me darling?” and she could not. I sat her up first and I thought maybe it was that she was all crunched up in the bed, and even after doing that, she still couldn’t take a deep breath.

[RN Fran interview 3]

RN Fran spoke about her distress at finding out that Martha had not received enough pain relief and she put this down to the inexperience of the nurse who was on before her:

Well [throws hands in air] Martha didn’t have enough pain relief on board, So consequently, that junior nurse who is only new to the job, and inexperienced, didn’t pick up on that, they will think that Martha’s fine, but as they get more experience, they will realise that what Martha was like, [it] is just not adequate, [points finger across table at me] Martha needed more pain relief even though that junior nurse [taps table with her finger] didn’t think she did.

[RN Fran interview 3]

RN Barbara also spoke about having an issue with newly graduated nurses about not documenting the care that they were providing during the bedside clinical handover process:

We are trying to educate all the new RNs what you do and it’s like the constant walk around bedside clinical handover--- because you can look at what’s going on and you go---- you haven’t written that in the notes, you told me that on the oral handover but its [taps table to emphasis] it’s not reflected in your written notes.

[RN Barbara interview 2]

**Review and summary**

This theme, *Nurses’ experiences of providing pain care for the older person* outlines the context and environment in which the study nurses attempted to provide pain care for the older hospitalised person. Outlined were the nurses’ attempts in providing
leadership, mentoring and education for others for problem solving pain in the older person. Presented were the stories provided by the nurses that motivated them when providing pain comfort care for the older person. Captured within the context of ward rounds were the processes undertaken by nurses to assess pain within an environment of auditing and compliance.

When being a leader for problem solving pain issues and concerns, for the nurses in this study this meant an attempt was made by them to ensure that they were available and approachable for their colleagues. This, the nurses in the study commented, was in order to facilitate opportunities for leadership, mentoring, and education whilst often having a patient load; however, they did not speak about the EBP resources nor were any observed to be used or referred to for input. Similarly, the nurses in this study alluded to having a lack of formal support for education provision and its implementation. The manner spoken of by the study nurses in their provision of education to junior transitional nurses was that of questioning, covert observation, and then checking by looking for wincing or grimacing of the older persons’ pain before provision of a statement about their assessment of that situation. The nurses in this study excluded the older person from engagement with their processes and approaches that they undertook when they were providing problem solving solutions, leadership interventions, reflection for mentoring, and education.

When the nurses in this study shared stories about being an advocate for the older person with pain, defining aspects of their advocacy included repetition of asking doctors for a change and increase of the strength of the medications charted, perseverence with asking different doctors to undertake this, and time. These were also key factors in the development of positive change for the management of the older person’s pain. The reflective statements made by the nurses in this study suggested they
know when an older person has pain, however, they retracted these statements by adding that the older person will not tell them that pain is present. The nurses spoke of believing that the older person had real and genuine pain, but also inferred that the older person has differing levels of what they termed was a pain threshold. A reliance on facial cues was spoken of as being an indicator of confirming the presence of pain, in particular, wincing or grimacing. What was termed by the nurses as sign language was relied on for those with a cognitive impairment. Throughout the study, the nurses employed provision of comfort for the older person by brief transient intimate moments of being close or use of touch when speaking about pain. The personal rewards that the nurses in this study felt when providing pain comfort were spoken of as being able to get the older person home and wanting to find out what their pain background was as well as setting goals and having reminders like newspaper cuttings of previous patients for inspiration. Nonetheless the efforts of advocacy pain success stories told by the nurses in this study are noticeable by the marked absence of input from the older person themselves within these stories.

Undertaking ward rounds by the nurses in this study was an attempt by them to provide continuity of pain care for the older person and this was gained by asking the older person to provide a singular numerical value for rating of the intensity of their pain. Presented were the efforts to provide education for the older person on how to score their pain. Captured were the difficulties encountered by the nurses when the older person had multiple sites and types of pain when they were trying to gain a singular pain score as a representation of their pain. Presented was how the nurses typically responded when in this situation by either being dismissive of the value provided or alternatively their active provision of a numerical score for the older person in order to comply with pain score documentation requirements.
The nurses in this study spoke at length about the importance placed on them for compliance with auditing of the SAGO chart, which they indicated was the only place for pain documentation. Furthermore it was suggested that compliance with auditing meant that these SAGO charts required 100% completion. Compliance with completion with documentation was spoken of anecdotally as being in relation to maintaining the high standards of that ward, and being seen to maintain the reputation of the ward by not gaining a black mark against it. The nurses in this study suggested that while comprehensive pain assessment charts were available for their use in the clinical setting to document assessment and management plans for pain they were not used, meaning that continuity of pain care was not documented. The bedside clinical handover was spoken of in positive terms in relation to the benefits for the study nurses to be informed about the clinical practices that the junior nurses had undertaken, and in particular, they spoke of its benefits for inclusion for education at the bedside. The clinical bedside handover, however, for the older person did not provide continuity for their pain story to be heard by the nurses from shift to shift.

This concludes the chapter of RN experiences of providing pain care for the older person in acute care. The following chapter presents the older persons’ perceptions and experiences of receiving pain care from nurses in the acute care environment.
Chapter seven: The experiences of the older person when receiving pain care

Chapter Introduction

In the previous chapter, I presented the experiences of the nurses when providing pain care for the older person. In this chapter, I present The experiences of the older person when receiving pain care. Here I explore the perceptions and experiences of the older person in relation to receiving pain care from nurses. The experiences of the older person when receiving pain care comprises three subthemes: not being heard, lost pain stories, and waiting in pain.

The first sub theme, Not being heard, depicts the older persons’ experiences of not having their pain concerns heard by the nurses who cared for them; or sometimes their pain was not believed. Yet, the older people in this study expressed the presence of pain through gestures, sounds, words and statements. They spoke at length about their experiences of having the same and constant pain while in acute care. This sub theme also captures the older persons’ reflections on having pain inflicted by nurses during clinical procedures such as insertion of IVCs, how they anticipated pain and the concerns when their complaints of pain were not believed. Not being heard for the older person meant that their stories about pain were not heard.

The second subtheme, Lost pain stories, provides insight into the older persons’ stories of having multiple sites and types of pain and of having these important pain histories lost during clinical handovers throughout their hospitalisation. Insight is gained into the difficulties experienced when being asked to provide a single numerical value for rating
the intensity of pain. The attempts by the older persons in providing a numerical value that includes their multiple types and sites of pain are shown. The story provided by Molly in recounting her pain story provides an evocative insight into the experiences of these older persons when their pain story was lost and the impacts that this had on them.

The final subtheme, *Waiting in pain*, begins with the retrospective accounts of both Simon and Molly in this study talking about their experiences of waiting in pain for analgesia to be provided by their nurse. Sally’s request for pain relief being forgotten is presented within the context of her nurse prioritising completion of a round of vital signs. The accommodation made by nurses engaged in a medication round in relation to Donna during her pain crisis is outlined. Captured as it unfolds is a description of the pain care provided by RN Clare for Brianna who is left waiting for a review of her pain by the treating team. Presented is the proactive response by Ninnette who managed her breakthrough pain. Insight and understanding is provided by the older patients in this study with advanced cancer diagnoses who used personal stocks of analgesics and adjuvants whilst in acute care without the nurses’ knowledge.

**Not being heard**

The sub-theme *not being heard* highlights how the older person clearly attempted to express the presence, the nature and their experiences of pain. Understanding is gained from exploration on how the older person will talk about the locations/s, their experiences of the nature, types and intensity of their pain/s. This sub-theme also captures the ways that the older persons in this study expressed, verbally and non-verbally, the extent of pain, as well as how they attempted to communicate their needs for pain relief. While the nurses listened to their comments about pain, often the older persons in this study felt they were not heard, despite clearly expressing the presence of
pain. This sub-theme also shows how some of the older patients endured their pain when they were not heard.

**When pain was not believed.**

Some of the older people in this study spoke about their feelings of anger, frustration, and annoyance about their experiences of not being believed about their pain. Brianna, who experiences chronic pain, talked about not understanding why a person would do that:

$I don’t understand that type thing, why would you say that you have got pain, when you haven’t type of thing?$  
[Brianna interview]

Older persons in this study spoke about that when their score of pain was not believed. They felt that they were being questioned by nurses about the accuracy of the score, the validity and extent of their pain. They described the importance nurses placed on being able to see the reason for, and the location or source of pain. For example, Ninnette (66) said it was *easier to have something to show as evidence* when speaking of her attempts to convince the nurses about the presence of pain when seeking pain relief. Ninnette talked of walking up and lifting her gown at the nursing station to expose and show those nurses present the painful rash on the base of her shoulders was the same as that on the side of her neck. Ninnette affirmed that it was *easier to have something to show* instead of *having to explain*:

Well it is easier to have something to show; well I think that for me it is easier, so I [can] go like with my neck, I showed you that, the rash that is there. That is all the evidence that I have and it is much easier to have something to show. Instead of explaining to people [nurses] I go “here--- look at this”, it is difficult to describe things to people, it is not always easy, that’s for sure.  
[Ninnette interview]
The older persons in this study expressed their lack of understanding for why a person would state that they had pain when they did not, and they perceived that the nurses required visual evidence of the presence of painful sites.

**Pain words and statements.**

When expressing the presence of pain, older participants used a combination and variety of words such as:

**Pathetic; it’s there all the time, and the pain was all over... Terrible amount of pain, sore, horrible level of pain, absolutely atrocious, it was so intense jamming all me joints, no movement between your bones, it struck me down.**

They also used terms to describe the nature of their pain such as:

**Dull ache; gripping, aches and pains, it gets itchy, numb and tingling, locking, burning, thunderous, constant, bad pain, flashing, It’s a sharp pain, like a throb. A shooting sharp pain, like a churning sensation, only a Panadol bad, a sharp sting, the worst pain, blinding headache, like a zap, hurts like buggery.**

Peter (73) employed the use of analogies to paint a picture when asked to share what his experience was like with pain from rheumatoid arthritis:

**Well [holds his leg up and demonstrates by pointing] the whole leg heats up, the whole joint heats up [is pointing to areas around the knee] and [it] gets red, inflamed--- hot [lifts hand away] and the bones just like grind, because there’s nothing in between them.**

[Peter interview]

When asked to talk about their pain to me, most of the older people in this study did not use a numerical value despite the fact that during ward rounds nurses asked them to rate or score their pain out of 10 as described in the previous chapter. Brianna gave a numerical value for her pain when asked however; she was a patient with chronic pain for 12 years. She still added a verbal descriptor when asked about her pain:
It’s sore today, six out of ten. [Brianna interview]

After prompting by their nurse, the older person then would provide a numerical value for their pain. Consistently the older persons in this study used any number of combinations of gestures and sounds to represent pain in their attempts to find a number to appropriately rate the intensity of their pain.

**Gestures and the sounds of pain.**

The older persons in this study were often observed to use hand, body, and facial gestures when expressing their pain. The use of these gestures supplemented and enhanced speech or they were deployed independently of verbal expression as they gestured in silence. These gestures were actions that appeared to be recognised and accepted as a symbolic representation of pain by both patients and nurses. The pain gestures observed in this study included facial wincing and flinching away from the pain source, and raising arms to block or guard pain sites. When the older person was observed to use these gestures to express pain it was usually as a way of demonstrating escalation of pain. The gestures used by these older patients suggested intense pain; they were active expressions of pain by the older person who was intent on establishing the veracity of their pain, to confirm its presence. The pain gestures used by the older patients were explicit in their deployment; for example, when patients actively blocked and deflected the advances of nurses who were intent on interrogating wounds for example.

When expressing pain through facial expression each older person had their own individual and unique mannerisms. At times their facial expression was brief or fleeting, and other times their expressions were held for a sustained time with intent by the older
patient to signal pain. The following typifies Suzanne’s (65) expression when experiencing pain:

Suzanne’s body again went stiff and tense. Her face is screwed into a knot, her lips are white and compressed but she makes no sound. She is staring intently in the other direction; her body is tense and rigid, her face fierce with awareness.

[RN Hermione observation period 1]

Instances when the older person’s pain experience became too much resulting in them blocking or deflecting out at the nurses was rare. The following exemplar highlights the circumstances that led up to this occurring when Jack (94) who was having his head wound redressed, found it was too painful for him; he waved his arms around as if to ward off the nurses. Captured are responses from both the wound CNC and RN Danielle who both withdrew from his reach to avoid injury. Afterwards, when asked to talk about what had happened, RN Danielle replied that:

Well the first thing I did was look for some pain relief for him [Jack] and I conferred with her [the wound CNC] and I said if I give him this [pain relief] then you can do your procedure after-- so letting it take effect (…) Once the pain relief started working, then we could restart the procedure. He [Jack] was happy with that, and I made him comfortable and he was no problems and everything was fine.

[RN Danielle interview 1]

However, the situation was a lot more complicated, complex, and different to that which was recounted later that afternoon by RN Danielle:

Jack (94) arrived at 0715 onto the ward. It is now 10.00. On his head is a clumsy looking crepe bandage, underneath it is the dressing pad, a ‘combine’ has been placed directly to his wound, it is covered in dried blood and adhered to his scalp by some tape. RN Danielle has paged for the wound CNC to assist. Firstly, they put water on the combine to dissolve the blood.

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32 It is unusual for patients to be transferred so early in the morning into other wards, normally a ward will wait until nursing handover is completed, typically after 0730
33 A combine is a basic absorbent dressing pad that has no non-adhesive covering
34 This was to help stop it from sticking to the wound and ease its removal
then they both stand on either side of Jack and begin picking and pulling at the tape.

[Reflective journal entry 36]

[Jack is sitting on the chair next to his bed, he calls out in pain and his face is grimacing as soon as they start]
“Ohhhh”

[RN Danielle puts her hand on his shoulder and leans around in front of Jack, looks him in the eyes and touches him on the leg]
“Sorry Jack, it’s not the best stuff that they have put on. Bit sore?”

[Jack’s face is grimacing more in pain and he lifts both arms up to his head and calls out in pain again]
“Ohhh! ---ohhhh ---it’s---it’s”

[RN Danielle then asks him while she and the wound CNC are still removing the dressing]
“It’s a bit tender there?”

[Jack replies shortly and sharply]
“Yes! A bit tender!?!?”

[RN Danielle then begins to ask Jack if he wants any pain relief. Both of them are still going, faster if anything]
“If we give you something to take the pain away”

[Jack interrupts her by waving his arms and they both have to step back, both have pulled their heads away as to not get hit-the dressing pad has been removed then Jack gasps in pain before responding]
“Can you?”

[RN Danielle looks across to wound CNC]
“Yes, then can I put you on the bed and give it [his head lac] a wash? Have you got any pain? Can you give me a score out of 10, if 10 is the worst and 0 is nothing---can you give me a score?”

[Jack’s face is a fretwork of wrinkles and his hands are still raised in the air he begins to wave them around]
“Ohhhh more than zero”

[RN Danielle looks across Jack’s head to the wound CNC and says to her]
“Ok it’s more than zero, but he can’t give me a number?!”

[She then enters into a discussion with the wound CNC on what to give him- they both consult his chart before the wound CNC points out]
“Hmmm look here, Panadiene forte- let’s give him that”

[RN Danielle then picks up chart and walks out with it with the wound CNC to check out some Panadiene forte for Jack. After getting the drug out they give it to Jack and the wound CNC goes to the dressing trolley for five minutes which is out in the hallway before wheeling it in and she recommences removing the stitches]

[RN Danielle observation period 1]
When asked to talk more about what hampered her RN Danielle spoke of her shock, that she wasn’t expecting the extent of the wound:

_That was a bit of a shock actually. I wasn’t---I wasn’t expecting that underneath that, they didn’t actually hand that over--- I took hand over this morning (...) they said he just had a small laceration (...) Hmm! I wanted to get a more expert opinion about that dressing for that wound, it was [the dressing was] totally inappropriate (...) poor man it hurt when it came off, so he had the pain relief which is good [spoken quickly] Panadiene Forte, and he was fine then._

[RN Danielle observation period 1]
The reactions of RN Danielle in asking Jack to rate his pain and her comments to the wound CNC nurse are indicative of her lacking confidence in her own ability to discern the level or intensity of pain that Jack was experiencing. The lack of leadership from the wound CNC in relation to pain management is also apparent. Absent from this exemplar is Jack’s version of events owning in part to the distress that he was experiencing and also that the next day he had a fall which was contributed to him having developed a delirium.

Sometimes the older person involuntarily gasped in pain; “Ohhh”, a strangulated cry of “hrrrnuph” and “ouch!” or “Ow” when they were in pain or when their pain escalated. At other times the older patient seemed to be unable to articulate any sound; the pain was too much to bear. Instead they made a sound associated with a sharp intake of breath that was held and expelled slowly with pursed lips, while their faces were distorted, contorted with fretful grimace: unable to verbally articulate at all. Silence was also an expression of pain as the following extract from Ninnette’s (66) interview shows:

_It was just [silence 5 seconds, she then scowls] the pain was soo severe._

[Ninnette interview]
The older people in this study relied on the use of analogies to mimic the sound of their pain when attempting to convey pain that went beyond words. Whilst difficult to replicate within text, the use of mimicry was powerfully distressing, and once heard it is hard to forget. For instance, Molly’s (73) cancellation of her surgery for a hip replacement, because she had a cardiac problem\textsuperscript{35}, left her still in considerable pain. In the following quote, Molly provides both verbal descriptors and mimicry to express the nature, extent, and intensity of her pain: the pain of bone grating on bone:

\textit{You can hear me bones going crunch crunch crackle pop when I walk. My bones go [imitates the sound of crunching bone] when you get up in the morning. You can feel it and hear it going [imitates the sound of crunching bone] you stand up at the toilet to pull your pants up [imitates the sound of crunching bone again] it’s that awful.}

[Molly interview]

The older persons in this study used a range of means to express the presence of pain other than gestures which included stiff stillness, silence, defensive blocking gestures, and mimicry in their efforts to enhance conveying the nature and experience of their pain.

\textbf{The sameness and constancy of pain.}

When asked in the interviews to discuss what their pain was like in acute care Allison (85), Molly (73), Belinda (76), and Martha (90) referred to their pain as being \textit{the same} since they arrived in acute care. That their pain was the same suggests little relief from the discomfort of pain. For Molly (73) her pain had been the same before she was even admitted into acute care:

\textsuperscript{35} During the pre-op clinic Molly was identified as requiring the insertion of a pace maker
I have suffered nothing but the same excruciating pain since my last cortisone injection a couple of weeks ago [for her right hip] it’s been absolutely dreadful.

[Molly interview]

Whereas, Martha (90), who was admitted due to a fall and fractured multiple ribs, said her pain was the same as it was three days previously when she fell:

I have had the same pain from the word “Go”. From when the ambulance man went to pick me up, and then I said “No” [don’t] I wouldn’t let him ‘cause I hurt so much. He tried to put his arms under my shoulders [to lift her up]. So one got hold of my legs, and then the other [held her torso]. So right until I got up to here [she waves her arm vaguely around the room]. Right until I got to this spot here [points to her bed before jabbing her finger into the bed with each word]. The---Pain---Was---The---Same.

[Martha interview]

Allison (85) was observed to be walking in a rush and appeared to be in difficulty during the observation period on the eighth day of her admission into hospital. The comments by Allison when stating that it still hurts the same when I walk and that the nurses always say ‘slow down Allison’ infer that the nature of her pain had the same onset as when she first experienced its presence:

I was alright until I was walking out on my front veranda to go to the ambulance and I said to the ambulance girl (...) “oh, my ankle’s hurting”. So when I got up here, [into hospital] I [found out that I had] broken my ankle. The pain is on the side of me leg, down there [points to ankle]; it still hurts the same when I walk. It just hurts, I think [pause 5 seconds] Jason is always saying to me “slow down Allison” and the nurses always say “slow down Allison” (...). When I was up walking before, I could feel it down the side of me there and well [pause 3 seconds] I just want to get there, so I hurry like [speaks softly] cause when I stop so does the pain.

[Allison interview]

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36 Martha also indicated that she suffered from ‘frozen shoulders’ and that she had limited range of movement
37 The physiotherapist
38 During the observation period
When Belinda (76) was interviewed on day four of her admission and asked to describe her pain from her new diagnosis of polymyalgia rheumatic. She spoke at length about how before her admission that her pain had moved from one location in her body to another. Belinda’s remarks on the nature of her pain being that it was still persisting are evocative of a sense of debilitating sameness:

I can now move that one [flaps right hand] alright now without any trouble, except one finger it’s still a bit sore, but the shoulders and the neck I just, the whole pain, the whole arm I still cannot move [them] at all and it’s still persisted [the pain] down that side [indicates left] and in that hand [left]. This morning is the first time that I have been able to stretch those fingers! [Demonstrates by opening out her left hand very slowly.]  

[Belinda interview]

Alternatively for Brianna (69) the intensity of her chronic pain was never the same and it was always present. She spoke of how it was a constant problem for her to try and tell the nurses about her pain while inferring that the nurses did not understand that the nature of her pain meant that it was never the same:

Sigh [Big sigh, followed by a pause for 10 seconds] it’s just; it’s a constant problem trying to tell nurses about my pain. They just don’t get it, it’s never the same [pause 3 seconds] it [the pain] never leaves--- it will go down and then it will come back, go up and then go down, and up.  

[Brianna interview]

Inflicted pain.

In addition any their pre-existing pain, the older people in this study also experienced pain inflicted during hospitalisation from medical and surgical interventions. During admission into acute care these older persons were subjected to painful events associated with nurses when they were attended to wound dressing changes and treatment also when nurses undertook intravenous cannula (IVC) insertion. Suzanne
(65) spoke about her experiences of having different nurses undertake separate failed attempts to insert an IVC on the same day:

*Look at that* [rotates the arm outwards to expose her forearm. It is mottled with bruises and reddened areas] *that's from them [the nurses] trying to get them in* [insert an IVC]. *When I went to x-ray the wards man just lifted it off* [disconnected her IVC infusion] *and left it there* [points to side of bed]. *So it stopped working then didn't it* [the IVC occluded]. *It took those nurses three goes to put another one in, and two people. They couldn't find a vein, or they would but then the vein would collapse. Oh! GASP!* [Emits a gasp of air] *you know some people when they are putting it in* [inserting an IVC], *it feels like one of those chicken kebab sticks going into your arm, oh Ouch. Ohhh it hurts like buggery.*

[Suzanne interview]

The following exemplar outlines when Suzanne (65) was having an IVC inserted. RN Hermione attempted to provide pre-emptive pain comfort care provision before her attempts of IVC insertion. She got Suzanne a cup of tea and then heated up a heat pack which she put on the site and chatted to help put her at her ease before beginning:

The site has been prepared, tourniquet is on, RN Hermione is poised- a centimetre away from being just about to actually insert the IVC into the skin and the phone rings. The phone is clipped to her hip, it is loud, shrill and insistent. RN Hermione stops and gets up to answer the phone. **[Reflective journal entry 58]**

[After get up and walking off to talk briefly on the phone out in the corridor Hermione then comes back into the room. She begins again by saying]

"Ok here we go; a little sting"

[As she punctures into the skin Suzanne flinches and winces and then she goes completely still, becomes rigid and looks tense.]

"Ouch---ok! [Flinches] If that’s the only---Ouch! [Winces] Ohhh I can feel it"

[On response to Suzanne flinching RN Hermione interjects]

"Ok with this arm that doesn’t help with you moving like that"

[Suzanne begins to stiffen more and her body is noticeably becoming more rigid. She calls out again in pain with the inflection of her voice rising.]

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39 RN Hermione is the ‘In charge’ RN and is carrying an official phone on her hip
40 RN Hermione has picked up another sterile stylet to insert the IVC
“That’s fine---ohhh”
“That’s exceptionally rude of it- it’s blown! See how it’s swelling up? Now I didn’t do that on purpose---Well obviously when you clench in fear that makes it a bit harder.”

[RN Hermione observation period 1]

RN Hermione was unsuccessful:

[RN Hermione punctured her skin for the second time, Suzanne’s body again went stiff and tense. Her face is screwed into a knot, her lips are white and compressed but she makes no sound. She is staring intently in the other direction; her body is tense and rigid, her face fierce with awareness. RN Hermione’s face is also a knot of concentration as she is attempting to find the vein while she speaks out aloud.]

“You have a lot of valves there---Hmmm I’m not going there
[pokes arm with hand]---Do you have the usual sensitivity?
[After Suzanne winced] Is it hyper or more sensitive to pain
[Suzanne’s arm]---You need to drink more ok”
[Another colleague walks into the room and begins to talk to RN Hermione they both enter into a very brief rapid discussion41. Then RN Hermione withdraws the insertion device, and comments to Suzanne]

“Sorry darling, in there [nods towards arm] would be great, but you have too many valves”

[RN Hermione puts an occlusive dressing in place; she resites the heat pack and walks off.]

[RN Hermione observation period 1]

During her follow up interview, Suzanne suggested that some nurses had the ability to reduce the amount of pain that was inflicted. She described them as gentle nurses who had a way or technique which made some more gentle than others:

That one today [RN Hermione] she wasn’t too bad, but some of them are so gentle that I don’t feel a thing. I don’t know what it is that makes some more gentle than others, I think it’s the way they do it, their technique perhaps? I don’t know what they do, but some they are just gentle.

[Suzanne interview]

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41 This is while RN Hermione has punctured the skin with the stylet to insert an IVC but is trying to find the vein. The insertion device is still embedded under the skin of Suzanne while she is speaking to her colleague
The ways in which a nurse applied a technique of providing pain care during procedures was by Suzanne’s account an indicator of how gentle some nurses will be, particularly more so in the manner in which it was applied.

The older people in this study talked about their relief at not remembering surgical procedures that required a general anaesthetic. In addition, they spoke about coming out of the operation and not having any immediate pain afterwards on waking in recovery. However, they talked about experiencing pain on the ward afterwards. Bridget (84) who is now on the sub-acute ward, speaks below about her experiences of coming out of the operating theatre after abdominal surgery for rectal cancer. She talked of only having pain until well after the initial surgery period had past, suggesting that initially her postoperative pain was well controlled:

_I remember going into the theatre. I can’t remember coming out. I hope that is a good thing, I didn’t really have any pain, not then. Early on in the piece here [waves hand vaguely] I did have pain, [points to her stomach] much pain actually, but that wasn’t until after the operation, that was well after, for like a few days after._

[Bridget interview]

Due to the nature of the reasons for their admissions into acute care at times the older persons in this study were required to undergo either major or minor procedures, which at times could contribute to the pain they were already experiencing. As Suzanne noted, it was the manner in which the nurses provided pain care during those times that was important. Bridget’s comments in relation to only developing pain until being transferred onto the surgical ward after having an operation infers that initially the management of her pain was optimal for her, however, this did not continue during her stay in the surgical ward.
Anticipating pain and avoiding embarrassment.

When speaking about the onset of pain in acute care some of the older patients talked about having a sense of “knowing” or “know-how” about the onset of their pain and its management. They talked about developing or using this know-how, as part of their pain knowledge gained from their own experiences of managing their pain and they provided a rationale for what caused the onset of pain during their hospitalisation. Martha (90) spoke of her pain causing her to hanging over the side of the bed and I sounded horrible, drawing towards her the unwanted attentions of fellow young male ED patient when she coughed. She also talked about her pain when I first got up here to the [surgical] ward on coughing from having multiple rib fractures as being agony to breathe, before her nurse RN Fran gave her analgesia and called the doctor to review her:

*I didn’t have any pain until I coughed in ED then I struggled a bit, I was hanging over the side of the bed and I sounded horrible (...) I must of sounded horrible there was a young fellow (...) [another patient] he was in the bed next to me and he was worried “Are you right love?” he said. And the pain! Ohhh! At first, when I first got up here to the [surgical] ward it was agony to breathe like.*

[Martha interview]

Knowing the causes for an onset of pain meant that for some older persons in this study they actively avoided in engaging in some activities. Molly (73) spoke of knowing that she was unable to walk quickly to the toilet because of her pain. She talked of her efforts negotiating with a nurse that morning to avoid the previous embarrassment she had encountered when left to feel like a fool and crying when I can’t walk anywhere in a hurry or a rush and when unable to make it to the bathroom in time on the previous day. As Molly said:
I just can’t do anything quick. I can’t walk anywhere in a hurry or a rush. I can hardly walk with this creaky old thing as it is [makes a gesture from right hip towards feet]. Anyway [pause---big breath in], I usually get up [and walk] to go to the toilet, well this morning I asked if I could go over on the chair\textsuperscript{42}, the nurse (…) She goes to me “Oh you walk alright”--- huh---alright? Well, I said that if I could walk I would, but I can’t go fast because it hurts too much and now I am worried that I will poo my pants (…) the other day when I couldn’t get to the toilet because my pain was so bad I was sooo embarrassed to have her [the nurse] sitting me behind the curtain [to] do a poo in the room. She said it was alright and nurses didn’t mind (…) and you know that’s fine that they don’t mind, but I was the one sitting there feeling like a fool and crying.

[Мolly interview]

Otherwise the onset of pain was gradual, such as from experiences whilst an inpatient in acute care. Bridget (84) spoke about her pain as being a \textit{sharp sting} from the development of a pressure ulcer on her heel which meant for her that on standing \textit{it just hurts too much}:

\begin{quote}
I get it when I stand up it’s like a sharp sting. I didn’t have it when I came in [the pressure area on her heel]. Now I cannot get my heel to the ground. I just can’t. It hurts too much. I try, but it just hurts too much.
\end{quote}

[Bridget interview]

Regardless of the cause of pain, its onset had an effect for the older person. Not only did they anticipate the onset of pain limiting or restricting the way in which they ambulated or moved but also a perceived loss of dignity associated by being in pain. These were stemming from situations when being placed in a predicament of being unable to maintain their dignity during moments of acute pain.

\textbf{Plans for managing pain.}

In this study, three older people spoke of having a pain management plan in place during their admission that they had devised with their treating doctors. Although

\textsuperscript{42} Shower chair on wheels
documentation was not outlining any particulars in detail within their medical and nursing notes, written were the analgesic medications in their medication charts. Belinda (78), Brianna (69) and Ninnette (66) spoke of the formation of their plan as being a discussion with the treating doctors which included what drugs they were currently on, what they previously used, and tolerated in terms of side effects and what had been effective in the past. In her interview Belinda attributed her current pain relief to a newly introduced medication: prednisolone prescribed as an adjuvant for pain and which promoted the movement she had regained:

> The prednisolone is working [nods] hmm I can feel the pain going, it’s not so intense. When I ended up coming in here, I thought they’d be, um, agh, helpful, and [huge beaming smile] I got in and out of bed by myself this morning and well, I can open my hand today too!

[Belinda interview]

Both Brianna and Ninnette talked at length and in detail about their pain management plans. Brianna (69) already had a pain management plan in place before her admission:

> I have been with the pain team for a long time\(^43\); I am under Dr Smith [Pseudonym]. There is the Panadiene fort and the jurmn [jurnista\(^44\)], because it is such a slow release, [the Jurnista], that when I get up it hasn’t quite kicked in yet, so that’s when I take the Panadiene forte. It just helps, gets me going for the morning until the other one kicks in. Dr Smith wants me to stop doing that, he was going to wean me off [the Panadiene forte] so we will go to the Panadol [for breakthrough], but we are not there yet.

[Brianna interview]

Ninnette (66) spoke of her pain management plan with her doctor from her current treating team who saw her on admission. Ninnette has two different types of neuropathic pain being chemotherapy induced neuropathic pain, and a current outbreak of shingles; she was able to outline in detail the separate plans for each. However, the

\(^{43}\) Later she tells me she has been involved with the pain team for more than 12 years

\(^{44}\) Slow release Hydromorphone
timing of the development of the plan for Ninnette’s shingles pain meant she will never forget that night whilst describing that she was screaming out for more pain relief and not receiving any change for the management of her pain until after that night, later that afternoon of the next day:

Well the first night I only had Panadol and I assure you it was not touching it at all, I was screaming out for more [pain relief]. I will never forget that night, when that first came on, I thought that I would have had clots in my lungs or something as the pain was in both of my lower shoulder blades at the same time. Well after that night, later that arvo first up they gave me [the treating team] the Panadiene forte with the Valtrex [Valacyclovir] and then the doctor thought perhaps a tablet by the name of [clicks tongue] what was it? Oh a tablet by the name of Endep [amitriptyline] that treats nerve pain would help.

[Ninnette interview]

Ninnette then went on to describe how the pain management plan; the analgesics and adjuvants were revised and to suit her responses and needs:

Well I couldn’t cope with that endep [amitriptyline]. I couldn’t function or even think properly when I took that. So I just cope with the Panadiene Forte and the antibiotic [Valacyclovir], I won’t have that Endep or anything like it again, no way!

[Ninnette interview]

She also described the pain management plan that the treating team doctor team had devised for her chemotherapy induced neuropathic pain:

During my first block of my chemotherapy I had a dream run (...) This time, possibly because I have been treated with arsenic, I have developed an itch (...) it’s like if you could imagine electric wire shocks; it’s aggravating, it’s in my hair and in my neck, it feels like it is burning. I can feel it around my neck [and] oh yes, in my private places, my legs get itchy, in my sides and under my breasts. So they are treating me with phergan [Promethazine] for that, the heat from it comes and

45 Ninnette is recounting her first experiences of having shingles and being in acute care while also receiving chemotherapy for the first time
46 “Arvo” is Australian slang for afternoon, a period of time that begins after lunchtime and is typically from 1pm onwards
goes, it’s not, not as intense all the time like with my shingles pain.

[Ninnette interview]

Within the medical notes it was documented that Ninnette is not for any sleeping tablets by the haematology team who admitted her into acute care:

Patient educated about chemotherapy concerns
Plan: Stay in hospital over weekend aim for discharge on Monday. For Bloods, Await echo report. Not for sleeping tablets overnight please [highlighted in fluorescent colour]

[Ninnette medical notes]

What Belinda, Ninnette, and Brianna do not mention is any discussion of involvement with their nurses in the development of these plans. Furthermore, there was an absence of documentation in their notes in relation to these pain management plans, although the prescribed medications were on their drug charts. For Ninnette, who was not located on the hematology ward and on a general surgical ward (because of a lack of beds during the weekend), this meant for her continuity of her pain management story was lost.

Lost pain stories

The sub theme of lost pain stories provides insight into how, in this study, the older persons’ pain story was lost during their journey through acute care. The lost pain stories were discovered serendipitously when interviewing the older person, and this information was more extensive than any documentation in their medical notes. For the older person, losing their pain story was continued when they experienced difficulties on being asked to provide a numerical value for a singular location for the intensity of their pain, despite often having multiple types and sites of pain. The older persons in this study spoke at length of their difficulties in having to rate or score their pain and an inability to compare different types of pain. Presented are the implications for the older person on having lost their pain story.
Finding the pain story.

The older people in this study often talked of having multiple sites and types of pain; however, despite this there was no complete or comprehensive formal documentation within their medical notes of their pains. Instead, this information was gained during the interviews when the older participants were offered an opportunity to describe and tell the researcher about their pain. When speaking of their sites and types of pain the older persons often began by telling their overall pain story. They were short stories, told simply. For instance, in response to the question inviting her to speak about her pain, Allison (85) begins her story simply:

Not while I’m lying down. When I was up walking before\(^{47}\) I could feel it down the side of me there. It’s on the side of me leg--down there [points to ankle].

[Allison interview]

Then Allison moved to the immediate past (three months ago) by speaking about a previous workplace incident when she was a volunteer, she fractured her pelvis after being knocked over and she also places her arthritis in her hip within the same time period:

I had six stitches here and bruises up here [points to her head] and I broke a bone or something down here [points to groin], whatever you like to call it [superior pubic rami] yeah down there. So, yes that was hurting too when I was walking then, plus the fact I have arthritis in my left hip I might add.

[Allison interview]

Then Allison moved to the distant past, which for her was a fall where she fractured her arm three years ago.

About three years ago, I broke my humerus bone up here [points to right arm with left hand]. I had a fall in the street, and now it

\(^{47}\) Allison was observed to be struggling to walk to the bathroom with the nurse assisting her
does not ache it’s not painful, it’s alright, it gets itchy sort of. But, I have no strength. I mean I can hardly lift that up sort of thing [demonstrates limited range of movement by showing inability to hold up a cup of water].

[Allison interview]

While Allison’s medical documentation noted a history of previous fractures and although she was in hospital for management of a current fractured ankle, she had other undocumented pre-existing sites, types, and sources of pain.

The alternative strategy used by some older people during conversations was to engage in a demonstration that listed what hurt, how, when, and where. This was undertaken in a spontaneous manner in addition to showing what the practical effects of that pain had on them. In her interview, Belinda (76), when asked to describe her pain, begins a list of what was alright, still persisting and what was a little bit sore by demonstrating:

That hand is alright [holds up right hand], except for the one finger [feebly wiggles right index finger] and that one finger was a little bit sore for a while as well [indicates second right finger by wiggling freely]. And I can move that one alright now without any trouble [flaps left hand] but the shoulders and the neck I just couldn’t move at all [attempts to shrug shoulders] and it’s still persisted down that side [indicates by shrugging again, her left side has a noticeable droop] and in that hand [flaps left hand again] this morning is the first time that I have been able to stretch those fingers [demonstrates with left hand by spreading out fingers].

[Belinda interview]

This shows the spontaneous nature in which the older persons in this study responded to a simply worded question such as ‘can you describe your pain’ or ‘tell me about your pain’ and how this elicited a concise and short story about their pain that was not present within their medical notes.
Not being able to rate pain.

For some patients, there was a certain level of anxiety expressed regarding the answer given by them when asked to rate their pain. One way that this was spoken about was of being compliant with the pain score questioning which Suzanne (65) and Rhonda (92) termed as providing a usual answer. Rhonda (92) talked of giving a usual answer to the regular questions asked by nurses to rate her pain:

*So I usually tell them [the nurses] it’s an eight or when it’s really bad a ten.*

[Rhonda interview]

Suzanne (65) stated that when she did give her usual response, that she hoped she gave the right, as opposed to wrong, answer:

*I can’t rate it [her pain]. I know I usually say about a two or a three. I just give a number and hope that I am right.*

[Suzanne interview]

When the older people interviewed in this study described having their pain assessed they spoke of two different approaches by the nurses. Mainly they referred to a process whereby nurses routinely asked the same questions, in a set manner and at a certain time.

*They [the nurses] come around in the morning and they ask me “What is your pain, what is your pain outta ten?”*

[Rhonda interview]

For many older persons like Allison (85), a positive interaction was not viewed by them as being woken up early in the morning by a nurse asking the perplexing set question of *How would you rate your pain?* With Allison commenting that this left her feeling as if she was not a very good person when unable to rate her pain first up in the morning, and that she said her reply was to say don’t ask me as I’ve just got a pain and that is it:
When all my nurse says to me first up [in the morning] is “How would you rate the pain?” I think--- well!---Golly---now you’re asking me. I’m not a very good person to help you, so I’ll say “don’t ask me!” I’ve just got a pain and that’s it.

[Allison interview]

It was as though Allison felt that in being unable to rate her pain, she therefore could not comply, and be a good person. For Allison this also meant her story of waking up in pain was lost.

Part of the barrier in providing a numerical value in response to being asked about their pain was that, with the exception of Brianna, none of the older people in this study within their interviews actually spoke or referred to their pain in relation to a numerical value. They talked more about how their pain made them feel and how it impacted on their ability to complete activities or comfort levels. Brianna (69), whose chronic pain for the past 12 years was being managed by the community chronic pain service, initially referred to an optimal numerical value for the level that she liked her pain to be at, so she was able to move independently:

> My pain--- if I can get it down to a 3 or a 4 that’s a good day for me. When it’s at that level I can move and do try to move.

[Brianna interview]

Typically, the older persons in this study spoke about having different types and sites of pain such as Peter (73) does below:

> The bones just like grind, because there’s nothing in between them. It’s very painful and it never goes away, it’s there all the time, sometimes it’s more extreme than the other pain I get, the bone cancer pain that is like an ache all over no matter what position I’m in.

[Peter interview]

Overwhelmingly the responses given by the older persons when asked about rating or scoring their pain were the difficulties they had in finding a way to respond.
How to compare pains.

The difficulty is having to rate pain involved, as Suzanne (65) comments, and having to compare one type of pain in one location with another type of pain in a separate location and then provide a singular value to rate their pain. This inability to rate their pain was more of an issue for those patients who had more than one site of pain. Suzanne, like many other older people in this study, had multiple sites, types and sources of pain. She talked about how difficult it was for her to answer when asked what her pain was like and to provide a score. To place these difficulties in answering within context, the following reflective journal excerpt in relation to meeting Suzanne is presented:

Suzanne has been newly diagnosed within the last eight weeks of an aggressive fatal form of brain cancer, and she has had two craniotomies in this period, leaving her with a seizure disorder, partial and incomplete paralysis along with intermittent headaches of varying severity. On the day interviewed, she had numerous attempts undertaken by nurses for insertion of an IVC leaving her arms bruised and sore. She has a recent [2 week] fractured left ankle, which she describes as a heavy weight, like an elephant on her foot. During the interview, she described a type of neuropathic pain that she called a zap into the cheek of her buttock.

[Reflective journal entry 59]

Suzanne spoke about her difficulties in responding when asked to compare all sites of her pain and then give a rating that summed it up. As she put it during her interview:

Like when people [nurses] ask you what your pain is like? I really don’t know, I have nothing to compare it with, because it is really hard, I don’t know how. How do you compare pain with pain and then rate it? How do you do that? I don’t know. All I do know is that the pain in my foot isn’t or hasn’t been as bad as some of the other pain that I have had, but I can’t rate it. Bad pain for me is a blinding headache, where I can’t see, but at the moment it is like a dull ache when I get it, like a throb. But I can’t rate it.

[Susanne interview]
It was also increasingly apparent that no relationship was placed by some older people in this study on why they were required to provide an answer for their pain score in regards to having their pain managed. For instance Belinda (76) appeared puzzled in her response, when asked what it was like for her to talk to a nurse about her pain:

*Well they [the nurses] ask how it is and is it getting worse or better [her pain] and I just answer them. I say which way or the other and so far it’s always mainly been getting better, so [shrugs her shoulders] I dunno, really, I thought they’d be more helpful, the nurses, I mean they ask if I want those pain tablets when they bring them around, and the Doctor suggested that I take them, so I have been.*  

[Belinda interview]

Suzanne provides insight and understanding into the difficulties experienced by the older people in this study by speaking of her difficulties of having to compare pain with pain and then having to rate it. Certainly, Belinda was puzzled when asked what it was like to speak to a nurse about her pain and this is allusive towards that conversation as never having taken place. Not having conversations about their pain stories with the nurses had a potential for distress when those older persons were transferred to another hospital or ward.

**Molly’s lost pain story.**

Arriving into a new ward after admission and then telling the nurses about their pain was often spoken of as a source of distress for the older patients. The older persons in this study often believed their pain stories were known, and they spoke of their amazement of having to repeat themselves to nurses who were not hearing what they were saying. This resulted in the patients feeling frustrated, angry, and isolated at having to retell their stories of pain on each new admission into a ward and for every shift. Molly (73) said:
I am sick of telling people [nurses] how sore my hip is. I don’t think that people realise.

[Molly interview]

It was common for the older person to be transferred between wards and hospital sites. When the nurses assessed their pain as part of a conversation, some patients became noticeably and increasingly abrupt. The following exemplar highlights this experience for Molly. Molly had been discharged two weeks ago following the insertion of a pacemaker, however, after her second fall at home following nausea and vomiting she was originally admitted into another hospital before being transferred into the study site.

Molly, like lost older persons, has a very complex and chronic medical history:

Osteoarthritis right hip, awaiting surgery, depression anxiety, T2 DM, COPD, sleep apnoea on own CPAP\[^{48}\] overnight, CCF, AF = warfarin, PPM feb ’13, HTN, GOUT, shingles, THR, TKR

[Molly medical notes]

The following was noted about Molly in my reflective journal:

After being on the waiting list for more than 18 months Molly was due to have a total hip replacement a month ago, however this was cancelled on the day she arrived to hospital. On receiving a pre-op check-up, atrial fibrillation was identified so that she required a pacemaker insertion.

[Reflective journal entry 64]

During this current admission into acute care, Molly spoke about how it had been a drama for her daughter who lives in New Zealand to keep in contact with her because they keep moving me. Molly talked of getting her neighbours to text her daughter to let her know which ward she is on:

It’s been a drama you know to keep in contact with Julia [daughter] all the different numbers, they keep moving me. From one hospital to another, ward to ward. They moved me from the Wallaby Base Hospital [pseudonym] to here. I’ve been on six different wards and two hospitals since a fortnight last Tuesday. So actually last night when Julia rang [and] I answered she

\[^{48}\] continuous positive airway pressure device
shouted, “Oh mamma don’t hang up, it’s taken me an hour to find you”.

[Molly interview]

When Molly’s nurse, RN Georgina, was undertaking routine vital sign monitoring and pain assessment, Molly was abrupt in her replies. From my reflective journal, I note:

Molly is in a single room and is talking energetically with her two visitors who are present when RN Georgina walks in with the OBS trolley.

[Reflective journal entry 64]

[RN Georgina to Molly while she attached the BP cuff]
“Have you got any pain?”
[Molly sighs and nods to her right hip, she sounds weary]
“[Sighs], only in the usual spot”
[RN Georgina then asks her]
“Where?”
[Molly runs her right hand down right side of hip and also points to her right side]
“Here”
[RN Georgina to Molly]
“Oh, do you have sciatica?”
[Molly rolls her eyes upwards, sighs and groans, her visitors are silent]
[RN Georgina flips through the chart and is looking downwards]
“Oh ok. What have you got for it?”
[Molly answers sharply]
“A patch!”
[RN Georgina doesn’t look up but points to the medication chart]
“Oh I see a fentanyl patch”
[Molly’s voice initially softens but then becomes abrupt]
“Yes--- and something else it starts with a C? I think”
[RN Georgina is now looking back down at the chart]
“You’re not thinking of Panadol are you?”
[Molly rolls her eyes, puts her hands up to her face and groans]
“Nope, hrrrrmpph”
[RN Georgina flips over a page and exclaims]
“Oh codeine phosphate”
“Yes that’s it”

[RN Georgina observation period 3]

49 Molly is on the waiting list for a hip replacement
Molly spoke about her frustration about having to repeat her pain story and not following her journey while an inpatient. When RN Georgina was asked to discuss where Molly was having pain her response was:

She didn't say that pain was from her hip, she said it was from her sciatica, not from her hip.  

[RN Georgina interview 3]

This exemplar highlights how Molly’s pain story was lost and how her pain concerns whilst being listened to by her nurse, were not heard. For some patients this meant enduring and having to wait in pain.

Waiting in pain

For the older persons in this study, waiting in pain meant enduring and suffering. Explored in this sub theme are the aspects that contributed to an older person waiting in pain and their experiences. This section begins with the retrospective accounts provided by both Simon and Molly speaking about their experiences of waiting while in pain for analgesia from a nurse. This is followed by a description of the experiences of Sally on being forgotten in her requests to her nurse for analgesia. Described are the actions undertaken by RN Clare to provide comfort for Brianna when she becomes aware that she is in pain, and her unsuccessful attempts for the treating team to change the timing of the PRN charting as well as come and review her. Captured are the reactions of Ninnette when told by her nurse RN Iona that she was not due for her PRN adjunctive medication for her chemotherapy induced neuropathic pain.

Enduring pain whilst waiting.

Within this section the reflections of Simon are presented. He spoke of spending a night in pain and Molly spoke of waiting in pain. Although the exploration of their
experiences is difficult, it is important to be mindful that other older persons in this study also spoke about enduring whilst waiting in pain (for instance refer back to the section in this chapter titled Plans for managing pain on page 209) when Ninnette outlined how her pain management plan was formed.

Simon (65) spoke at length about his experiences of being in pain while his family were visiting him, of waiting in pain for a nurse to provide pain medication, and for a doctor to review him until his pain had eased to the point when he could sleep. For Simon this was a period of nine hours, with the onset being before 2000 during the visit from his family and not until 0500, the next morning by his account had his pain eased enough for him to go to sleep. The following was noted in the reflective journal about the documentation of Simon’s pain crisis the previous night:

Simon experienced an adverse event while an inpatient. On day five, he developed hepatic encephalopathy requiring an ICU admission with intubation. Two days ago he was discharged from ICU back to the same medical ward. I noted written in the medical notes was that he had become ‘aggressive’ later the previous evening and had started ‘to pace the room’, he had received a stat dose of IV 1 mg Haloperidol ‘for agitation’ at 2000. Then he received the same dose of IR oral Oxycodone 2.5mg at 21.30, again at 0030 and then 0400. Simon said that he eventually fell asleep at 0500 when the pain wasn’t there anymore.

[Reflective journal entry 24]

Simon was from a very close family with strong cultural ties including his extended family of ten brothers and three sisters. He spoke of his house as being a meeting place that his family would come to meet up and discuss family issues or concerns, whereas home was a traditional old place back on the island. He talked of family meetings at his house when the older family members coming in first, with only the ladies having a sit down at his really big table to discuss family, with other family members coming in

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50 Simon was a Pacific Islander
or out to exchange places. This was a process that he called a lot of sit downs and this was how all family members were equally informed about what was going on. Now that he was in hospital, his family came in there to have meetings with him to keep him informed. Simon talked about waiting for the pain relief as robbing him of time with his family. He said:

*I didn’t have much time with my family (...) The pain started to come back, it was, well I started to [Silence 10 seconds] I got stressed out! [Frowns] So I went into the bathroom and I locked myself in there. I was crying. I’m thinking “ohhh no, oh not again”. I wanted to hide my head under the pillow and then I cried. That meant I didn’t have much time with my family. My head wasn’t in the right place and with the stories and things that they were talking about. So tonight I’m waiting for them. I can’t wait, I have to apologise to them about my attitude to them yesterday.*

[Simon interview]

Simon spoke of his distress with having his family present and waiting for the doctors to chart pain relief, do a follow up review to see if the pain medications had been effective and on more waiting after receiving the pain medication to have an effect:

*Last night, before the doctors arrived, [then] I hid my head under the pillow and I cried. Ohhh dear. [Silence 5 seconds] It was twelve thirty [am] yeah! When they turned up [the doctor for a review] and three thirty [am] it was still going. Well the three nurses were here and then they went, but [voice rises] they came back at three thirty when the doctor turned up again didn’t they? [He had a follow up review by the doctor.] And they were still working on it. At about four [am] I got the Endone, the pain tablet and [voice softens] I fell asleep about five o’clock [am] when the pain wasn’t there anymore.*

[Simon interview]

When Simon was asked to talk about how this made him feel he talked about how uncomfortable it was to be in pain, waiting for pain relief made him feel angry and frustrated as well he spoke of praying to God that the pain will not come back:
I hate being like that. I hope its gunna stay like this no more pain. Because being in pain is soo uncomfortable [and] I get frustrated--- frustrated---as well I get angry, because I know I can’t do things (…) That's when I get angry and frustrated (…) it’s not happening tonight, tonight I will be happy with the family, last night---I didn’t want much, but it’s done now and I'm hoping, I'm praying to God [Whispers] the pain won’t come back [silence 3 seconds] it’s just the aching it’s horrible.  

[Simon interview]

The next morning Simon developed an onset of pain again, but the way in which he dealt with this new situation suggests that it was different from the previous night:

It is the morning 0725; Simon has sat out of bed to have breakfast in a chair. Twenty minutes later after being asked if he had pain by RN Ann, Simon’s pain has increased. He begins moaning and groaning loudly. A doctor walks into the room while RN Ann is getting him comfortable and picks up Simon’s chart; they identify themselves as being the night shift doctor. RN Ann uses this as an opportunity to have Simon reviewed. That doctor increases his PRN dose of Endone after looking at yesterday’s blood results.  

[Reflective journal entry 24]

[RN Ann walks back in and sees that Simon has finished his breakfast, she makes eye contact and touches his arm]  
“Alright Simon, are you alright to have a bit of a rest now?”  
[Simon responds by saying]  
“I was going to ask for some Endone---it’s back bad”  
[RN Ann replies by saying while nodding]  
“I know alright”  
[Simon is moaning and groaning as he gets up and puts himself on top of the bed. RN Ann uses the bed controls to sit his head and puts his legs up by placing a pillow under them for elevation.]  
“Lie back--- I want your head up a bit. I’ll get you comfortable and I’ll look after your leg.”  
[A Dr walks in and picks up Simon’s bedside chart RN Ann turns to this Dr]  
“Can I--- can I talk to you Dr erm?”  
[Dr “I’m the afterhours RMO- I saw Simon last night and I am just checking up on him before I finish so I can go home, why is he in quite a lot of pain now?” RN Ann then said to the Dr]  
“He can only have Endone TDS. He’s just plateaued out”  
[Dr “You really need to give him something now, Why can’t we increase his Endone? I’ll bump it up to 5mg 6th hourly- he was pretty bad at midnight and again at 03:30 this morning ”].
[Simon is moaning and groaning loudly on the bed. RN Ann then says]
“It’s just so painful, I’ll get him something now”
[As she walks out of the room with the chart in her hand and goes to get him some Endone]

Later during his interview, Simon talked about the pain that he had had that morning. He talked of not feeling as stressed as the previous night because of knowing and being informed that something was gunna get done about it. Although Simon did not have any input nor was he invited to participate in the discussion between this nurse and the doctor, he was able to hear the process. Apparently, Simon became reassured when RN Ann had talked out aloud in front of him and discussed with the doctor a plan for a pharmacological intervention:

_I told the nurses [about my pain]. They told me that they would tell that doctor, which drops my stress and worries, and stops me from [doing all that] stressing out, cause then I know it’s gunna happen and something is gunna get done._

[Simon interview]

Knowing that relief was on its way and being informed about it was spoken of as a source of comfort for the older persons in this study. Molly (73) spoke of her experience of waiting 11 hours for pain relief at another hospital, before transfer into the study site. She spoke about not knowing the pain management plan, only that analgesia was _not allowed_ with _no alternatives_ offered. Molly spoke of those nurses involved as being inflexible, not offering a solution to her situation, and having to wait in pain:

_I had some medication at 0400 in the morning, and then they gave me some, oh I don’t know at 0800 or something and then I asked for them and I got them at something before twelve. But anyway I couldn’t get any more and it was not long gone one o’clock. But they couldn’t give me any because I had had my quota for the day. So I had to [pause 10 seconds], um--- wait until midnight and [speaks quickly and fiercely] NO, No, nope, no alternatives, none what so ever. [Big breath in] So I just sat, I’m fine so long as I haven’t got to move. So I didn’t [nods]._
They [the nurses had] made a mistake, they gave me three doses instead of two or something. So I would have to wait until midnight! And this was just after lunch. And at five to twelve [midnight] I pressed that button [loud angry voice] and I said---“PAIN---Relief---NOW” It was awful.

[Molly interview]

Within the reflections of both Molly and Simon and conspicuous is the absence of any mention of nurses being present while they were enduring. It is suggestive that not knowing what was going on merely contributed to their distress. Importantly is the point made by Simon that knowing that the doctor knew and being informed helped reduce his stress and worry while waiting in pain. Hearing a nurse speak out aloud their acknowledgement of their pain provided the older person with a certain level of comfort.

**When complaints of pain were forgotten.**

During the observation periods when nurses were engaged in undertaking a round of vital sign observations or medication dispensing they focused their attentions on gaining this information patient by patient. This meant that for some patients, for example Sally, she was heard being told to wait until RN Danielle finished their round. The implication was for Sally that not only did she have to wait for pain relief but she was also forgotten.

In the following exemplar, Sally (86) complains of having pain in her right calf while RN Danielle is doing a round of vital sign observations and from when Sally complained of having pain to when she received her pain medication an hour passes. As Sally’s bed was the first bed on the left hand side of the doorway, this meant that she was the first person to have her vital signs taken during RN Danielle’s round. However when Sally complained of pain it was after her vital signs had been taken, and RN
Danielle had moved on to the third patient in the room; at this point she informed Sally to wait until she had finished her round.

Sally had been admitted into acute care after calling an ambulance at home because of an injury from a fall; a circumferential skin tear around her right calf, exacerbated by venous leg ulcers. She lived alone at home and was independent. Presented below are Sally’s nursing triage notes:

*Presents with injury BIBA. Was washing leg, large skin tear to same. Nil distress (...) Ambulance service states very SOB on exertion. 3x dressings in situ and blood stained. Fragile dry skin and chronic venous stasis. Large skin tear with minimal trauma. Superficial skin, sloughed off. Hematoserous discharge. Skin around slightly warmer to touch.*

[Sally medical notes]

During her admission, Sally had been in a total of three different acute care wards within the same hospital. It is repeatedly documented in her medical notes that she is experiencing a lot of pain in her right leg, particularly during her daily dressing changes.

On return from her morning tea RN Danielle walked with purpose into the room and makes a statement with her hands on her hips that she is “going to do a round of OBS” on the four patients who are all present. She has a trolley, which has an automatic blood pressure machine on it and a temperature probe.

[Reflective journal field notes entry 62]

[RN Danielle sits on bed next to Sally who is in a chair and as she attaches the BP cuff asks her while making eye contact]

“*How’s your pain in your leg? In your leg now? The pain?*”

[Sally shrugged her shoulders, rubbed her hand down her right leg gently and starts to fiddle with the bandage and then comments]

“Alright, it’s gone now”

[RN Danielle makes a comment about her dressing while taking her OBS]

“Yeah it’s the bandages; they are going to check it tomorrow, it’s not breaking through, otherwise I would change it. Ok that’s good. Your BP is good, pain is good, managed today so that’s right and you opened your bowels-perfect-that’s what you are, perfect”
[RN Danielle is looking down at Sally’s chart and writing while she is talking. Then she gets up, and walks over to the next patient Mildred who is second on the left, does her OBS and then goes over to Rhonda who is furthest from the door on the right. Then Sally pointed to her leg, screwed her face up in a grimace of pain and she calls out]

“It hurts now. Now, it just hurts here”

[RN Danielle looked back across to Sally. One of Sally’s hands is across her eyes, her face is contorted and with the other she begins picking absently at her skin on her arm. She looks distressed. RN Danielle turns away and then looks back again across to Sally]

“Well you will have to wait until I do the OBS on everyone else and then I’ll get you some pain relief, I’ll get you some early Panadol then”

[RN Danielle then finished the OBS on Rhonda, before going to Allison (85) the fourth patient in the room, before she walked out to the computer in the hallway and printed off some nursing handover sheets]

[RN Danielle observation period 4]

A total period of 20 minutes had passed before Sally then activates her nurse call buzzer. Sally tells RN Danielle that she had forgotten her:

[Patient buzzer is activated: it is Sally’s. RN Danielle gets up from the computer and walks in to Sally. She asks her as she reached around behind her to press the ‘cancel buzzer’ button]

“What’s up?”

“You forgot the pain relief; you said that you’d get me something?”

“Oh, the Panadol, I’m sorry I forgot”

[Sally is sitting with her head in her hands, rocking her head slowly side to side]

“Alright I’ll just go and get some pain relief, I need the chart”

[RN Danielle grabbed the medication chart and walked out. She returns with a feeder bib that she hands to Allison (85) first]

“Here you go darling”

[Then she turned to Sally with a cup of water]

“Now Sally here’s yours, you take yours now, you need a rechart”

[Give her the Panadol a total of 60 minutes has passed since Sally asked for it]

[RN Danielle observation period 4]
When invited to talk about Sally, RN Danielle said she *doesn’t seem to be in a lot of pain* and that she was constantly *reminding her on* what she *should be doing for her pain*:

*Sally with the leg ulcers? Today, all day, she seems to be asking me constantly for pain relief. She doesn’t seem to be in a lot of pain, so I gave her the Panadol early at lunch. She had Endone earlier today when I took her to the shower, and she didn’t seem to be having any pain episodes then. She chin wags away and keeps on reminding me on things that I should be doing for her pain, that I should be elevating her legs, and should I be doing this and I should be doing that.*

[RN Danielle interview 4]

When asked to clarify in more detail what she thought that Sally meant RN Danielle replied that:

*I think that if her legs are so painful that maybe she should change positions (…) it’s just a sort of scraping sort of wound and well---she is a little bit demented you know.*

[RN Danielle interview 4]

As the exemplar shows, when the older persons’ pain complaint was forgotten, it was a lot more complex to the situation than just the context of a busy work environment. Of note was the typical inability of RN Danielle to break off when engaged in a round, however, some nurses, while not breaking a round, at times did alter the way in which they undertook a round.

**Inflexibility of nursing rounds.**

The following exemplar provides insight into how nurses will slow down a round to accommodate another patient who was not part of their round. This aspect was observed consistently to be as close as nurses got to interrupting a round and being flexible within the progress of the round. The following was noted in my reflective diary:

*It is 0800 and during a hectic busy morning shift, RN Elise who is doing a round of medications was informed that a patient,*
Donna (84) was experiencing a pain crisis in the bathroom. ‘Donna’ says Grant the student nurse who has walked up to RN Elise while she is at the medication trolley, urgently stated ‘she’s in a bad way’. Donna was admitted after a fall at home with a history of a recurrent prolapsed bowel and a fungating sarcoma on her thigh. A week later, she passes away while an inpatient.

[Reflective journal entry 37]

[RN Elise then has a discussion with Grant about Donna getting Panadol at 0600]
“I’ll get her some Endone- she can have it PRN, yep I will get her some Endone”
[RN Elise then turned to medication trolley and then looked at the patient Rhonda]
“Can you tell me your name and date of birth please?”

[RN Elise observation period 2]

[Although RN Elise has been informed that Donna has pain she does not go and review her. Instead, she finishes the task at hand being handing out medications and then she goes to look for her colleague to check out the drugs. I noted that ten minutes has passed since she was informed about Donna and her pain. RN Elise then stopped in hallway to speak to another colleague]
“You got the keys31? It’s for Donna, she’s not on regular pain relief but she is sitting there in pain”
[Both then go into the drug room to check out the restricted drugs, they then walk back down the corridor into the room. Both the RNs walked past Donna in the bathroom. I can hear a low moan emitting from the toilet, and Grant is hanging around in the hallway. However, they both walked past Donna in the bathroom and go back into the room and they give Rhonda her S8 slow release pain medication first and then they go back to Donna (who they had walked past previously) to give her the Endone. Donna I noted had waited a total of 15 minutes.]

[Reflective journal entry 37]

Although I cannot see the interaction of the RN with Donna, I hear it:

“Knock knock Donna [outside toilet door] we have some strong pain killers for you darling”
[She then opens door-I am in hallway so I cannot see]
“What’s your name, date of birth and allergies?”
[Donna responded in a muffled tone]
“There’s your pain killers darling”
[Steps in and hands Donna a cup with a tablet who sobbed]
“Yes thank you [sobs] this is not life anymore”.

[RN Elise observation period 2]

31 Drug keys for the medication cupboard of S8 and S4 restricted drugs
Later in her follow up interview RN Elise was asked to describe what happened that morning in relation to Donna. In her reply RN Elise spoke of how she had responded instantly. It is notable that her recollection was in variance to what was observed to occur:

Yeah yeah she [Donna] just, they [Grant] said that she is in really bad pain, like a ten out of ten pain and I was “ok no dramas I will just go and get her some Endone then for her” and so we did that, I can’t remember the time I gave her the Endone it was really close to 0800 and I knew that [pause 5 seconds] that she would get up when she is ready to go and have a shower, so there was no rush, no rush at all and so she’s just had one now[ a shower].

[RN Elise interview 2]

Throughout this study it was apparent that once engaged in a round, it was difficult for the nurses to actually break it, which only occurred during instances of rapid response calls to other patients who were clinically deteriorating. Flexibility within rounds to incorporate unplanned requests from the older persons for pain relief by the nurses was difficult for them to achieve. Notably absent within the reflective comments of the nurses involved was any mention of the time that the older person had to wait for them and this infers a lack of insight into what this meant for the older person concerned.

Receiving comfort while waiting.

It is important to note that not all of the older persons in this study were left bereft of pain care provision whilst enduring or waiting in pain. Brianna received comfort from RN Clare while waiting more than 1 hour and 55 minutes\textsuperscript{52} for the doctors to review her increased pain. The situation which had unfolded as noted within the reflective journal being that:

When Brianna had increased pain at 10.40 she informed RN Clare who paged the doctor and asked for a phone order, as the PRN chart stated that Brianna was not due for any more

\textsuperscript{52} The observation period ended with the treating team coming to review her.
Panadiene forte. The response heard to be provided by RN Clare when speaking on the phone was that on hearing that junior doctor and the registrar were doing ward rounds was that they were to ring her back in a half hour with a phone order. Then RN Clare walked back into the room and used simple touch while talking to Brianna and standing close with eye contact while speaking out aloud what was happening to inform her. Then she offered to provide a heat pack for Brianna’s back to relieve her pain.

[Reflective journal entry 35]

[It is 11.15 on a busy surgical ward, RN Clare walks back into the room and goes over to Brianna and stands mid-way at the bed on the left side that she lying on]
“Brianna what I have done is phoned your Doctor, So I will wait a half hour, so if she doesn’t ring back I will re page and ask for a phone order”
[She then leans forward and places hands on bed and touches Brianna’s left arm]
“ I know that your back is sore Brianna, but is it ok if I do your leg dressing?”
“Yes”
[She does the dressing and leaves the room, later at 11.45 she walks back in to Brianna’s bed and stands at foot of bed; while she is talking to her she touches Brianna gently on her leg]
“ ok I have the Doctor on the phone, what do you normally take when your pain is this bad”
“I normally take some Panadiene forte”
[RN Clare repeats the answer]
“You take a couple of Panadiene forte?”
“Yes”
“All right” [she walks off]
[At 12.05 RN Clare returns and walks up to side of Brianna’s bed, she leans in and touches Brianna on her arm]
“They are reluctant to give you more. I have told them that you are sitting here with 6 ½ out of ten pain. I have asked her to consult with the registrar. Until then how about I heat up a hot towel for your back?”
“Yes---ok that’d be alright”
[Two minutes later RN Clare returns with a hot towel and places it against Brianna’s back, who is now lying on her right side]
[RN Clare observation period 1]

In her interview Brianna was asked to discuss what helped her to cope when her chronic pain increased, in particular, she was asked if she used hot packs at home. Brianna replied that at home she did use them and that the hot pack that RN Clare had devised did work for her:
Did a little bit, the hot towel--- it helped to soften the pain a little bit.

[Brianna interview]

When RN Clare was asked to talk about how she felt while waiting for the resident doctor to return her page she spoke of becoming quite stressed about leaving Brianna in pain and how the ward CNC had suggested the hot towel for localised comfort:

I did ask the Resident and I said well could you just reiterate to your registrar again that she is a six and a half out of ten pain. I was becoming quite stressed to think of leaving Brianna in pain.

[Pause, deep breath] meanwhile I spoke to the Nurse Consultant on the ward, and she suggested that we heat up a towel and put it against her back which I did to give her some local comfort.

[RN Clare interview 1]

When the nurses became aware that the older person had pain and was waiting in pain outside of the times when they were engaged in a round, the nurses were proactive in providing pain care for them. However within the exemplars shown within the sub theme of waiting in pain is a core issue that surrounds the inflexibility of the charting of PRN pain relief. When faced with this situation and not able to have any breakthrough pain relief in what the older person considered as a timely manner, some older persons in this study became proactive.

**Being proactive about pain relief.**

When they did not know the plan of pain management or when they experienced pain outside of the flexibility of the PRN chart, the older persons in this study talked about instances of tension with nurses about their requests for pain relief and enduring unrelieved pain. The tension present when the older person was enduring a wait for pain relief was explored previously within the recounted experiences of Simon’s overnight wait and the actions that he undertook for coping. This tension was also evident within
the increasingly abrupt replies provided by the older person when being questioned by the nurses about pain as shown previously by Molly.

The following is an exemplar on how this situation unfolded for Ninnette, who reacted vastly differently from Molly, Simon, and Brianna when asking her nurse RN Iona for PRN adjunctive pain relief for her chemotherapy induced neuropathic pain. When Ninnette was asked if she has any pain by RN Iona, she responded by asking for a specific class of drug:

“Any pain at the moment?”
[Ninnette responds by asking for a specific class of drug]
“I was going to ask if I could have an antihistamine”
[RN Iona retort was to ask a question while attaching the BP cuff to her arm]
“Why does that help?”
[Ninnette answered by pulling out her gown to expose a clustered bright red area of the side of her neck and she begins to come across as being abrupt]
“It’s like an irritation in my throat and mouth; she [a doctor] charted it for me today for when I needed it”
[On looking at Ninnette’s neck closer RN Iona replied]
“Oh ok, I’ll have a look for your antihistamine and when you can have it”
[Ninnette began to talk shortly with clipped words suggestive of irritation]
“Thanks, when you have time”
[RN Iona answers by stating that she has the time to look and asks Ninnette again if she has any pain]
“I have time now, so I will look, have you any pain at the moment?”
[Ninnette retorts with a wry smile on her face and stated curtly]
“No that’s enough for the moment!”
[RN Iona walks out of the room and returns to inform Ninnette she is not ‘due’ for her Phenergan]

[RN Iona observation period 1]

RN Iona then attempted to offer Ninnette some Panadol

“How about a couple of Panadol\textsuperscript{53}, will that help?”

\textsuperscript{53} The use of the term ‘panamax’ to refer to paracetamol is a very common term used by older Australian patients. It is a particular brand name of paracetamol. It is unusual for a nurse to refer to paracetamol in this manner by that term.
Ninnette then questioned RN Iona, before turning to her husband to ask:

“What’s the dose of the Phenergan? Should I wait until tonight? When I was upstairs in haematology and when I had it, I had it then and there when the shingles came on!”

[The reaction of RN Iona was to not answer the question about the dose of Phenergan and instead she suggests a topical alternative therapy intervention]

“You can have it from 1900 and another at 2400. Have you tried other things like calmoseptine54 lotion?”

[Ninnette responds with an exasperated smile.]

“No it’s more inside- to explain it; it is like electric doses and shocks in my scalp, down my fingers. A shooting pain in my neck”

[She then extends her arms with her palms outstretched towards RN Iona. She then stamps her foot in exasperation and then turns to her husband]

“Ohhh it makes me irritable, the itching!”

RN Iona again reacted to this by walking out of the room and returning to Ninnette with some paracetamol in a medication cup, which she did not take. She did not return with the other intervention that she had offered, being the ‘calmoseptine’ (the topical lotion used for its calming and soothing effects) either.

I am in the room while RN Iona has gone out, Ninnette looks angry, she scowls and asks her husband for her handbag, I can hear rustling and the sound of a tablet being ‘popped’ out of a packet. Ninnette puts something in her mouth and has a big drink of water.

[Ninnette relies on her husband when informed by her nurse “she wasn’t due for her Phenergan”:

\[Grrrrrrmph\] [Angry moan followed by a ten second silence] I just think that, well actually I think thank god that I had my husband with me and my own Phenergan and I took a couple. I then later asked for Panadol, [and] I don’t know if it did anything or will mask anything. I don’t think that it helped me one bit, maybe psychologically it helped me feel better (...) but now that I am due for my Phenergan I can have that and hopefully I will be able to settle down again.

54 A topical ointment that acts as a multipurpose moisture barrier to help relieve discomfort and itching
RN Iona spoke of being aware of Ninnette’s rash and that she was experiencing a level of discomfort from it:

*I asked her- ‘what or where, what has she got? Is it internal or external?’ Because I thought that, I can see it on her neck- it’s all red. But she said that it is not external but internal sensation.*

[RN Iona interview 1]

It appeared that RN Iona was unable to comprehend fully the cause of the pain and instead she alludes to its attributes or source as being a tangible cause, as opposed to an intangible or indiscernible cause:

*I was thinking to give her calmoseptine or calamine lotion (...) Sometimes it does work, for their backs, when they are sleeping on their back and get too itchy from the mattress and sweat, because it is all plastic and they get all sweaty.*

[RN Iona interview 1]

During a second follow up interview, Ninnette was discussed again with RN Iona, who gave more information regarding the observed interaction. RN Iona spoke of having an agreement with Ninnette about when she could have the Phenergan:

*We had an agreement and (...) that it was a bit too early, she had asked for it a bit too early, she asked for it around 4 o’clock, that’s way too early.*

[RN Iona interview 2]

Additionally RN Iona commented in what appeared to be a negative manner about the itch that Ninnette had on her neck and asking for the Phenergan:

*Huh. That itch on her neck? You know that I gave her the Phenergan around 8.30pm. Because you know what? She wanted it nearer to her sleeping time, to help her sleep. That’s because she’s not allowed to have any sleeping tablets.*

[RN Iona interview 2]

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55 A topical non pharmacological lotion made from the calamine plant used to soothe stings and itchiness.
This is very suggestive of RN Iona casting an aspersion on Ninnette that she wanted the Phenergan for its known side effect of having sedation like properties, as opposed to provision of pain relief from her distress and pain from having shingles. Within this study Ninnette was not the only older person who was proactive in providing their own pain relief by engaging in acts of subversion.

**Engaging in acts of subversion.**

In this study, those older persons who also had advanced cancer diagnoses described managing their pain using their personal stock of analgesics and adjuvants which they had brought into the hospital with them. When the nurses found these drugs, they took the drugs off them, and stored them elsewhere. These included such drugs as paracetamol derivatives and adjuvants such as Phenergan and restricted drugs for example Panadiene Forte (an S4) and liquid morphine (an S8). For instance Terry (85) who was admitted after a fall at home and who was under the community palliative care team for management of his pain from his end stage cancer had his bottle of liquid Ordine (morphine) removed from him on admission. Whilst the nurses confiscated Suzanne’s (65) personal supply of drugs, she was not thwarted. Instead, she requested her husband to bring into hospital selected medications from her personal supply at home. As she said:

\[ I \text{ had to get my husband to bring in some more [medications], giggles] because they [the nurses] took it [her Oesteo Panadol}\]^{56} \text{off me. They only have the normal Panadol here.} \]

[Suzanne interview]

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56 Marketed as slow release osteoarthritis paracetamol and spoken of in Australian vernacular as being “Oesteo Panadol”
When asked why she was taking a slow release paracetamol she indicated that she had problems with her body temperature and the use of her left side from her recent previous surgery being a craniotomy for the removal of a brain tumour:

> Every time I get cold I ask them to take my temperature. If I have a temperature the night before, the next day I can’t move my arm. So I take the Oesteo Panadol (…) But [speaks seriously] because when my temperature keeps going up I lose the use of my left arm. I don’t have much [movement] left in my [left] leg, I can feel stuff. I can feel my hand, but it is floppy and [it] won’t do what it is supposed to. And now I am getting that [loss of movement in her arm], every time I get a temperature.

[Suzanne interview]

In relation to pharmacological management of pain, the older people who also had advanced cancer diagnoses spoke of knowing what drugs they were receiving and the names of those drugs along with the mode of action. During observations, when sitting or lying in bed, they were seen reading their bedside medication charts when left in the room and they quizzed the nurses on what drugs they were receiving. Peter (73) was not charted regular paracetamol and did not receive any PRN or NIM paracetamol during his admission period up to his interview.

> Did you know you got to keep your [level of] Panadol [Paracetamol] up for it to work? They said this to me at Iron Bark Hospital [pseudonym] I’ve done it. I’ve taken Panadol regularly and I don’t have much pain now. It’s worked for me. I found that if you take it regularly, you eliminate a lot of pain and that's something that I haven’t learnt, until late in life.

[Peter interview]

Peter also self-medicated whilst in hospital using this own supply of analgesics. He regularly took paracetamol and he had a personal supply of Panadiene forte if he needed it:

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57 Suzanne has feeling in her left side but is now experiencing partial motor loss of her left arm
58 Peter was in Iron Bark Hospital six weeks ago for a thoracotomy. Iron Bark Hospital is outside of the area health service, and is a major hospital which is located in a capital city
So I bring in my own Panadol and I’ve also got Panadiene Forte that I keep at night. I won’t take things unless I need them. So, yes [nods] I brought in my own.

[Peter interview]

These acts of subversion were suggestive that this sub set of older people with advanced cancer diagnoses had at some time learnt to bring in their own pain or adjunct medications, that this was a conscious decision made by them. These older person patients were very highly informed about what drugs they were being charted, the dosing and timing gained by reading their bedside medication charts or questioning the nurses. When these medications were removed the familiarity in which they spoke of their reliance on family or visitors to restock them alludes towards this being a regular occurrence.

**Review and summary**

This chapter highlighted the older person’s experiences of not being heard, on having their pain stories lost and waiting in pain. Presented were the unique perspectives of the older persons in this study about their experiences of pain and receiving pain care by nurses within the context of acute care.

Although shocked, angry, and frustrated at not having their complaints of pain believed, the older people in this study spoke of the value in having tangible visible sites of painful areas to show nurses as evidence for the presence of pain. The older persons experiences in this study of not being heard was at times due to them being left unable to verbalise as sound eluded them due to the level of pain being experienced and their attempts to use analogies to convey this pain. Typically the older person in this study used an array of pain words and statements coherently and clearly to convey their expressions in relation to the nature of their pain. The comments by them in relation to a
sense of sameness is suggestive for some that the intensity of their pain had not reduced during their stay and that the nature of their pain in relation to its onset or debilitating aspects was still present and current. The reflections of the older person of having pain inflicted was that typically its onset when the result of surgery was well after, with the poignant point that some nurses were more gentle than others in relation to reducing pain during completion of technical tasks such as IVC insertion. The accounts of the older persons in this study on anticipating pain were in relation to causes of the onset of pain and that they actively engaged in negotiation with the nurses to avoid its onset and this more so when they had experienced previous embarrassing consequences because of their pain.

For the older person having their pain story lost meant for them that they had to rely on each separate nurse knowing what their story was and attempted to inform them about their presence of pain when they did not and this was required due to the complete absence of comprehensive documentation within their medical notes. Common plots within these stories were multiple types and sites of pain that had been present over a period of several years. Presented are the comments by the older person and their statements about their difficulties in providing an answer and how hard it was to rate their pain. Statements by the older person in this study suggested that they could not provide an answer that provided an all-encompassing value for comparison when experiencing multiple sites and types of pain simultaneously. The exemplar capturing the experiences of Molly when transferred from one hospital to another, through multiple wards, highlights the frustration and despair experienced by the older person when their pain story was lost and their comments were not heard as well as being excluded by the acute care system.
Waiting in pain for the older person whilst hospitalised was unfortunately characterised by waiting periods that went from 15 minutes to several hours, and even overnight for Simon and Ninnette. The reflective accounts of those patients who did speak of waiting in excess of several hours were that they were not informed of the management plan and that the nurses were both absent and inflexible. Certainly, the exemplars of Donna, Brianna, and Sally provide insight into the series of events that may lead up to an older person having to wait. The reflections of the nurses about how long these events went for are dissimilar to what was observed and this is allusive towards nurses lacking insight into the patients’ situation. During the observation periods when a patient was observed to be waiting in pain, as shown by the exemplar of Brianna’s experience, it was noted that the nurses found this equally distressing and they attempted to provide comfort care by non-pharmacological means. Interestingly the reactions by Ninnette in becoming proactive when she was informed that she was not due for her adjuvant medication by taking her own medication was found to be common for those older persons who experienced this type of situation. Those older persons, not unlike Ninnette who had advanced cancer diagnoses, spoke candidly and freely about being subversive and taking their own medications, reading the drug charts as well as questioning the nurses freely about these medications.

This findings chapter has provided insight into the older persons’ experiences of what it is like for them to be in pain whilst hospitalised. The next findings chapter extends and builds on this further by presenting how tension unfolds within a busy dynamic acute care environment when managing pain.
Chapter eight: Pain care, tension, and disjunction

Chapter Introduction

This final findings chapter describes the theme; this chapter provides the alternating perspectives held between nurses and the older person about the provision of pain care that lead to their experiences of tension and often resulting in feelings of disjunction. The consistent threads throughout this theme are the instances for potential and actual situations of frustration or distress that arise not only for the older persons in this study, but also for the nurses themselves.

This chapter has four subthemes, beginning with *Breakthrough pain relief: Risks and special occasions* which outline the beliefs held by nurses in relation to an unwritten (and non-existent) policy/procedure. The second subtheme *Unpopular patients* begins with the reflections of the nurses about those they deemed as being unpopular when referring to those older persons as complainers of abject pain, noncompliant, and drug seeking. Presented are the thoughts of the older person on what it was like for them to interrupt the busy nurses and attempting to remain a good patient whilst attempting to confront the nurses about their pain management requirements. The third subtheme *Pain care and cognitive impairment* explores the experiences of nurses when providing pain care for those older persons within this study who have a cognitive impairment: dementia, delirium or a disability. The final sub-theme *The constantly transferred: pain care for the dying* captures the plight of those older persons receiving terminal pain care within the acute care system.

The first sub theme, *Breakthrough pain relief: Risks and special occasions*, explores the beliefs held by all nurses within this study, regardless of hospital site or ward type in the
existence of an unwritten policy/procedure. It was stated by the nurses in this study that
this unwritten policy/procedure outlined that they were not able to use the IV route for
breakthrough pain relief when it was charted PRN and that instead they relied on the
oral or sub-cut route. This is despite EBP which stipulates for the management of severe
or acute pain and for cancer breakthrough pain that the IV route is the one to use as it
provides the fastest onset for relief. When invited to discuss this unwritten
policy/procedure the nurses in this study spoke about the risks involved in inadvertent
narcotisation of the older person if a PRN IV opioid was used for breakthrough pain
relief. The times when breakthrough IV opioids were provided to the older person were
spoken of as being a “special occasion”.

The second subtheme, Unpopular patients, begins with the nurses’ perspectives before
the older persons’ viewpoints are presented. The nurses share their thoughts about those
older persons they labelled as complainers, noncompliant with the nurses’ directives
and those whom they stated engaged in drug seeking behaviours. Provided are the
statements made by some nurses in this study on being obliged to provide pain care for
those older persons who they inferred were a financial drain on the wards’ budget.
Explored are the older persons’ experiences of being moved constantly through the
hospital system and what it was like for them to have to interrupt the busy nurses.
Presented are the accounts by the older persons in this study on their efforts to be a good
patient for these busy nurses. Captured are the voices of those older persons in this
study on their retrospective accounts of their experiences of what they termed as
‘medication mistakes’ from analgesia provided, or not, as the case may be, by the
nurses. This section concludes with their experiences of these mistakes, and how they
attempted to get an answer from the busy nurses.
The third subtheme, *Pain care and cognitive impairment*, captures both observations of instances and statements about pain comfort care for older people with cognitive impairment associated with dementia, delirium, and a disability. Captured are statements by nurses relating to these older persons which suggest they do *not belong* on their ward. Explored are the reflections of six nurses on the subject of assessing pain in older people with cognitive impairment and their unsuccessful attempts at using the faces pain assessment tool (Wong & Baker, 1988)\(^{59}\). Captured and observed during the interactions with those older persons with dementia and a communication disability was the lack of the use of any pain assessment tool by the nurses.

The final subtheme, *The constantly transferred: pain care for the dying*, addresses the provision of palliative terminal pain care for those older persons in the terminal stage and actively dying in acute care. This section begins with the experiences of those older persons who, whilst not dying or receiving palliative care shared their thoughts on feeling unwelcome when moved and transferred within the hospital system. The transfer of dying patients during the middle of the night into other wards is explored. The reflections of RN Danielle about Donna’s death highlights the distress encountered by some older persons who are actively dying and when in this situation of being transferred between wards.

**Breakthrough pain relief: Risks and special occasions**

This subtheme presents the nurses’ reflections and perspectives about the provision of IV opioids for breakthrough pain relief from the PRN chart. Overwhelmingly when asked specifically if they gave out breakthrough pain relief by the IV route from the PRN chart the nurses in this study consistently said ‘no’. This was due in part to their...

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59 This was originally devised and commonly used for paediatric patients and is not considered as best practice for use for an older person with a cognitive or communication impairment.
belief that a protocol or policy existed within their hospital that they were not able to use this route for PRN and that they relied on the oral or sub-cut route when required to provide breakthrough pain relief. This belief existed within both hospital sites and all ward types, however, no written documented evidence could be found for the existence of this policy/procedure. The nurses in this study spoke of the risks involved when giving PRN opioids by the IV route and spoke of their fears of inadvertently narcotising the older person. When asked to speak about when they did provide breakthrough pain relief by the IV route some of the nurses in this study referred to this as being a special occasion.

**PRN opioids not given by IV for breakthrough pain.**

The comment “We don’t give out PRN IV opioids” summarised the approach by nurses for the management of patients who required breakthrough pain relief:

> On the ward we don’t give out PRN IV opioids [as a push directly into the IVC]. We either give it [opioids] orally or sub-cut--- and everybody tells you that here.

[RN Hermione interview 1]

During discussion with RN Fran about Martha (90) the medication chart was being used as a prompt. In the PRN section charted was both oral and IV routes for opioids, and on seeing this RN Fran immediately began speaking about how on the ward:

> I will not do morphine that way; we don’t do PRN IV on the ward. Yeah we don’t do IV morphine on the ward; we will only give it sub cut.

[RN Fran interview 3]

When asked why not, RN Fran said it was policy that nurses could not give PRN IV morphine directly through the IVC. Consistently the nurses in this study indicated that

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60 Meaning a choice was made by the nurses to not provide pain relief as an IV opioid from the PRN chart by an IV route as a push directly into the bloodstream.
any opioids prescribed by the IV route in the PRN chart were not able to be given by
them in this manner, and that this was hospital policy. There was no evidence found of
the existence of this policy document at any site or ward stipulating that opioids were
not to be given by the IV route when charted PRN, furthermore, none of the nurses
could produce this document when asked. Notable, however, were the observations of
nurses providing opioids orally, via a subcutaneous injection and with a PCA but never
directly by the IV route. When RN Danielle was asked to clarify the reasons for this, her
reply was echoed by the other nurses in this study:

It’s the protocol [here] in [identifying name deleted] hospital. Everybody tells you that here and I was told on the ward you
give subcutaneous or intramuscular morphine and not, never PRN IV [as a push] and listen, I’ve looked for it [gestures
towards the computer] and I would love someone to show me the protocol too.

[RN Danielle interview 1]

When asked to clarify further about providing IV opioids for PRN pain relief RNs Fran
and Danielle referred to the rules being different in acute care. For instance RN Fran
talked about working previously in ED and giving PRN IV opioids as pain relief whilst
in ED, but not in the acute care setting due to what she termed as the rules being
different:

But you know the rules down there in ED are different to the
rules up here [in acute care].

[RN Fran interview 3]

RN Danielle inferred that if a patient had been charted PRN IV morphine for
breakthrough pain relief while in acute care, that this was a charting error, and she gave
the dose by a different route, being sub cut:

Sometimes if it’s a new Doctor, they might chart IV or IM
morphine, but you just give the known, which is sub-cut.

[RN Danielle interview 1]
The nurses in this study feared inadvertently narcotising their older patients through the use of opioids. Within the nurses’ conversations RN Georgina was the only nurse that mentioned that older people could be narcotised following the accumulative effect of oral opioids when she said:

_Pain wise, people forget that people’s legs are older, and when they are 80-90 [years] old, have dementia and a fracture or something and you give them Endone, Endone, Endone, Endone, for their pain that you would give a younger person, it just---knocks them off their socks_.

They will be awake, awake, awake and then go “bang”---flat [slaps hand down on table], for a day or several days, because it has just accumulated in their liver, and [has been] released in one go.

[RN Georgina interview 2]

The other nurses in this study talked about the risks of narcotising older people following opioids given intravenously. For example RN Danielle spoke about how older patients become narcotised if given IV opioids _too quickly_ and that _you can’t reverse_ its actions:

_I think when you give the opioid IV it goes in the body quicker, therefore if you gave it too quickly you can’t reverse the actions of it_, but not like if you give it [the opioid] sub cut.

[RN Danielle interview 1]

When speaking about the actions or pharmacodynamics of injectable opioids the nurses in this study were not clear about these. For instance RN Clare when asked said:

61 Being “knocked off your socks” meaning an inability to get up due to decreased level of consciousness

62 Morphine has complicated pharmacokinetic and pharmacodynamics that are exhibited by its metabolites (6MG and 3MG). While morphine can be metabolised quickly by the liver, this will be dependent on the blood flow to the liver and for those with hepatic disease the plasma protein binding of morphine will be increased (Bosilkovska, Walder, Besson, Daali, & Desmeules, 2012; Srinivas, 2013). It will be the renal function that will directly influence the clearance from the body of both 6MG and 3MG metabolites (Srinivas, 2013).

63 Not correct- reversal is by use of naloxone

64 Most nurses in this study were unable to cite clearly, coherently and correctly the mechanisms of how narcotisation occurred and how to reverse it, nor did they comment about the effects that it had on the individual patient
I think with subcut the opioid seems to last longer as it stays in
the system more, whereas IV it seems to leave the system
faster\textsuperscript{65}.

[RN Clare interview 1]

When providing IV opioids to patients RN Clare said:

\textit{At the end of the day that is a kind of emergency situation that
you want to avoid, because I always say to the other nurses,
once you have given it--- you can’t take it back\textsuperscript{66}, so you really
have to assess the situation properly before you give it.}

[RN Clare interview 1]

When invited to speak about their experiences of managing a narcotised patient the
nurses spoke about knowing something was wrong with the patients but not being sure.
For instance when RN Georgina spoke of having to give Astrid (79) subcutaneous pain
relief she recollected about an event the previous week:

\textit{The reason we had to give Astrid\textsuperscript{67} fentanyl sub-cut was that
she’s got poor veins, even the Naloxone\textsuperscript{68} last week I had to give
it (…) sub cut as well because we couldn’t get a vein.}

[RN Georgina interview 3]

When RN Georgina was asked to clarify why Astrid was given Naloxone she began to
talk about a medication error that had occurred when she was not present but found on
commencement of her shift previously and that Astrid had been given an incorrect
amount of morphine\textsuperscript{69}. RN Georgina spoke about how when she came on the next day
that Astrid had dilated pupils and that the nurses were worried and it was not until the
pharmacist did the drug count that it was realised what had happened\textsuperscript{70}.

\textit{That. [Seven second pause] Was a medication error. [Big breath
in and then expelled slowly] It was a big medication error, poor

\textsuperscript{65} The rate of excretion is dependent on renal function and protein binding of morphine (Bosilkovska et
al., 2012; Srinivas, 2013).
\textsuperscript{66} See footnote 59 above
\textsuperscript{67} The subcutaneous route
\textsuperscript{68} Naloxone
\textsuperscript{69} Astrid has chronic renal failure
\textsuperscript{70} As per policy and procedure Astrid’s family members were informed and a formal IMMs completed.
little old lady [Astrid]. Um that morning I thought gee (…) she didn’t have pin point pupils, she had dilated pupils, we thought “oh that’s strange”, I thought that maybe she had a little TIA, maybe she had an event through the night, we were getting really worried, and when they [the pharmacist and another RN] did the drug count, they discovered that she had had 30mg instead of 5mg [sub-cutaneous morphine] and that sort of explained why she was a little bit groggy (…) even the pharmacist said by the morning that it should have worn off by now, she had 400mcg of Naloxone or was it 200mcg I think, anyway it was only a little dose.

[RN Georgina interview 3]

The nurses in this study spoke of unwritten rules; the existence of a policy or procedure that outlined that for breakthrough pain relief the IV route was not given by them for opioids, and instead they used either an oral or sub-cutaneous route. The implication was a longer time for any onset to occur for efficacy of pain relief for those older persons who were experiencing acute or severe pain. Notable within the comments by the nurses is a lack of knowledge about EBP and drug pharmacology and how narcotisation can occur. The reasons given for not providing opioids by the IV route were the perceived risks of narcotising the older person.

It is too risky.

When talking about why they did not give PRN IV opioids for breakthrough pain relief for the older person, RNs Hermione, Fran and Georgina spoke about risks and a requirement for the presence of medical back up. RN Hermione spoke of providing PRN breakthrough pain relief by the IV route as being considered as too much of a risk on her oncology ward for the older person:

71 Astrid has developed miosis from central nervous system depression (Larson, 2008)
72 Transient ischemic attack
73 A daily counting of the drugs of restriction and addiction which by law are locked in a cupboard
74 That is 6 times the dose charted
75 Astrid has presented with acute and chronic renal failure, with a previous admission for polynephritis. The use of morphine for those with renal impairment requires close monitoring for development of neurotoxicity as morphine-6-glucuronide may accumulate in these patients (Bosilkovska et al., 2012; Srinivas, 2013).
In ED and ICU they do it [give PRN IV opioids as a push] because they’ve got medical back up there, (…) because here [there] is no doctor on the ward\textsuperscript{76} and or even there may not be one on the floor\textsuperscript{77}, here it’s considered too much of a risk if there is any reaction, acute sensitivity, anything like that, so on the wards you can’t do it.

[RN Hermione interview 1]

RNs Fran and Iona spoke of having to work harder to provide monitoring of vital signs and that we just tend to give opioids subcut here instead of PRN IV. These increased monitoring requirements for when an IV dose of opioids were given were viewed, as RN Fran stated, an inconvenience and the cited regularity required of the undertaking of these vital signs related to the unwritten policy or procedure which was:

Whereas up here [on the ward], you need to do the five minutely OBS and all that sort of business\textsuperscript{78}, so we just tend to give it [opioids] subcut here. I know it sounds like I’m not going to give you PRN IV as the best adequate pain relief because it’s going to be an inconvenience to me and ultimately I’m going to have to work a bit harder. It’s more for me that I can’t work as safely as they want me to [in order to] keep an eye on that person.

[RN Fran interview 3]

The comments by RN Fran (aside from the inconvenience to herself) suggest a presence of knowledge that at times a PRN IV opioid was the best pain relief and this infers that on occasions she has been in situations when IV PRN opioids have been given.

**Special occasions for PRN IV opioids as pain relief.**

The instances spoken of by RNs Hermione and Iona of giving PRN IV opioids for breakthrough pain relief was when the doctors decided to give it. They spoke of patients in the midst of undergoing a procedure or during a rapid response situation and being

\textsuperscript{76} All wards had a treating team assigned to them
\textsuperscript{77} ‘On the floor’ means a person who is both physically present and at work, ‘not on the floor’ means present but their shift has ended and they have unfinished business like writing up notes
\textsuperscript{78} This is part of an unwritten policy or procedure
directed by the doctor to use the IV route as charted on the PRN chart. When RN Iona was asked to clarify more, she referred to them as *special occasions*:

> *I can only think of special occasions, like once [when] the patient was getting an ICC\(^{79}\) inserted on the ward and the doctors decided to give the PRN morphine as IV instead of sub-cut, because it was obvious that he was in a lot of pain, (…) and the other time was for a patient, who had fractured ribs and couldn’t breathe, (…) I did give it [morphine IV out from the PRN chart] once because the patient had chest pain and the cardiac nurse that I was working with said to give it, so I did give it IV, but that was for chest pain.*

[RN Iona interview 2]

Those instances that the nurses provided charted PRN pain relief by the IV route infer not only that the patients were already in situations of acute or severe pain but also when either a doctor was present or their nursing colleague had an advanced role.

**Unpopular patients**

The subtheme unpopular patients explores the nurses’ negative perceptions about those older persons in this study whom they spoke of as being complainers, noncompliant and also drug seeking. Provided are the statements made by some nurses in this study on being obliged to provide pain care for those older persons they inferred were a financial drain on the wards’ budget. The nurses in this study spoke of these patients as saying that they *know the right things to say*, that they have the worst pain, being ten out of ten and this, the nurses inferred, meant that they were obliged to provide them with pain relief. Conversely for the older persons in this study they spoke of feeling like they had annoyed the nurses in their requests for pain relief and that they had to interrupt the busy nurses who responded by coming across as being rude. This meant for some older people that they spoke of wanting to be a good patient and not put the nurses off side.

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\(^{79}\) Inter costal catheter inserted between the ribs
which left them feeling like they were a second class citizen. This meant for those nine older persons interviewed out of the total 11 who spoke of experiencing what they termed as a *medication error* from a nurse in relation to pain medication, that these situations were fraught with tension and frustration.

**Complainers, the noncompliant, and drug seeking.**

Some nurses spoke negatively in their conversations about older patients who had *unresolved pain:*

RN Danielle mentioned that Ian was a complainer because he was a person who is:

“...someone who’s complaining of abject pain all the time”

RN Georgina said about Hilda

“It’s like a revolving door [Hilda’s] in and out in and out” and that

“she will still [be] complaining of ten out of ten pain despite being offered an intervention ”

RN Ann said about Simon

“he runs his own race”

RN Iona to Ninnette

“you know the rules, what’s your pain outta ten?”

These older patients were spoken of as being non-compliant and labelled variously by the nurses by using such terms as:

_She was a bit special, a bit precious, it’s a drama, he/she is drug seeking, a “frequent flyer”^{80}, they are complainers, they’re back again, he/she thinks they are on a holiday._

Some were non-compliant with mobilisation after being provided with pre-emptive analgesia as RN Fran noted below:

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^{80} The term “frequent flyer” is Australian slang for a person who once discharged from hospital will be re-admitted in a short period of time.
Like with bed one, she is still asleep in bed, but I know her from before- she’s been in and out of hospital for months. There’s no point trying to get her to move or do anything or--- she won’t do that, (...) she won’t do anything until she is good and ready to do it.

[RN Fran interview 2]

Non-compliant patients RN Georgina mentioned were those who, when offered medication for their pain, then refused to take it. Hilda (78) had complained to RN Georgina of having ten out of ten pain and wanted some pain relief, but refused to take the Panadol offered. RN Georgina spoke of distancing herself away from Hilda and that she preferred to just walk away and not go there:

With Hilda, it’s like, oh my god, she’s back again, and it’s like a revolving door, in and out, in and out. You get to know who they are, like when she said “No” to the Panadol, because if you had ten out of ten pain you would have taken the Panadol, But she said “No, I don’t want it!” [sighs] I tend to not get involved, No I walk away because I just wouldn’t go there.

[RN Georgina interview 2]

The nurses spoke about how much these patients complained. RN Elise talked about an older patient who was about to be discharged who bad mouthed everyone and complained about the same things all the time. She also said these patients know the system and what to say in order to get pain relief medications:

Sigh [sounds exasperated and pauses] you try not to be rude [pause] it’s hard because she [the patient] is in everybody else’s business, we can’t do a bedside hand over at all. Or anywhere down there (...) she will bad mouth you, every staff member, she will bad mouth the patients (...) she will be complaining about the same things, about the night staff or the afternoon staff, or the man here or woman there. It doesn’t matter who. She bad mouths her own children for bringing her here. But [spoken slowly with emphasis while wagging her finger in the air] she knows the system and what to say.

[RN Elise interview 1]

When asked to clarify; they know the right things to say, RN Elise said that some patients know to respond to questions about the intensity of their pain by saying; I’ve
got ten out of ten pain. The term drug seeking was used to apply to these patients as RN Georgina noted below:

Look, a lot of them are drug seeking, they will be someone who’s complaining of abject pain. And you know what, they know the right things to say “I’ve got pain, I’ve got ten out of ten pain. I want an Endone please”. I go, “well ok, [sighs] it’s charted, I’ll just go get it shall I”.

[RN Georgina interview 4]

RN Georgina was asked to clarify this in more detail and her response was:

Well they are charted [lists on her fingers] Endone, Oxycontin, gabapentin and what not. They have everything [points finger towards researcher], maximum amounts and they are still complaining of ten out of ten pain and rolling around in the bed and (...) they will go “I’m still in pain, it’s ten out of ten and I need some Endone” and I’m like “you were just asleep, you just woke up” (...) although some of them genuinely do have a lot of pain (...) you do the same thing you always do (...) call the doctor to review, review, review, until someone [a doctor] says “Do not call me anymore”, (...) it gets to that point where we go “I can’t give you any more” and it’s amazing that then they [the patient] know they are at the end of that road, they get up and go home.

[RN Georgina interview 4]

That the patients are stating that their pain is ten suggests their pain is unrelieved and that the nurse caring for the patient does not believe this claim. It is also suggested that the nurses have a level of awareness that this may be the case when RN Georgina commented that although some of them genuinely do have a lot of pain. Of interest is the description of the efforts these patients took to gain the attention of nurses, such as RN Georgina’s comment of the patient rolling around in the bed and also the RNs Fran, Danielle, and Elise speaking of these patients as constant complainers.
Being obliged to care: costs of pain care.

Within the study four nurses spoke negatively about economic considerations surrounding the older hospitalised person being transferred onto their ward. These were openly made about how much it cost the community financially to keep an older person in hospital or order equipment and costs to the ward. When asked to clarify what her goal was for pain management for Simon who had end stage liver disease RN Ann spoke about making him comfortable while he was enduring, being obliged to look after everybody and that this was a huge cost to the community:

*The goal is to make them as comfortable as possible while they are enduring this, absolutely (...) I am very much aware that it is a huge cost to the community, they take up an acute bed, they have all the drugs, but we are obliged to look after everybody, whether they are addicted or not.*

[RN Ann interview 2]

RN Georgina was asked to talk about the sub-acute ward, and she began talking about how the patients were admitted into that ward because it was cheaper than in a bed there at the hospital:

*Well I think that an acute care bed is what eight or nine hundred dollars, intensive care beds are what thousands of dollars a bed (...) it’s cheaper to keep elderly people here than in a bed there at the hospital.*

[RN Georgina interview 1]

The costs to the ward for the external hiring of comfort provision equipment from a government contracted supplier were spoken of as being a consideration. RN Barbara spoke about Marcus (who had been transferred into her ward from being made palliative) as not having a pressure reliving mattress due to the ward having an
unwritten *in-house* policy that they could only have five pressure relieving mattresses\(^1\) at any one time on the ward:

*Marcus would be a good candidate for a nimbus but that's a lot of financial constraints (...), it's really dependant on how many others [patients using a nimbus] we have got going on the ward--and at the moment we are up to our maximum. Five per ward or something like that. I don’t know if there is a policy for that, I think that it is an in-house thing, something that I have heard.*

[RN Barbara interview 4]

She then went on to speak about not ordering one for Marcus (89) because of:

*It’s not dependant on his longevity [ordering a mattress], but you don’t want to get it in case he does pass [die] tonight.*

[RN Barbara interview 4]

Bridget also spoke about being told that once transferred from the surgical ward that she was to receive a nimbus pressure relieving air mattress but she did not:

*I was supposed to get one of those, what are they called ‘an air bed’. I was supposed to get one, but I didn’t! The surgical nurses said that I would get one when I came here and so didn’t need to order it then, but now that I am here, I haven’t got one yet. I know I was supposed to get one here because of my heel.*

[Bridget interview]

This ordering of equipment was spoken of by RN Clare as being a factor dependant solely on the patients’ risk of developing a pressure sore, as opposed to provision of comfort. When Janet complained of her discomfort from sitting due to her elective gynaecological surgical procedure RN Clare gestured towards a pillow and suggested to her to sit on that. RN Clare was asked to elaborate about this and she replied that:

*[If] Janet was at risk of a pressure sore we could of gotten her a RoHo cushion\(^2\) (...) she doesn’t really come into that category that lady, she doesn’t have an air mattress\(^3\) [either], she can

\(^1\) Termed a Nimbus mattress
\(^2\) An inflatable pressure relieving cushion hired externally from the hospital and placed on a chair as a cushion
\(^3\) Nimbus air mattress for pressure relieving care
The older persons in this study talked of not being made to feel welcome when being transferred to different wards. Certainly the comments made by the RNs suggests that the transfers of some older persons into their wards was not viewed in a positive manner and expressed as a monetary cost to either the ward or the community.

**Being moved from ward to ward.**

I wish to provide here the perspectives of those older persons cognitively intact and able to articulate their experiences of being moved around or within the hospital system. For all the older persons in this study it was not uncommon for them to have been moved through several wards and hospitals during their stay. Rhonda called this *doing the grand tour* when asked to speak about her stay in hospital:

*Different wards [15 second pause] I thought I was doing the grand tour. Ohhh I came on through ED, then to the big ward over there where they do the operations, then to surgical [ward] and then I came to down there [points down corridor to the medical ward] and the other day I came here [to the sub-acute ward]. I have been all over the hospital.*

[Rhonda interview]

When Ninnette was asked to talk about why she was here in hospital she immediately responded by saying:

*I am in the surgical ward here in the [deleted] hospital, because they had no beds left in the haematology department.*

[Ninnette interview]

Molly spoke of her stay as being one of being moved all the time:

*They keep moving me. From one hospital to another, ward to ward.*

[Molly interview]
Being moved from one ward to another for Suzanne meant having to adjust to differing routines. She spoke about the previous ward she was on that the nurses offered to make toast and cups of tea or coffee for any of the patients who were awake early in the morning before breakfast. Suzanne mentioned that she enjoyed and looked forward to this simple offer as she was now unable to ambulate independently after having partial paralysis in her left side:

> There was one of the nurses that used to make toast for breakfast if we wanted it on the other ward. He just came and asked [big smile and then a sigh] but he wasn’t on this ward. So I said to one of the other nurses on the new ward, I asked them if anyone was making toast and she said um [silence 15 seconds] she was really short with me [blows nose] she goes “can’t you do it yourself?” [20 second pause] and I said that I can’t, you know [gestures towards her left side] I...she-- knew I couldn’t walk there and come back. And she said “well I'm not making it because you can’t be bothered getting up” and I said “well I didn’t ask you to do it”. She was very short, rude and really short. I never saw her again.

[Suzanne interview]

**Interrupting the busy nurse.**

Alternatively for the older person, being in pain meant gaining the attention of the nurses and that meant upsetting their routine. The older persons in this study spoke of having to actively interrupt the provision of care processes. Brianna spoke about feeling she was imposing on the nurses and that requesting their attention was a source of annoyance to them:

> They [the nurses] are run off their feet, I hold off from using the buzzer, because I just don’t like annoying people and that’s because I can see it does annoy them [silence four seconds]. I think that I am imposing on them, yeah that’s it--- imposing. No. You can see they get a bit annoyed when people buzz all the time. Particularly at night.

[Brianna interview]

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84 Suzanne has increasing and partial paralysis of her left side and has a fractured ankle in a CAM boot.
Patients spoke about being frustrated at times with not knowing who amongst those who care for her were their nurses. Martha (90) commented about this when asked about her experiences:

*I don’t know if I was talking to a nurse about how much pain I had or who I was talking to, I can’t tell who is who. I’ve had no problems with doctors [because] they have got the stethoscope.*

[Martha interview]

Having to interrupt nurses was not viewed favourably by the older people in this study, particularly if they were requesting a restricted drug for pain relief. Peter pointed this out when talking about asking for stronger pain relief medications. Peter spoke of nurses in his experiences from *I have been in a lot of hospitals* due to his cancer diagnosis, that nurses became *rude*, they were too *busy* and become *rattled* when responding to his requests for restricted drugs for pain:

*I see this lot and I have been in a lot of hospitals, I know [that] you go through the right channels for anything stronger [restricted drugs for pain relief]. I believe in that too, it’s just that they [the nurses] get a bit rattled, some of them when you ask, it’s like a pressure they can’t get back to you [imitates an agitated person shrugging their shoulders] “oh- oh” and they are really frazzled, they get rattled a bit [again imitates an agitated person shrugging their shoulders] “oh- oh-oh I’m busy, I’m too busy” and some of them get a bit rude.*

[Peter interview]

When speaking about having to interrupt and impose on the busy nurses a sense was gained that the older person was speaking about nurses who were annoyed and agitated at being interrupted. This meant the older people in this study viewed them as being generally unhelpful and rude when being asked, and for Peter this meant restricted drugs for pain relief, regardless whether it was day or night time.
One patient, Ninnette, talked about feeling like a *hypochondriac* when being treated in acute care as an outpatient and about how she had different sites and types of pain. Ninnette spoke of her pain and discomfort increasing until she walked up to the nurses’ station and physically showed them the site of her shingles. The treating doctor then admitted Ninnette after review into another acute care ward. When asked to describe what her pain was like, Ninnette talked about her multiple sites and types of pain and being questioned about the validity of her pain by the nurses:

*I have had the chicken pox as child and the itchiness is different to that. No. Shingles is, [sigh] Oh shingles pain is a pathetic pain that doesn’t stop. Like a thunderous pain I had in my base of my shoulder blades, I will never forget the night that that first came on, I thought that I would have had clots in my lungs or something because they were on both the lower shoulder blades at the same time. I couldn’t understand what was going on [silence] (...) Well. I walked up to the nurses’ desk in Sunset ward [Pseudonym] (...) I showed them [nods]. And as soon as they saw it, they knew--- that was what it was (...) Oh the pain from having them (...) It was just [silence 5 seconds], [she then scowls] the pain was soo severe.

[Ninnette interview]

Ninnette on review was diagnosed as having a pleural effusion, upper respiratory tract infection and a shingles outbreak bi-laterally across the base of her shoulder blades.

When asked how she felt about this, Ninnette said:

*Well I can truthfully say, those girls [nurses] in Sunset ward must of thought that they were dealing with a total hypochondriac. Well, I had so many different side effects presenting and every day it was different, but I was not well and it was hard to describe to them, but every day I was off in another place.*

[Ninnette interview]

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85 Ninnette presents daily to the acute care ward for her chemotherapy, which has a room set aside for patients like her
For Brianna, Ninnette and Peter asking for pain relief from the nurses meant interrupting them within their busy routines and this meant for them that they risked being treated as an unpopular patient, as opposed to a good patient.

**Being a good patient: On edge, complying, feeling bad, and just feeling like a peasant.**

It was held as an important value by the older people in this study to be seen as a good patient for the nurses. This meant that when they talked about nurses, they were always quick to point out how much they liked the nurses, whilst downplaying any issues they had. When asked to describe what it was like to have a nurse looking after her pain, Martha (90) talked of how good the nurses were to her, while at the same time spoke of feeling on edge and that on asking the majority will comply:

*Oh they [the nurses] are always good. I don’t know they just have got something about them, they are so friendly and so, when they are busy, you don’t have to be so on the edge all the time with them. They are lovely girls, the majority of them, you only got to ask for something and they will do it for you.*

[Martha interview]

Two of the older patients talked of being aware of the implications of not complying with the requests of a nurse when in pain and Rhonda (92) spoke first hand of witnessing previous interactions that nurses had with other patients in pain. Rhonda (92) recounts an experience that she had on observing a negative interaction between a patient in pain and a nurse:

*Can I tell you? I’ll never forget this. This lady in her eighties had an operation. The next morning she refused to get out of bed. The nurse said “Well you didn’t have a leg off, so what are you moaning about?” I thought [speaks slowly with emphasis in a shocked voice] you---are---supposed to be---a nurse! It made everyone feel really bad, a terrible way to speak like that. The nurses are different in every hospital; you*
get some that are very nice. But others, well they are in the wrong profession, they should of been a kennel maid like for the dogs and cats, instead of looking after people, not got a scrap of patience and should of never of been a nurse.

[Rhonda interview]

Peter (73) spoke about feeling like just a peasant and not wanting to upset the nurses by having a run in with them. He talked of wanting to put the brakes on when he felt this was happening. Peter provided a sense of knowing how far he could go before upsetting the nurses, when in his interview he was speaking of not allowing a nurse to comply with a charting error and put ear drops in his eyes. He was upset and frustrated that he did not receive an official apology, but at the same time he said he did not want to push the issue too far:

No I, no I [silence 5 seconds] I know when to pull the brakes on. When you are in the hospital, I'm in their hands and that always rings a bell. I think sometimes they [nurses] think that you are just a peasant.

[Peter interview]

It was as though the older people in this study were aware that while an inpatient in hospital they had a loss of power and, as such, their position was of compromise as a patient to begin with. Three of the older person patients, Peter, Rhonda, and Martha, spoke of wanting to be able to make a choice in which hospital that they will present to when sick. Rhonda summed this up by saying you see one bad nurse and that puts you off everything there:

Oh some of the nurses today I wouldn’t want to have a run in with them [silence six seconds] no I wouldn’t argue with them up at [the] Bottlebrush hospital. You see one bad nurse and that puts you off everything there. Some of the nurses shouldn’t never been nurses [silence ten seconds] this one nurse, I still remember it, she was the worse one of the lot, bad tempered and filthy. I caught her up on her swearing. We don’t have to listen to that, but I have heard other people say that they won’t go to [the] Bottlebrush hospital again either.

[Rhonda interview]
When speaking about being a good patient the older persons interviewed in this study spoke about feeling on edge and also not as an individual but as a member of a group or class that had no voice or power. Rhonda spoke of some nurses being in the *wrong profession* and that they should have been a *kennel maid for cats and dogs* and this provided a distinct impression of her feeling like she was one of many who were being treated in a controlled manner and viewed like an animal that had no say. This aspect was also spoken of by Peter when talking about nurses thinking that he was *just a peasant*. It was as though a tension existed when the older person made a choice to be compliant for the nurses and when to put the brakes on or by avoiding the situation by not presenting to that hospital. So when they did attempt to confront the nurses directly the result was tension and frustration.

**Confronting nurses about medication mistakes and wanting an answer.**

Of the 11 older people interviewed in this study, nine retrospectively recounted their experiences over the past of medication error by nurses in relation to pain medication. They called this a *medication mistake* when describing their frustration, anger and fear as well as pain and suffering. They spoke about their experiences of picking up charting errors, being denied pain relief due to medication charting errors and also being narcotised by the nurses.

Older people in this study often read their medication charts if left in the room; they knew the names of their drugs and also they knew the route that drugs were to be administered. Therefore, when a drug was charted incorrectly, they pointed this out to the nurses and asked for it to be corrected. Peter (73) commented when he handed over a dropper bottle to me in the interview that he had *picked up a couple of mistakes:*
“Well I--- look I know, I picked up a couple of mistakes! [Silence] ahh ah well, look they logged that in as eye drops!” [He hands over to a dropper bottle and I comment dryly on looking at it]
“IT says ‘ear’ here on it” [Peter replies]
“I know--- I know that! They get carried away. ‘Oh these are all eye drops’ the nurses say, well they’re NOT [speaks loudly], and all I get, all I get is silence from them, you know”. [Peter interview]

Peter spoke about how his eyes were sore and dried out more since his stroke. He was also on a course of ear drops for a current ear infection.

When the older person spoke about bringing an issue to the attention of nurses in relation to charting errors and their pain medications, they said the nurses actively avoided engaging with them. Molly spoke of this when she asked why she could not have any more pain relief as:

Oh they just don’t say anything! [Molly interview]

Brianna spoke about her dawning realisation that something was wrong because the nurses started coming into the room to take her observations more regularly during that day. She questioned the nurses to discover she had inadvertently been given what she termed as the fast dose instead of the slow dose of her hydromorphone. She spoke about feeling funny in the head but still knowing what was going on, that it was scary, being worried that the nurses would not come in time and that the pain had gone:

They [the nurses] gave me 16 of the new drug that I am on, Jurnista, but they gave it to me in a full, fast dose, rather than the slow dose. I am on a slow release form of Jurnista that gives out constant pain relief. [Brianna interview]

Written in the medication chart
When asked to describe how she felt Brianna imitated this by demonstrating closing her eyes and trying to lift up her eyelids while making snoring noises. She spoke of not knowing what was going on and her heightened anxiety of being told to inform the nurses if she felt excessively drowsy:

So yesterday, well they keep checking up on me, every hour and I knew that something was going on, you know yourself. [But] I didn’t know what was going on, it was scary. I was a bit like this you see [half closes eyes to imitate going to sleep, nods head and makes a loud snoring sound\textsuperscript{87}] but then I noticed that they were coming in every hour to take my blood pressure like, that’s when I got stressed and [then] I asked them what was going on. “What was going on?” I asked them. They said that they had given me my dose all at once instead of slow release and that they would have to watch me all day. And--- I was to tell them--- if I felt too drowsy or anything.

[Brianna interview]

Brianna’s anxiety was compounded by a previous adverse experience with her medication and she developed what sounded like an episode of psychosis.

‘It was scary, very scary I know because before when they [the pain team] changed me\textsuperscript{88} up from one tablet to two tablets last year I ended up in here, and then they had to transfer me into the Kangaroo Point Hospital\textsuperscript{89} because I went funny in the head. I got stressed, in my head. I got stressed from the changeover. I didn’t know what was happening and I knew about it at the same time. It was scary so they put in a van\textsuperscript{90} and took me to the Kangaroo Point. I thought that I was going nutty. I didn’t know what was going on in my head.

[Brianna interview]

Having a previous negative experience from a medication that affected her mental health meant for Brianna that she did not want to go home until she was sure that she felt safe herself:

\textit{I was frightened that my head was going to go this time too. At the moment the only reason why I am still here is that I am}

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\textsuperscript{87} This is suggestive that she had been narcotised
\textsuperscript{88} She later informed me it was the pain team changing her regime
\textsuperscript{89} Kangaroo Point hospital specialises in clinical mental health care
\textsuperscript{90} Ambulance
concerned about the after effects of the drug that they gave me yesterday, that’s all. Otherwise I would be home.

[Brianna interview]

When asked how he felt finding a charting error Peter expressed his frustration that the nurses were keeping away from him and that all he wanted was feedback:

*It disgusts me! And if I am being a little bit critical of them [nurses], they sort of go, “I’ll keep away from that”, and then they panic a bit and this is how I see it, this is how I feel. It doesn’t annoy me [when they go] “Look Peter, I can’t give you an answer for, whatever, they haven’t told me”. See I just, look give me an answer.*

[Peter interview]

When Peter was asked to talk more about this he spoke about the public hospital system did not treat him as a customer:

*This is something that I have learnt from the public system I guess, I stay, I go mostly to private hospitals and I am always fairly satisfied, like everyone makes mistakes it’s--- it’s (...) they’ve got to fight for their customers (...) they come to you, because that's the private system (...) they have got to fight for their paying patients, but the problem [is] the other public system doesn’t you know...*

[Peter interview]

When asked how this made him feel, Peter commented that:

*I---I won’t go near a public [silence 5 seconds] I don’t like being treated like [expletive] and no, you shouldn’t be, but I think the whole public service does. It’s like they’ve got a job, well I have got a job--- we all work to do the right thing, try to. And I think that we should all adopt that attitude---not that---not a “well I’m secure for life, I can’t get the sack” type of thing, but I’d like to see that happen (...) I think the more that we talk about things, we can solve a lot more problems---I think it is that we don’t talk---nobody talks anymore.*

[Peter interview]

Overwhelmingly the older persons interviewed in this study talked of wanting to be more informed when pain medication errors occurred and that they felt that the nurses involved responded in an inappropriate manner when confronted and questioned by them. That the older person challenged the nurses to provide accountability for their
actions and also provide them with education and information about what was happening is an important point, given the previously outlined risks that they ran in being viewed as an unpopular patient. This is also a pertinent point for those older persons who are unable to provide a voice and speak about their experiences, in particular, those who have a cognitive impairment from dementia, delirium, or disabilities and those who are in their terminal stage and actively dying.

**Pain care and cognitive impairment**

When speaking about providing pain care for those older patients with a level of cognitive impairment stemming from either dementia, delirium, or a disability or terminal pain care for the dying, some nurses in this study (n=5) suggested that they did not belong on their wards. Of concern is that all of these patients had medical histories that suggested pain. For instance RN Danielle said:

\[\text{We are not supposed to have demented patients here, we have just started to ask for MMSE}^{91}\text{ because there have been instances where they have begun to slip through. We had one patient [here] with an MMSE with 13/30, so we sent them back to the ward they came from, we refused them.}\]

[RN Danielle interview 4]

Further RN Danielle said [we will have them]:

\[\text{As long as they are not aggressive, if there is any aggression we will not accept them, so if they are one of those little ones that are compliant and happy to do stuff then we will accept them.}\]

[RN Danielle interview 4]

When an older person, like all other patients, became aggressive the nurses spoke about following policy and procedure known as a *code black*. The following is RN Georgina speaking about an older person ‘Judith’ who was not part of the study, but whom she mentioned had *chronic back pain* and *dementia*, had a code black called because she

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91 See glossary
became *very agitated as well as aggressive*. RN Georgina noted that the family had informed her that *often she will just throw the pills at them* and Judith had *refused her two lots of her Panadiene forte* on being asked if she wanted that special Panadiene forte for her pain:

> She [Judith] had a code black called on her here the other night, she was very agitated and aggressive. But I haven’t had much problem with her so far, touch wood [slaps hand on table] but she gets a bit agitated, she sundowns with her dementia. She has chronic back pain as well. I mean yesterday with us she refused twice her two lots of her Panadiene forte and when I looked at her notes yesterday, her family said that often she will just throw the pills at them.

[RN Georgina interview 1]

Older people who were suspected of being in delirium required closer nursing observation. RN Hermione talked about an older person who was not part of the study as coming *in late last night* and being placed on a *delirium score* to monitor her delirium. She suggested that the older person be transferred to another medical ward where she belongs:

> The other lady who came in late last night, she’s on a delirium score, at the moment, I don’t know why they brought her here but---well, she has a history of short term memory loss, dementia as well. [Pause] I’ve seen her on her feet though and she is stable. Otherwise we would have moved her down to a bed where we can actually see her--- there are certain beds we can put people so that they are under observation all the time but she will go off to where she belongs, you know, to Acacia [medical ward] soon as a bed is available.

[RN Hermione interview 1]

Older patients who were unable to communicate verbally due to their disability experiences were referred to by RNs Ann and Hermione as *DD* and that they were

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92 This is a common superstition in Australia, where if you say ‘touch wood’, you need to actually touch a piece of wood afterwards

93 When those with dementia experience a disturbance of their circadian rhythm leading to an exacerbation of behavioural symptoms in the afternoon and evening (Volicer, Harper, Manning, Goldstein, & Satlin, 2001)

94 Termed used to indicate those who are Developmentally Delayed
unable to interact with them. When asked to speak about Justin who has a mild cognitive impairment, has no communication impairment and lives independently in the community RN Ann said:

We get a lot of DD patients here, from the community and from Spotted Gum. This is their hospital of choice, they regularly send them here. The ones from Spotted Gum you cannot interact with them much, the ones with really bad cerebral palsy and that. It’s more like (…) you assess them mentally on how they respond to you and that’s gained mainly from experience, having to deal with these people and reading their notes.

[RN Ann interview 1]

RN Hermione commented that:

At the moment we have a DD lady who will stay with us because she usually lives in a group home, but we’ve had another couple from group homes we have refused to treat because as far as we are concerned there is no family – as far as we are concerned, we couldn’t get informed consent. I remember once you know, this guy was late 80s and it was absolutely ludicrous to treat him so the nurses turned around and said we are not doing it to the [deleted] if you want to do it, you get consent and you do it. This is not the first time either---really I mean sometimes they are referred by a GP and the [deleted] has never met them until they hit the hospital ready for treatment and it’s like---you’re not in the condition I thought you would be in, and things like that.

[RN Hermione interview 1]

When four of the nurses in this study made statements suggesting that those of the most vulnerable older persons do not belong on their wards and infer that their fellow nursing colleagues refused to treat or accept them is allusive towards a prevailing ageist attitude. In light of this, for those older persons in pain with a cognitive impairment, the assessment of their pain had the potential to cause tension for the nurses in this study.
Assessing pain for those with cognitive impairment.

When speaking of those with a cognitive impairment many of the nurses in this study said that those older patients who were unable to understand or to use their words were unable to get the concept of pain. For instance RN Barbara spoke of asking a patient with a cognitive impairment to point and rate his/her pain and she said that the patient pointed at silly things and you think well you really have not got the concept:

You show them [patients with a cognitive impairment] the faces\(^98\) [pain scale] [and you] ask “You sore? (...) You feel like that [imitates pointing] sad face or [do] you feel like that [imitates pointing] happy face, or [do] you feel like that?” and then you go “Ohh ok”. Most people can actually point, although they may point at silly things, such as other people in the room and all over the place and you think well you really have not got the concept of pain.

[RN Barbara interview 3]

RN Georgina also talked about using the Wong and Baker (1988) faces tool, which she termed as the smiley faces tool:

Sometimes I will use the smiley faces tool and ask them [those with a cognitive impairment] to match it up with the grimacing face, or the not happy face or non-smiley face. Some [patients] will think that you are just an idiot for giving it to them, and they just point at everything around the room except for the tool.

[RN Georgina interview 1]

Assessment of pain in older patients with a cognitive impairment and communication difficulty was a challenge for some nurses who talked of unsuccessful attempts using the Faces pain scale. Of concern is that some nurses may not understand the concept of cognitive impairment. I wondered why they did not consider the use of an alternative tool such as the Abbey pain scale which is recommended for this population (Abbey et al., 2004).

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\(^98\) Faces pain tool Wong-Baker FACES Pain Rating Scale for paediatrics
When asked about the use of specific pain assessment tools, such as the Abbey pain scale\textsuperscript{99} for assessing pain in the older person with a cognitive impairment RN Barbara stated this was \textit{not} part of the nurses’ \textit{common practice}. Although RN Barbara indicated awareness of a recognised need for an appropriate pain assessment tool for use with older people with cognitive impairment. RN Barbara spoke of attempting to implement change within the clinical practices of her ward by downloading pain assessment tools off the intranet\textsuperscript{100} and distributing the tools for use by the nurses on the ward:

\begin{quote}
We do have a tool and every time I put the tool out it disappears, it’s the Abbey pain scale. I put it in the filling system, in the slots that are provided (...) but it just goes. So whoever is tidying up, usually its night staff or it could be any one, it goes. I don’t know where they go. I don’t know if Tea tree [ward] are coming down and pinching them, if they use the tool up there or what. So therefore we don’t use the tool.
\end{quote}

[RN Barbara interview 2]

None of these tools were found or observed to be either in use or on the ward during the length of the field work undertaken within this study.

When RN Elise was asked why she was writing her nursing report whilst in Lily’s (91) room, she said she was waiting for Lily’s husband to arrive so she could elicit the behavioural indicators that indicated pain in Lily:

\begin{quote}
I waited for him [Lily’s husband] because he will elaborate that “When she is at home and in pain I know when she is in pain cause she will do this and this”
\end{quote}

[RN Elise interview 3]

For older people who had dementia and were still able to verbalise, nurses such as RN Georgina emphasised they were able to inform them if they had pain:

\begin{quote}
So you know, all demented people, they still can tell you if they have pain or not, sometimes they are more aggressive because they have got pain.
\end{quote}

\textsuperscript{99}(Abbey et al., 2004)

\textsuperscript{100}The area health internet service that is only accessible from computers within that health care system
RN Elise asserted that people with a cognitive impairment and who were unable to verbalise were able to communicate their pain by using sign language. As RN Elise said:

_Probably at the end you know they mightn’t be able to communicate that [they have pain] but you can communicate and find out bits and pieces, you can use sign language [to communicate]. I’ve done that many times, you can sort of get there you know._

When RN Elise was asked to explain in more detail what she meant by using sign language for those older persons who have a cognitive impairment she replied that:

_Well there are other ways of communicating, you don’t need to, the words don’t need to have to come out, and it’s like communicating with---oh going overseas and communicating with a German or French person – you don’t know the language and they don’t know your language but you can communicate and find out bits and pieces._

This suggests that RN Elise is inferring that those with dementia and unable to communicate is merely in relation to them having transcended the English language into another complete articulate and silent foreign form of language. The comments made by the RN Elise allude towards a lack of education or knowledge on her behalf of being able to demonstrate understanding of what a cognitive impairment entails in relation to the ability to communicate verbally as well as the learning of another language. The comments made by RNs Barbara, Elise and Georgina suggest that in relation to the lack of using both an EBP pain assessment tool and within their communication processes for those with a cognitive impairment, implies that those with a cognitive impairment may experience substantive barriers to having their pain assessed.
Having dementia and being in pain.

Whilst nurses said they used the Faces pain tool none of the nurses were observed to use any pain assessment tool for those with a diagnosis of dementia, or any other cognitive or communication impairment during this study. In the following exemplar, Astrid (79) who has dementia, indicated to her nurse RN Georgina, the presence of pain just below her sternum in the centre of her chest. RN Georgina is doing a round of assessing vital signs during a night shift.

It is late, 22.30 and dark. RN Georgina is in a four bed room of women and they all have their curtains drawn. Astrid is the third patient in the room to have hers done, as the nurse is moving in a clockwise manner around the room. She pulls back the curtain and goes towards Astrid who is lying in bed.

[Reflective journal entry 62]

[Astrid is frowning and lying slumped in the bed. On seeing RN Georgina move her bedside curtain back she goes]

“I can’t breathe, I can’t sleep. I get dreadful pain every time here [when] I breathe in [points to right side of episternum region]”

[RN Georgina reaches to the back of the bed and gets the oxygen nasal prongs and puts them on Astrid, and then she uses bed mechanics to sit Astrid up before repositioning by fluffing her pillows and tucking her in]

“It’s ok, here have some oxygen”
[Astrid is still frowning]

“That’s a bit better I can breathe now”

[RN Georgina then connects Astrid to the OBS machine while talking to her]

“How’s your pain? You got that needle tonight already, has it worked?”
[Astrid replies by sounding very vague]

“I had a needle?”

[RN Georgina presses the start button on the OBS machine]

“Yes the nurses gave it to you[101]”
[Astrid then replies]

“God bless you all, you are very kind”

[RN Georgina then ensures that the nurse call buzzer is within her reach]

“I’ll give you the buzzer, the lights will go off soon”

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101 Astrid had received 25mcg of sub cutaneous fentanyl at 1800, four and half hours ago
[She disconnects Astrid from the OBS machine, gels her hands and pushes it out of the curtains into the next bay]

[RN Georgina observation period 2]

At this point RN Georgina turned and mentioned to me that she knew that Astrid was not experiencing cardiac pain. Later that night RN Georgina was invited to reflect on what had happened. The version of the event that she supplied was markedly dissimilar to that which was observed:

*Like tonight, I said “that needle you had last night”, [and] Astrid said “yes, that is good”, I said “well you have already had that [again] tonight and she said “oh, have I?” I said “you’ve already had that tonight, and so I said it should work”, and so she was happy that I had reminded her that she had had the needle [of] sub cut Fentanyl.*

[RN Georgina interview 2]

Interestingly RN Georgina differentiated between the management of *chest pain* and what she termed was *central pain*. When asked to clarify her knowledge of Astrid’s pain in more detail, RN Georgina began to talk about her by saying that *she can’t tell you what type of pain* she is experiencing:

*Astrid she’s got pain, but she can’t tell you what type of pain, like last night she was complaining of central pain*[^102] and I said to her “Is that your epi-gastric post gall stones?” And she said “I don’t know”. I kept saying “where is your pain?” and she goes “In here I can’t breathe, I can’t breathe, I can’t breathe” she kept saying [that] over and over again. I had to do all the things that you would have done for chest pain[^103] to settle her down.

[RN Georgina interview 2]

When asked to clarify what *I had to do all the things that you would have done for chest pain* meant, RN Georgina spoke about the medications and procedure she followed for treating chest pain previously on her shift *last night* while speaking of the decision made by the RMO that Astrid did not have cardiac chest pain:

[^102]: RN Georgina here is avoiding the use of the term “chest pain”
[^103]: Here RN Georgina is using the term “chest pain”
So I just called for a review. I gave her some Mylanta and a ½ Anginie and did an ECG. The RMO came, reviewed her ECG. Then we started prodding, we were on her gall bladder she said “Oh that is the pain, there”. The doctor said “I don’t think it is cardiac related, I think it is more to do with her gall stones” so that’s when we gave her the needle [of sub cut fentanyl].

[RN Georgina interview 2]

Astrid received a second dose of sub-cutaneous Fentanyl later that night at 2400 which was an hour and half later after her initial compliant of pain. The efficiency of that intervention was reassessed at the next round of night visual observations when at 0300 she was observed visually by RN Georgina.

Pantomime and pain assessment.

When the older person was unable to articulate words either due to their disease progress and/or as a result of a surgical intervention, they were observed to use a lot of pointing, gestures of shaking or nodding of heads for “yes” or “no” when being questioned about pain by the nurses. The resulting exemplar highlights this situation as experienced by Terry (85) who was admitted after he had a fall at home.

On admission Terry has had his bottle of liquid Ordine [liquid morphine] removed from him. It is now day eight of his admission with no documented input from palliative care. Terry is hearing impaired and had a laryngectomy in 19XX. His speech pathologist recommends that he be encouraged to use his electro larynx.

[Reflective diary entry 24]

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104 When nurses speak of “calling for a review” this is an Australian nursing term for asking for a medical clinical review to be conducted within a half hour. This is the accepted step before calling a RRT or immediate clinical review.
105 Over the counter anti reflux liquid
106 Sub lingual tablet for treatment of angina
107 Electrocardiogram
108 It was documented that Terry had complained of a decline in clarity of his verbal output when using this device. On review the speech pathologist advised Terry to decrease his rate of speech, not to over articulate and use short phrases.
RN Ann is doing a round of medications during a busy morning on the medical ward. She begins the assessment process by asking three questions in rapid succession.

The trolley is outside in the hallway and Terry is the last patient that RN Ann comes to as his bed is on the right near the door entrance in a four bed room. During this interaction it is only RN Ann who speaks. Terry communicates by nods and gestures. He does have an electronic vocal device on his bedside locker but does not use it.

[Reflective journal entry 24]

[RN Ann stands next to Terry who is lying on top of his bed and leans forward and asks him]

“So Terry, pain? Have you been having any pain? You have Panadol\(^\text{109}\), but you have been having morphine\(^\text{110}\) for your pain?”

[Terry nods a ‘yes’].

“So where was the pain?”

[Terry holds his right hand with forefinger extended to point at the side of his face just above his left eye and moves it down to his left cheekbone]\(^\text{111}\)

“Oh---ok on the side of your head?”

[Terry nods a ‘yes’ and moves his hand upwards to indicate an increase or rise of pain\(^\text{112}\) while frowning and looking sad]

“Are you Ok now?”

[Terry nods a ‘yes’ and then moved his hand downwards to indicate a decrease and he smiles]

“Do you want anything at all?”

[Terry moves head side to side for a ‘no’]

“So you are alright?”

[Terry nods a ‘yes’ and smiles]

“Well ok, let me know if---”

Terry nods another ‘yes’ and then smiles. RN Ann then returns to the medication trolley outside in the hallway and begins to get out his medications.

[RN Ann observation period 2]

For those older persons in this study who were cognitively intact but unable to verbalise due to a surgical intervention or disease process the observed pain assessment resembled that of a pantomime. This also suggests that for those patients that a

\(^{109}\) In Terry’s chart there was no charting of either regular or PRN Panadol nor did he receive any NIM Panadol

\(^{110}\) Over his eight day admission period Terry received a regular dose of PRN 2.5mg liquid Ordine between the time of 1930 to 2020

\(^{111}\) Here he is pointing in a tangible gesture to the site of pain

\(^{112}\) Terry is representing his pain in an abstract gesture here. High and frowning infers a lot of pain- with low and smiling to indicate not much pain
relationship had been developed between them and the nurse who was looking after them. For those older persons in this study who were transferred between wards or hospitals and had a cognitive impairment that limited their ability to interact, such as those who were in the terminal stages of dying, the nurses changed the way that they provided pain care.

The constantly transferred: Pain care for the dying

The observational data concerning provision of palliative pain care in the acute care setting in one hospital location identified an emerging pattern regarding these patients and that was they were often transferred into an acute care ward from another ward at any hour of the day or night. To say that having a terminal stage patient (referred to by the nurses in this study as palliated) transferred into their ward with limited advance knowledge of their imminent arrival was a considerable source of distress and concern is a massive understatement. The following reflective journal comment highlights how patients arrived with little pre-emptive warning to those nurses on the wards, and lacking any communication as well as palliative pain care plans in place:

I am in the middle of an observation period with RN Barbara who is in charge of the ward. (She is speaking on the I/C phone to another ward about a patient transfer). A nurse is running towards us, her face red, full of tears and she looks really flustered, and she breathlessly informs RN Barbara a patient is on their way from ED whom the nurse said “has a heart rate of 30bpm, which keeps stopping what should I do? They are on their way now, they are coming and you were on the phone” [they both depart quickly]. It turns out the patient was palliated in ED and passes away on the ward. But this information had not been provided in a timely manner to any of the ward nurses, including RN Barbara who was in charge of the ward.

[Reflective journal entry 19]
When RN Barbara was asked about what she wanted for pain care of these terminal palliative patients she spoke of using what she referred to as a *triple M* infusion and referring to a guideline devised by palliative care Australia from another local hospital.

The palliative care guideline used by the other hospital site was not available to this hospital study site online; it had been provided by a nurse who had attended a palliative care workshop. However, I was unable to locate it during the study period and when I asked about it I was informed that another nurse had taken it home to use in an assignment.

[Reflective journal entry 20]

When asked to describe what was a triple M infusion RN Barbara replied:

*The triple M [infusion] is morphine, midazolam and maxalon [metoclopramide].*

[RN Barbara interview 4]

This combination of drugs for terminal palliative pain care are not recommended in the AIHW(2014) palliative care guidelines (Ellershaw & Wilkinson, 2003) being referred to by RN Barbara. When talking about caring for a patient who was dying in acute care nurses talked about requiring a formal decision to be made by the doctors that the patient was to be *palliated*¹¹³. RNs Danielle, Barbara, and Elise talked about palliative patients having their nursing care and treatment focus altered from curative to end of life care as being a source of distress for them. With RN Barbara reflecting on a patient who had arrived to the ward with a low level of consciousness but was still for active treatment until as she noted *the family came in and made a decision about them becoming palliated* and then she stated:

*Which I just think [she speaks slowly with emphasis] why---are---we---doing---this? It’s all this life prolonging stuff.*

[RN Barbara interview 2]

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¹¹³ Actively dying and deemed to be close to death
Palliative patients were placed in single rooms or transferred to another ward. Obtaining the decision from medical staff that a patient was to be palliated was difficult and a source of frustration and distress for nurses. When RN Elise spoke of dying patients, she spoke of them as not belonging, and suggested that the care of these patients was not what we are here for:

We do get a couple of palliated patients, but they are very rare here, because we are sub-acute, they have to be medically stable to be here and we will tend to refer them back to the acute team rather than have them here. Because our aim is to mainly [5 second pause] to be able to send them back to where they came from, not [5 second pause] to heaven you know. What I mean [is] that’s not what we are here for and they don’t belong here.

[RN Elise interview 2]

Evident within the comments made by the RNs is a switch being made from a curative to a palliative focus. Not unlike the comments made about those patients with a cognitive impairment, the suggestion by RN Elise that dying patients do not belong here suggests an unwelcoming attitude, more so when these patients were being transferred into these wards at any time of the day or night.

**Transferred to another ward in the middle of the night.**

In this study one patient Marcus (89) (see within the section titled Looking for wincing or grimacing as a sign of pain on page 173) had indicated to his family that he wished to be included in the study before he deteriorated. When Marcus began to actively die, he was transferred into another ward in the middle of the night. When asked to speak of Marcus’s journey RN Barbara commented that:

Yes, they did that late last night---he was on Wattle ward, looking at, or maybe it was Acacia ward--- and looking at going home, they were planning for discharge but his umm renal failure decided to turn (…) so he got transferred down here.

[RN Barbara interview 4]
The following exemplar shows how RN Barbara undertook a pain assessment on Marcus before turning him to provide pressure area care:

Marcus was admitted five days ago originally for management of acute pulmonary oedema. He was transferred into the coronary care ward and on having this resolved he was then transferred into the medical ward, before going to the sub-acute ward and looking at being discharged home. However, his kidney function was steadily declining and he deteriorated rapidly and was transferred into the medical ward in the middle of the night.

[Reflective journal entry 23]

In the follow up interview RN Barbara spoke about how when she started her shift that Marcus did not have a line in\textsuperscript{114} for PRN sub cut pain relief and so she put one in\textsuperscript{115}. When asked why she wanted a line put in her response was:

\textit{Because I felt that he is palliative--- for his own comfort--- that one needle is enough and he’d probably have more than the dose that I gave him over the ensuing days---so it’s mainly for his comfort, its one intervention there and then no more (…) this man may need three or four shots a day or he may need less. Either way, you don’t need to be stuck with a needle every time. So it’s just one of those things that you just do. To relieve his pain.}

[RN Barbara interview 4]

When asked to clarify what \textit{intuitive stuff} meant RN Barbara begin to talk about reliance on facial cues and looking for grimacing:

\textit{Depending on how or what that was there’s a lot going on (…) because I look at the faces pain scale---and I sort of go with that. You can have a grimace which means “Ohh I really didn’t like my arm being moved” or (…)“I really just hate what it is that you are doing” and then go from there (…) But I wouldn’t hesitate to, even if there was some discomfort (…) look I don’t have to give morphine, maybe it’s just an irritation, they are just agitated or distressed I will look for more signs, like if it doesn’t stop does it continue?}

[RN Barbara interview 4]

\textsuperscript{114} “Having a line in” is Australian nursing slang for a sub cutaneous port to be inserted under the patients’ skin. This way PRN doses can be administered through the port and not require a multitude of potentially painful or uncomfortable injections

\textsuperscript{115} See note above
When asked to clarify more about what she meant RN Barbara began to talk about providing patients with sedation rather than pain relief for management of distress:

*You can get that sort of startle thing happening (...) we have just given someone midazolam rather than morphine because we felt that they were agitated more than in pain and they usually do this finger clenching and they look anguished. It’s time to maybe put the other little dose in, maybe Xanax\textsuperscript{116} or midazolam (...) rather than pain relief. So distress and pain they are different but they do go hand in hand.*

[RN Barbara interview 4]

The lack of the use of an EBP pain assessment tool and the comments by RN Barbara inferring the use of midazolam, to provide sedation rather than morphine for pain is suggestive of a knowledge deficit. For those older persons who are unable to communicate and had a cognitive impairment or were terminal as in the case of Marcus, once the decision was made that they were to be palliated they were moved from one ward to another and their pain story was lost. Being in this situation was a source of distress not only for those patients involved, but the nurses as well when trying to provide pain care continuity for dying patients.

**Pain care continuity lost for dying patients.**

Getting a plan in place for pain management before that palliated patient was to be transferred or arrived onto another ward was a source of frustration for the nurses in this study at one hospital location. They spoke about being distressed and concerned about these patients while expressing their exasperation that the current treating team would not take responsibility for organising a palliative infusion to be charted before the patient was moved. RN Danielle spoke of her feelings of frustration when knowing that

\textsuperscript{116} Alprazolam - a benzodiazepine
Donna (who when transferred was deemed to become palliated) was going to be transferred into another ward but did not have any PRN opioids charted for pain relief:

_I just keep asking [the treating team] and in the end it was just “no if she’s going to be palliated, she’s not our patient” and we have to move her to the acute sector ward._

[RN Danielle interview 4]

RN Danielle spoke about family members being contacted and informed that Donna was dying, and then still having a delay by the current treating team in getting a continuous infusion for pain care charted. The situation as RN Danielle describes it was:

_The son [Donna’s] was contacted on the Thursday by us and he was told that she [Donna] had an ischemic bowel and that it would probably be quick for her to go [pass away]. And he was asked what were his wishes, because she had no ‘not for resus’ order. So yes he said no NFR no RRT calls, only comfort measures--- but the treating team still didn’t put up an infusion for the continuous pain relief._

[RN Danielle interview 4]

Both RNs Danielle and Barbara who were located within one hospital site spoke about the difficulties that they encountered in managing pain crisis situations with patients who had been palliated. They spoke about their efforts for pain care interventions for provision of breakthrough pain relief as having to constantly ask the treating team to chart them as RN Barbara noted:

_They [the medical team] started palliation with him but with miniscule doses and they were not looking at his PRN doses and taking them into account. What we [nursing staff] wanted to do was put his infusion up, which is in the guideline. So palliative care have those guidelines and you can throw that at them so I got hold of Helen our clinical CNS here, and that’s when we got the infusion changed, and upped the infusion rate._

[RN Barbara interview 4]

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117 Here she is speaking about a lack of an advanced care directive being in place
118 Chart the infusion on the PRN chart
When speaking of the difficulties they had, typically it appeared that this was in relation to communication with the treating teams regarding breakthrough pain management for dying patients. The RNs Danielle and Barbara spoke of a gradual escalation from the initial step being provision of oral drugs for pain relief before moving to sub cutaneous PRN injections then giving a constant sub cutaneous infusion. When asking the treating doctors to chart a palliative infusion for a patient who had recently arrived onto the ward, RN Barbara spoke about her frustration about the ways that they sourced information and charting of what she felt was inappropriate doses that were not effective when used for palliation:

*I found this IMO today [who] charted it [midazolam] at a miniscule dose\(^{119}\) and only STAT\(^{120}\) [slaps table with hand] you need to---look at that---in relation to palliative care as well, you just don’t need to look at CiAP\(^{121}\) and MIMS\(^{122}\)---you have to actually---if you come with a palliative care focus, look at the patient, (…) speak to the nurses --- Ring palliative care. You need to actually pick up a phone and actually talk to someone in [speaks slowly to emphasis last two words] Palliative---Care!\(^{123}\)*

[RN Barbara interview 2]

When this gradual progression of escalation was reflected on by RN Danielle about Donna’s death, it appears that it was not occurring within a person centred timely manner:

*Donna was charted some Endone and some sub cutaneous [fentanyl], They [the previous nurses on shift] gave her the Endone\(^{123}\) and it didn’t touch the sides\(^{124}\), so I got actually got that changed and I gave her the 25 mcgs sub cutaneous fentanyl, [five second pause] she was charted that hourly, five minutes later she was still writhing and screaming in pain. So I said we are going to put a line in, [four second pause] so*

\(^{119}\) RN Barbara later showed me the chart, the midazolam had been charted as 1mg Stat sub cut
\(^{120}\) From the Latin word statum, meaning 'immediately'
\(^{121}\) Clinical information access portal
\(^{122}\) Monthly Index of Medical Specialties
\(^{123}\) RN Danielle was quick to point out that Donna had not been made NBM and was still receiving oral medications despite being diagnosed with an ischemic bowel
\(^{124}\) Had no efficiency for Donna, in that it did not provide any relief for her
I could put the [PRN] sub cutaneous fentanyl in a little bit easier for her [sighs and blows nose]. But she was just writhing around in pain. I did that twice more, she had had the three more lots of 75 mcgs [fentanyl] with me before [lunchtime], so she seemed to settle more. I kept asked the doctors “Can you review her pain relief? Can you have a look at her, it’s not working!” By the time they [the treating team] went in there it was after lunch, after their rounds, and they said “that she looked fine, and [15 second pause] that she wasn’t in pain right?”

[RN Danielle interview 4]

When RN Danielle was asked to talk more about how she felt about the situation her reply was almost inarticulate due to the level of frustration and distress she experienced:

‘I was so, so very frustrated---very very very frustrated ---so that is why I was saying [inarticulate] it was kind of getting really very complex and just something---just so out of the scope of what it was [raises her voice and points her finger at me] a lady---pain---ischemic bowel---24 hours to live, maybe 48 hours---being put on antibiotics and oral pain meds, and NOT palliated---seemed very strange [Pause 30 seconds] I’m glad we got her some sub cut before the end though.

[RN Danielle interview 4]

The communication between the nurses, family members and the treating team for those older persons who were terminal and dying appeared to be less than optimal. It appears that a lack of resources and EBP specific for palliative pain care contributed to these situations of poor communication and collaboration. It is suggested that these situations appeared to be revolving around a reactive response to increased pain and distressed experience by this very vulnerable group of older persons causing a lot of disjunction for some nurses on different wards within a singular hospital location.
Review and summary

This final findings chapter titled pain care, tension, and disjunction presented both the older persons’ and nurses’ experiences about when the provision of pain care leads to tension and/or disjunction. Although missing are the thoughts of those who had a cognitive impairment through dementia, delirium, disability or dying, captured were those older persons who were cognitively intact to provide perspective and insight into what it was like for them.

The beliefs held by the nurses within acute care that they were not able to provide PRN breakthrough pain relief by the IV route for opioids alludes towards a starting point for tension and frustration to begin for those older persons suffering from acute, severe or cancer breakthrough episodes. As for those older persons in that situation, they were reliant on the nurses providing pharmacological interventions via an oral or subcutaneous route which has a slower onset that that of IV. These beliefs held by the nurse are suggestive of stemming from a lack of knowledge as well as clinical reflection.

When nurses in this study referred negatively to older persons who complained of abject pain were being viewed as being unpopular, and a drain on the wards’ budget as well as nurses speaking of feeling obliged to care for them is disturbing. Explored are the patients’ perceptions of having to interrupt a busy nurse and their thoughts on the importance of being a good patient whilst being in situations when they required answers from the nurses about what they termed were medication mistakes. Gaining a connection with nurses in a climate of constant transfer between hospitals and wards was spoken of as difficult for the older persons interviewed in this study. They spoke of feeling like they were imposing and being a burden on the nurses, particularly during the night time. Insight and understanding is gained into the tension evident when the
older person in this study spoke of their attempts to confront the nurses about medication errors. Asking for more pain relief from their busy nurse was spoken of as being a trigger for the nurse to become rude towards them and being overtly confrontational towards these nurses was one way used to get their attention. The older persons spoke of some nurses as being like a kennel maid for cats and dogs or leaving them to feel like a peasant, and this infers a deeper endemic problem than that of ageism as being present.

When the nurses in this study openly spoke about discriminating against the older person with a cognitive impairment by having a stated preference for those who were compliant, not aggressive, along with gross generalisations, this infers not only a lack of knowledge, but also a lack of clinical reflection and leadership. In particular, when the nurses spoke of difficulties that they encountered in their previous attempts in using a formal pain assessment tool for those older persons with a cognitive impairment, absent is a lack of use of EBP. Comments about those older persons with dementia and alluding to this group of people as being unable to get the concept in relation to pain is suggestive of and infers ignorance.

The predicament for those older persons with no voice and in pain can only be inferred from those exemplars presented of those with a cognitive impairment, communication disability or dying. Certainly, within those exemplars it is strongly suggestive that at times it was common for these groups of older persons to be enduring and suffering in pain whilst hospitalised.

The following chapter presents the discussion and conclusion that situates all the findings further within the context of the literature reviews.
Chapter nine: Discussion and conclusion

Chapter Introduction

The aim of the research reported here was to explore the clinical practice of nurses when assessing and managing pain in older people in the acute care setting. This thesis explored how the culturally mediated practices of nurses can impact on the assessment and management of pain in older people in acute care settings and the barriers and facilitators of pain care for the older person in acute care. This thesis shows how the values and beliefs of nurses can shape clinical practices as well as the uptake of best practice in the assessment and management of pain in older people.

In the following sections I address the research aims and questions by showing the impact of the nurses’ culturally mediated practices, which have called into question the espoused philosophies of care. In particular, I explore those aspects of care that value the patient, the person, the individual and the evidence regarding best practice for pain care provision that gives primacy to the notion of “pain is what the patient says it is” (McCaffery, 1968). I begin this by revisiting the research questions and situating them within the conceptual framework underpinning this study to outline the care practices of nurses when providing pain care for the older hospitalised person. Outlined in summary are the barriers and facilitators to the provision of pain care for the older person by the nurses within this study. These findings are discussed as they relate to the literature review undertaken in chapter two. This chapter presents the implications of the findings from this study for nursing clinical practice, together with recommendations are made for changes. This chapter also discusses the elements of trustworthiness that related to
The research aims and questions.

The aim of the research reported in this thesis was to explore the clinical practice of nurses when assessing and managing pain in older people in the acute care setting.

The research questions asked:

1. What are the culturally mediated practices of nurses during the assessment and management of pain when caring for older people in acute care?

2. What are the culturally mediated facilitators and barriers to practice?

The research sub-questions were:

- What are the values and beliefs of nurses regarding pain in older people, pain assessment and management processes?

- What are the nurses’ motivations when assessing and managing pain in older people?

- What artefacts (such as documentation, policy, guidelines and assessment tools) within the organisation or ward setting are used by nurses to guide their pain assessment and management practices for older people?

- What are the routine care processes undertaken by nurses for the assessment and management of pain in older people?

- Are there rituals associated with assessing and managing pain in older people?

- What is the older person’s experience of having their pain assessed and managed by nurses?

- What are the environmental influences on the practice of nurses when assessing and managing pain in older people?

Based on the research questions, I set out to explore the clinical practices of nurses when they were assessing and managing pain in the older person within the acute care setting. Through the application of Leininger’s culture care theory (1988) as a
conceptual framework and by a focused ethnographic approach insight and understanding was gained from both the nurses and the older persons’ viewpoint about pain care provision. In this final chapter the findings from this study are reviewed and discussed.

**Review and summary of thesis chapters.**

The first chapter provided an outline of the study context, evidence based best practice for pain care provision and the impact of an organisational culture within hospitals. The known barriers for effective implementation of EBP pain care provision that can cause a drift away from the espoused organisational values in place within hospital settings were identified in the first chapter as inconsistent leadership and a lack of research evidence implementation.

The second chapter, a systematic search and critical review of the literature review, opened with discussion outlining definitions of pain, and best practice relating to the undertaking of assessment as well as management for the older hospitalised person. The literature that outlined the experiences of the older person in acute care and their reasons for admission into hospital as well as the evidence suggesting that they continue to experience unrelieved pain whilst an inpatient was presented. The work of registered nurses within acute care and a requirement for the specialisation within nursing for care of the older hospitalised person were identified along with issues involved in relation to levels of knowledge nurses hold about pain. Presented was a summary of a systematic search of the grey literature available to the nurses in this study to access within their wards, and to determine availability as well as accessibility of current guidelines, policies and procedures within the setting. The critical review of the literature by use of the McMaster critical review form (Letts et al., 2007) was used to assess the quality of
the articles before a thematic analysis was undertaken guided by Schein (2010). Within the critical review of the literature, a further separate critique also occurred on those ten research studies that used ethnography for qualitative research devised by Tracy (2010), which was applied in order to consolidate knowledge and provide rigor for the methods used in this study. The review of the literature identified a paucity of research relating to pain care provision by nurses within the context of acute care that is inclusive of the older person. A knowledge gap has been identified between availability and use of EBP guidelines within the research setting.

Chapter three, the conceptual framework and methodology chapter, outlined how the use of Leininger’s culture care theory (1988) was used as the framework to guide the methodology, focused ethnography, used in this study. Chapter four, the method and design chapter, provided discussion on the research design and methods used in the study and included the location and description of the settings, recruitment of participants, and the ethical considerations. Description of the methods of participant observation, semi-structured interviews, and the document review were also discussed in that chapter. A prologue to the findings chapters six, seven and eight introduced the older person participants. The findings chapters provided descriptive accounts and insight into the provision of pain care by nurses for older patients.

The conceptual framework revisited

The goal of using Leininger’s culture care theory (1988) in this study was to explore how pain care was being provided to the older person by nurses in a culturally congruent manner. As noted previously in chapter one, the provision of pain care by nurses that the older person considers safe, satisfying and beneficial is known as care provision which is culturally congruent (Leininger, 2006). The utility of using
Leininger’s culture care theory (1988) meant that the professional care practices as well as how the nurses accommodated their practices for pain care provision, were explored. The older persons’ perceptions and experiences of receiving pain care provision are also gained in order to provide information about nurses’ clinical practices for when adaptation, accommodation or negotiation is required which is of benefit for the older person. To date, this use of Leininger’s culture care theory (1988) has not previously been used for exploration of pain care provision for the older person in acute care settings and this study’s use of it provided valuable insight into how acute care nurses can provide culturally congruent pain care and avoid cultural conflict. Cultural conflict occurs when the provision of pain care is viewed as being of no benefit, unsafe or inappropriate by the older person (Leininger, 2002). Leininger’s culture care theory (1988) as a conceptualisation has provided much needed, timely insight and reflection into the provision of pain care by nurses for the older person in acute care.

**The care practices of nurses**

Within this section, a discussion will occur that outlines the findings that captured the roles of the nurses and the efforts that they undertook to provide assistance and support as well as facilitate or retain and maintain the older person’s well-being in relation to the provision of pain care. It will draw on the study findings that highlighted how the social structures of the nurses’ pain care provision, the generic knowledge of the older person, and the professional care-cure practices that are in place, were applied for the provision of culturally congruent pain care provision. These aspects are then discussed regarding how they emerged within the care practices of the nurses. From the application of the knowledge that has been gained in this study, recommendations for nursing clinical practices as to how the most appropriate, beneficial, safe, and above all
meaningful as well as acceptable provision of culturally congruent pain care for the older persons are provided.

**The role of the nurse.**

The nurse’s experiences of providing pain care for the older person varied from mentoring junior transitional nurses and being in-charge of the ward with or without a patient load or patients to care for, as well as auditing of data for quality improvement processes, and providing education for others on the ward as well as providing patient care. The observed leadership lacked clarity of role direction, and was delivered in a style reminiscent of a controlling manner by a set or series of commands, which were often inconsistent. This stemmed from the constant flux of roles that the nurses were required to undertake and fulfil, often with little notice. This was observed to cause transient periods of confusion for the study nurses about clarity of the role they were in, and at times, they questioned others for affirmation of what their role was.

The nurses in this study disseminated their perceptions of what clinical practices were in relation to pain care provision. The use of Leininger’s culture care theory (1988) allowed exploration of whether the nurses could apply their knowledge of pain care by active negotiation on behalf of the older person as a means to accommodate or facilitate their pain care provision as an adaptation within that context of the acute care system. However, the nurses were observed to instead prompt their own set of social rules, which was more accommodating for a fit within the context of acute care that was of benefit for the nurses undertaking their clinical practices, as opposed to having the older persons’ best interests at heart. The exception was when the nurses provided non-pharmacological interventions for comfort provision and this was when the nurses
actively accommodated the older persons’ wishes for comfort such as by devising heat packs. This is discussed in more detail later.

When the nurses were observed to be asked to fulfil another role it was in order to complete a task and came as a directive from those within a position of authority, for example the NUM or Acting NUM. The nurses in this study viewed this inconsistency of roles as being sanctioned by the organisation. The completion of a task within a role therefore held a high value as an expectation was placed on it for the nurse’s compliance. The nurses in this study valued being able to be placed in situations to complete tasks that other nurses relied on. The implication for the older person occurred when the nurse who was allocated to them had their role changed. The older person was not informed of this, and was unable to distinguish which nurse was providing their care. Notably absent from the nurses in this study when speaking and observed within their own clinical practices was a lack of translation of EBP. For example, none of the nurses in this study referred to pain as being what the person says it is. This also extended into their education.

A lack of formal education in relation to provision or sharing of knowledge by the nurses in this study was noted to occur for the older person about how they could manage their pain better or learn new information about their pain during observed interactions about pain. Although some nurses spoke of gaining a pain history, this was not observed nor documented within the nursing medical notes. Informal education was observed to have been provided by the study nurses to the older person to manage their pain better, such as when they informed the older person that they could elevate their legs for more comfort.
The nurses in this study spoke about providing education sessions for their colleagues about assessment or management of pain. During the study period, no official education about pain or care of the older person was observed as being advertised or provided to the study nurses nor did they speak of receiving any. When the nurses in this study talked of their efforts of pain education provision, they spoke of it as a list of instructions for how the other nurses could act to provide pain relief. This provision of pain education was observed to occur during episodic social interactions and was based on the study nurse saying what they would have done as well as what the other nurse could have done as a reaction to that situation, instead of being proactive.

The nurses in this study focused on what they held as a perceived deficiency of the junior transitional nurses’ pain knowledge. While the study nurses spoke of watching the junior transitional nurses and their pain care provision practices from a distance, this was not observed to occur, but questioning by the study nurses did occur about why they were checking out S4 or S8 drugs for their patients. The study nurses believed that they were required to monitor and undertake surveillance of these junior transitional nurses for their compliance with completion of pain assessment documentation about pain scoring on the SAGO charts.

The nurses in this study spoke of using their leadership abilities and status as an unofficial ward champion to problem solve pain issues and concerns of the older person. These were observed to be expressed as an imposition of a set of rigid social rules, such as not using the PRN IV route for breakthrough pain relief and not using EBP pain assessment tools for those older persons with a cognitive impairment. The social rules cited by the study nurses typically lacked individualisation for the older person and did not reference pain related EBP implementation or translation. These social rules were the result of the assumptions held by the study nurses that were based
on a set of reactions that they had devised as a means of a best fit to react to a situation of an older person in pain, and they had evolved from their own interpretations and meaning of what was EBP. This was noted to be the application of the study nurses’ own, and often incorrect, meanings to interpret what EBP terms actually meant. The nurses in this study were observed to use their own incorrect interpretations or versions of EBP terms about pain. For instance, the meanings stated in the interviews on the use of terms that they had applied during the observation periods for pain threshold, genuine pain, triggers for pain onset, and low pain threshold were not consistent with EBP.

The assumptions or beliefs held by the nurses in this study about pain and their interpretations of EBP pain terminology for the older person were used to direct their own clinical practices, but were also passed on to other nursing colleagues. The observed lack of actual use and/or searching by the nurses for individualisation of EBP assessment tools and management guidelines to inform them whilst assessing an older person’s pain meant that they made assumptions about assessment of pain and management of pain that were at times incongruent with EBP. For instance, the nurses were often not able to differentiate between different types of pain or to identify when the older person had multiple sites and types of pain.

**Pain assessment mediated by a set of social rules.**

When the study nurses were providing pain assessment as defined within their own set of social rules, the implication was a lack of detail that was specific for each older person and this resulted in a lack of continuity of assessment processes as well as management planning. Numerous social rules were observed to be in use and spoken of by the study nurses for the assessment of pain in the older person. The imposition of these social rules, as noted below in more detail, was so ingrained and rigid within the
psyche of the nurses that it extended, for example, into a set of meanings based on what they heard the older person say to them about their pain. When the older person spoke of their pain to the study nurses, at times the nurses were observed to not acknowledge what it was that the older person had to say. This was despite the older person clearly and succinctly articulating what their pain meant to them.

A set of social rules devised by the study nurses was that they believed that they had the ability to discern the presence of pain intensity in an older person on a visual observation and by knowing the surgical procedure that the patient had received. This belief in their ability to seemingly discern the presence of what the nurses termed was genuine pain was based on the older person’s behaviour. The nurses spoke of genuine pain as the presence of facial expressions in combination with an overt exhibition such as a patient rolling around in bed and yelling out in pain. These mannerisms spoken of by the nurses are more evocative of being consistent with the presence of pain with a severe intensity, as opposed to the actual presence of pain.

During assessment, when the older person was asked to rate his/her pain, the study nurses were observed to be focused on gaining a numerical value for pain located in one specific site. The frequency of a follow up use of the same pain score to determine if pain had reduced was witnessed to rarely occur in a timely manner that was appropriate to the type of pain. When the nurses did undertake a reassessment they were heard to reiterate the previously stated value back to the older person before asking if the numerical value had decreased.

The nurses in this study relied on the patients to provide a set singular numerical answer. The meanings of the responses provided by the patients perplexed the nurses at times if the older person attempted to describe more than one site or different types of
pain. When the older person did not provide a numerical value the nurses were observed to provide one for them as a total to encompass all of their pain, or as it was noted after the document review of the observation period, the nurses had documented that no pain was present on the SAGO chart. Similarly, the nurses become confounded when the older person stated a numerical value that the nurses thought was incommensurate with their pain. The set manner by which the older person was being asked to provide a numerical value for their pain and the value that the nurses placed on gaining it, meant that undertaking a pain assessment in this manner was in the majority of times meaningless for the older person.

A rigid imposition of social rules was in place that lacked flexibility for pain assessment by the nurses in this study and was also extended towards those older persons with a cognitive impairment. Much of what was said to occur in the interviews by the nurses about communication with the older cognitively impaired person was not reflected within their actual clinical practices. An example was the nurses speaking in the interviews about those with a cognitive impairment as having the ability to inform them when they had pain present; however, the observed ability of the nurses to actually ‘hear’ this was different. The spoken sentiments by the nurses in this study that they would go out of their way to improvise when communicating about pain with those older persons with a developmental disability or communication impairment was not observed to occur at all. During assessment for this group of older persons the nurses were observed to have devised their own reactive form of communication that was not documented. Additionally, some nurses spoke of believing incorrectly that those with a diagnosis of dementia were able to learn a new communication style and adapt the way in which they interacted with them to convey meaning as well as provide clarification.
about the presence of pain. This is not consistent with EBP for communication with those with a cognitive impairment.

The undertaking of a pain assessment for a cognitively impaired older person was spoken of as a social rule that served to normalise the personal challenges involved for the nurses in this study. The nurses recounted instances of feeling uncomfortable when attempting to use EBP tools to assess pain for this group of older patients. The nurses did not use an individualised EBP tool, and therefore their approaches were not standardised nor could others consistently apply them for a later pain re-assessment.

The use of Leininger’s culture care theory (1988) facilitated exploration of how the nurses negotiated and accommodated within the acute care context the undertaking of pain assessment processes for the benefit of the older person with a cognitive impairment. The nurses spoke of this as a reliance on the carer to turn up, or be present, and who would then inform the nurses of behaviours typically exhibited by that person when in pain. Rarely was this observed to occur and no documentation was noted within the follow up document review about these events either. The result for the older person with a cognitive impairment was similar to those cognitively intact, in that provision of pain assessment by the nurses lacked the active implementation of EBP to provide in depth knowledge that was specific about them for any continuity to be provided.

Management of pain mediated by a set of social rules.

Similar to the assessment social rules in place, patterning was evident of a lack of flexibility of the study nurses that extended towards pain management. When the nurses spoke of managing pain, they talked of what their reaction was to a patient in pain, and this was opposed to talking about being proactive in avoiding the onset of that pain. This meant that the nurses lacked skills within their clinical practices of EBP pain
management for advocacy, such as pre-emptive pain relief for procedural pain during wound care. Moreover, the nurses’ reaction to an older person in pain was observed to lack the ability to differentiate between various types and sites of pain. This meant that there was inability of the nurses was present to effectively undertake or implement plans for pain management that was meaningful for the older person.

Numerous social rules were observed to be in place that the nurses in this study had devised for management of pain that were more adaptive and accommodating towards maintaining the status quo within the ward, as opposed to being devised for the older persons’ benefit. For example, pain management plans were spoken of and observed as being a constant repetition by the nurses to ask the treating team to increase over a period of time and sometimes days, the amount of slow release pain medications that had been regularly charted.

The most disturbing example was the presence of a set of social rules and beliefs that governed the management of episodic acute pain, as a reliance of the study nurses on oral opioids for the older person, and not the use of PRN nurse initiated pushes of IV breakthrough opioids. This meant that the nurses were risk adverse when reacting to acute pain episodes. The rationale given by the nurses for preferring an oral route was reflective of risk management and they spoke of wanting to avoid being in a situation of having to monitor and possibly react to a patient becoming overly sedated. When the older person did receive breakthrough pain relief, this was observed to be after care procedures that enhanced and/or caused pain or inflicted pain. If an opioid was observed to be provided, it was never seen to be delivered by the IV route, only by the oral route. When these instances occurred a very short time frame was provided by the nurse, and often noted to be from two to ten minutes for the drug to have any onset before they resumed the task.
Notably absent from the nurses’ conversations were the use of terms consistent with EBP when describing the management of breakthrough pain, the causes of narcotisation or the processes required for them to detect or undertake for any reversal of excessive sedation. For example, there were a lack of comments by the nurses in their interviews on what the clinical signs of narcotisation are and how to call for a review by the treating team or to provide Naloxone (opioid reversal agent). When the nurses spoke of their efforts for pain advocacy they related it to being in a protective role, or being directed to provide opioids by the IV route by a doctor present. This was contradictory to being in the role of an advocate and reducing the likelihood of the older person being coerced to participate in known painful procedures being undertaken on the ward or when the patient is deteriorating in a rapid respond situation. One nurse spoke of these situations as special occasions when providing an IV intervention for the management of pain. When these special occasions were recounted and described, they were situations when patients were in an acute pain crisis as well as experiencing severe pain. However, the nurses spoke of preferring a sub-cut route for management of pain for those older persons who were dying.

**Motivations for accommodation and negotiation within pain care provision.**

The motivation to continue social rule enforcement expressed by the nurses in this study was heard within their success stories of pain care provision for the older person. Central was the time and effort taken by the nurses to be an advocate on behalf of the older person. During observation periods the older person was noted to be excluded from these discussions. The end of these stories was an outcome with the eventual removal of that patient from their ward. The nurses viewed this removal as a relocation
to where they thought the older person belonged, be that to their home, the acute care ward, or troublingly another ward, because of a perceived or actual cognitive impairment.

Any mention of the potential or actual negative effects or implications that a pain crisis had for the older person was absent from interview conversations. For instance, notably absent from within their interviews about incidents of inadvertent narcotisation was any consideration expressed for the negative effects on the older person that included both short term and possible long-term consequences. Instead, the nurses spoke about what they had to do within the immediate situation and how they had complied with the reporting processes within policy and procedures that are in place.

When providing pain care the nurses in this study were motivated to be reactive to pain situations and not motivated to be proactive to pre-empt them from occurring. The nurses were constantly observed to encourage the older person to complete a set task that they were engaged in such as walking to the bathroom despite the older person’s complaints of pain. The offer of pre-emptive pain relief before activities of daily living such as moving in the bed, wound care and or ambulating were not observed to occur even though, in their interviews the nurses stated that they did occur. The only exception was the sole patient with a PCA who was encouraged to use it before being asked to deep breathe and cough by their nurse. During wound care provision, the nurses only halted the activity if their personal safety was at risk from the patient striking out at them in reaction to their pain.

A positive aspect was that nurses spoke of being motivated to be an advocate for the older person and viewed this as essential. Conversely, this meant they spoke of not believing that the older person would tell them about their pain. When observed to
engage in these advocacy actions, the nurses did not facilitate the older person’s input directly. For example, the nurses held advocacy sessions with other health care providers away from the person with their compliance being the only input required in relation to the interventions provided to them by the nurses. When observed to engage the older person directly during advocacy this was noted to be the result of a direct request from a medical officer who was not present, but for example who was on the phone and was using the nurse as a conduit for asking a question.

When speaking face to face with an older person the nurses invariably called them by their first name, although they were never observed to ask the older person if they could use their first name in this manner. The nurses in this study were heard constantly to not refer to the older person as an individual and this was demonstrated by their continued reference to the older person as a bed number, or as a diagnosis such as a fracture, and to their length of stay as well as whether a cognitive impairment was either correctly or incorrectly present.

When divergence occurred from any set of social rules, the nurses viewed this as a threat and they dealt with these circumstances with open suspicion. In particular, this was observed to be directed towards those patients who were able to articulate a high level of pharmacological knowledge about how they wanted their pain management to occur, and who requested involvement in the negotiation or accommodation for their provision of pain relief. This resulted in observed instances of tension occurring between the nurses who spoke of viewing those older persons as being drug seeking, and non-compliant as opposed to requiring increased input or review by the treating team. Additionally, those older persons with complex pain management regimes and who were still experiencing intractable pain were openly viewed as being unpopular and spoken of as being drug seeking by the nurses in this study. Unpopular patients in pain
meant that the nurses lacked motivation to investigate aspects of their complaints of pain further with, for example, the treating team. The result for those older persons requiring complex pain regimes and who were able to articulate multiple types of pain or sites of pain, was the possibility that their pain remained inappropriately managed during their stay.

Being viewed as unpopular also meant that the nurses in this study considered the economic considerations, such as hiring of equipment for comfort provision that came out of the ward budget. The implication was that at times some nurses in this study spoke of interpreted the cost of hiring equipment as a basis of a set of social rules. This was spoken of as undeserving for those patients deemed unpopular, and did not justify the financial cost to the group collective of the ward as a whole. However, this was not observed to occur in clinical practice.

Some study nurses spoke of being motivated to place EBP pain assessment tools out on the ward for the other nurses to use within their clinical practices for those patients who were cognitively impaired. The nurses stated that they did not know the outcomes of these tools or if they were being used or not. It must be noted that at no time were any of these tools observed to be placed out on the wards for use by the nurses. Within the document review no evidence of the use of any specialist EBP pain assessment tool for the cognitively impaired person was found.

The nurses in this study spoke of participating in clinical audits and they confirmed that they only audited what the organisation directed them to. This meant when they had attempted to disseminate tools for pain assessment that no knowledge or feedback of their impact or use was provided back to them. The study nurses talked of the failures of
an implementation attempt as a collective form of sabotage that had been directed towards their ward by others.

** Artefact use within the organisation to guide pain care provision. **

This section focuses on the enabling professional actions undertaken by the nurses in this study to assist, support, and facilitate the implementation as well as translation into clinical pain care practices of the EB guidelines or policies and procedures available to them within the organisation. Practical aspects were also explored, such as the types of forms relied on to document pain or the improvisation undertaken by the nurses when providing non-pharmacological interventions.

The comprehensive search of the grey literature presented in chapter two was the result of an online document review of the National, State health care and Local Area health service policy and procedure archives, as well as a manual search within each ward setting. This was to find if any policies or procedures could be found that served to guide the nurses’ clinical practices for EBP assessing and managing pain in adults or the older person. A nationally available best care for older people everywhere toolkit by the Victorian Department of Health (2012) which has an extensive section for pain assessment and management, was located, and has been adapted for use within South Australia, but is not in use within the other states or territories of Australia. A mandated state-wide policy was in place for the evaluation of chest pain in adult patients. A paediatric pain assessment and management procedure was located and a policy was found for both hospitals that provided ED senior nurses with the ability to nurse initiate IV or IM morphine for the management of severe pain in those aged over 16 years.

Despite an exhaustive manual and electronic search within the study context, the only guideline found for pain care provision was a summary of the Australian Pain Society.
(2005) for pain in residential aged care facilitated management strategies for the older person which was located on the APS area health website. However, this website was never spoken of as being accessed by the nurses nor was it observed to be viewed by them during the study period. One hospital had embedded within their very extensive and thick clinical care management policy a stipulation that pain was to be assessed regularly and that the APS were to be contacted within a reasonable period if any problems arose. Furthermore, this policy stated that all patients admitted into ED with fractured ribs and oncology/medical patients with pathological fractured ribs were to be reviewed by the APS.

The nurses in this study affirmed that a policy was in place that prohibited them from using an IV route for PRN opioids for provision of breakthrough pain relief. An extensive search failed to produce any evidence of this policy. There was no policy or procedure found to be in place that stipulated that acute care nurses were to not use IV opioids and instead to rely on the oral route for the management of breakthrough pain in the acute care wards for the older person. This was despite the study nurses’ assurances that it did exist. When asked to provide help in finding it, they indicated that it was their own inability to use the computer system to find it. The study nurses were unable to provide an alternative source of this information such as citing EBP guidelines to affirm a basis for their beliefs.

The nurses in this study relied on the patients’ bedside SAGO chart for documentation of their pain score and the bedside medical chart for drugs to be used for management of pain. The original purpose of the SAGO chart was not to provide that function as they are designed to detect the deteriorating patient. Within both of these charts, there is no provision for a comprehensive assessment of the patients’ pain, their pain history, nor a location for their pain management plans. The document review of the patient’s medical
notes also failed to find any provision of a succinct personalised pain history, or assessment processes and management plans for the older person undertaken by the nurses.

The document review of the older person’s medical notes and bedside charts did not find a summary of their journey through the acute care system. Any information about their pain history was subsumed within the hand written documentation by the treating team and nurses. Pain documentation was often incomplete and sparse. The nurses’ written documentation about pain had characteristically repetitive sentences stating that the patient ‘had no pain present’ or that the ‘patient had complained of pain and analgesia had then been provided with good effect’. A common theme within the nursing pain documentation was the deficiency of detail about the history of an older person’s pain, no information on how pain was assessed such as documentation of the tool used, and a complete absence of any documented nursing pain management plan. The implication for the older person was that their pain story was not fully documented nor was it available and easily accessible for others to find.

Within both hospital settings an individualised form for the documentation of adult inpatients’ pain history, assessment and management did exist, however the use of any singular form specific for the comprehensive documentation of pain care provision was not observed to be used or referred to by the nurses during the study period. When asked about whether they used a specific, comprehensive form for pain, the nurses simply declared that they did not use them. Furthermore, within the document review of patient’s bedside charts and medical notes none of these forms were found to be completed or filled out
The non-use of the existing comprehensive pain charts by the nurses in this study was a direct reflection of their beliefs held about the organisation as having a high value on gaining full compliance by the completion of documentation for the SAGO charts. The study nurses undertook the collection of audit data themselves but they also spoke of the direct feedback they had received from audit results and this was specific for their ward in relation to their levels of compliance. This left the study nurses with a palatable sense of ownership for achieving compliance with the audits as one of their roles.

A source of environmental influence was the support of the organisational culture in place towards a drift away from EBP by its emphasis on gaining compliance with auditing. The onus was spoken of as being directly placed on the study nurses to be compliant with the SAGO chart auditing processes and this meant that the pain score value had to be completed; otherwise, the chart would be deemed incomplete for auditing purposes. Gaining a poor outcome for compliance was spoken of as the ward itself gaining a bad reputation. The implication was that the original meaning for the purpose of why a pain score was asked in the first place had decreased in value, and instead the social rule for completion of documentation of the SAGO chart held a perceived higher value.

Both hospital sites had a lack of flow and transfer of knowledge between, within, and outside the area health service. This meant that difficulties existed in gaining pain care provision information about the older person. Furthermore, no external interest was present to gather data about pain care provision to provide accountability, and benchmark the acute care wards as well as follow that older person’s pain journey. Moreover, there were no state-wide polices or procedures in place to facilitate or mandate the older person’s pain care provision information transfer.
The acute pain service within the local area health had a physical presence within one hospital setting. All the nurses in this study were able to articulate what, or who, comprised the membership of a pain team, however they countered this by consistently speaking of not being able to initiate direct contact with the APS team. At no time during this study did any observed face to face or telephone contact occur between an APS representative and the study nurses.

The nurses in their interviews spoke of a lack of support for them to undertake or implement new clinical practices for pain assessment, research activities to gather their own data to inform change, and their involvement of running or directing clinical reflection processes. Absent from within their conversations was mentioning of benchmarking or even collaboration with other acute care wards about pain care provision. The exception was the sub-acute ward that was required to gather rehabilitation data and share this state-wide. However, within that collection of data there was no provision for input about pain care provision required for the older person.

**Routine and rituals involved in nurses’ pain care provision.**

A recent clinical practice change that the area health service had implemented into each hospital setting was the introduction of the undertaking of a bedside handover whose intent was for more inclusion of the input by the patients for their care. However, it was observed to be customary for the nurses to not include the older person and this had extended to the newly introduced bedside handover. Although the study nurses spoke of identifying a value that the bedside handover had in its potential to contribute to improvements in their clinical practices, this did not extend to their own abilities, and instead they directed this towards the junior transitional nurses, whom they believed required constant vigilance. As a result, the nurses in this study spoke of not conducting
the bedside handover process at the actual side of the patient’s bed, but talked of being more motivated to undertake it at the doorway and they believed, incorrectly, that its use was for the checking of compliance of their colleagues.

For the older person it was routine for them to have to wait at times for pain care provision. They waited for the assessment of pain to occur and for the provision of pharmacological interventions to arrive before an onset of relief that was meaningful for them. Some older persons spoke about often being left to feel as though they were impinging on the nurses and irritating them when asking for assistance or for drugs that were an S4 or S8. The older persons in this study also spoke about how regular it was for nurses to express their annoyance at them when they interrupted them in their routines such as a round of vital signs.

When the nurses were undertaking a round of vital sign monitoring within a four-bed room, they were observed to move in a set clockwise manner around the room. This was regardless of the patients’ reason for admission into that ward and, if any beds were vacant the nurses by-passed them, but they still continued in a clockwise fashion. This meant that it was rare to observe the nurses to ask for a pain score outside of a round. Conversely, clarity was lacking from the nurses if when they were actually asking for a pain score if it was the sixth vital sign or not.

**Pain care provision experiences for the older person.**

The older persons in this study valued highly knowing who the nurse was that had been allocated to them to provide their care. Nevertheless, absent from their conversations were the names of the nurses providing that care. Although the nurses in this study all wore mandatory name badges placed on numerous locations on their body, for example at hip height or chest height, their names remained unknown by the older person. This
meant that the older person relied on knowing what their nurse looked like, to determine if they were their nurse. This inevitably meant that they were unable to ask for their nurse by name to get use any assistance from them. When the older persons were observed to interrupt or attempt to gain the attention of their nurse, this was undertaken in a deferential and polite manner as they could not use that nurse’s name.

One aspect that the nurses had devised within their set of social rules to accommodate the older persons’ pain care provision preferences was the provision of comfort by non-pharmacological interventions. Non-pharmacological interventions were routinely improvised by the nurses for pain care provision by an array of heated wet towels in the microwave as a proxy hot pack, air heated blankets rolled up as pillows for positioning in addition to rolled up towels for patients to brace with when deep breathing and coughing. The nurses spoke of being aware of the implications of using a heat pack incorrectly that may result in the patient experiencing a burn. This, they said, had resulted in the removal of those objects from the ward, however this did not stop the nurses from transforming everyday bed linen into objects of support to elevate limbs to provide comfort for the older person.

The older person spoke of valuing the nurses for asking them about their pain, but they did not think of the nurses as being involved in the management of their pain. This meant that at times the older person made no connection made the assessment processes being undertaken by the nurses with an outcome being a reduction in their pain relief. The older persons’ experiences of having their pain assessed and managed by the study nurses was an experience of pain care provision that at times excluded their input and lacked implementation of EBP, personhood, as well as elements of person centred care.
This resulted in the older person experiencing tension when the pain care provided to them did not provide a meaningful or beneficial outcome for them. For some older persons this meant that they had learnt to be proactive and engage in acts of subversion by taking their own pain medication, which they had brought into hospital with them, or they got family members to bring in. This led to a lack of understanding and hampering of communication between nurses and the older person. Additionally evident was a lack of information, education, and sharing of knowledge about pain occurring between nurses and the older person. This was evident for instance within the observed interaction between Ninnette and RN Iona in Chapter seven: The experiences of the older person when receiving pain care in the section titled Being proactive about pain relief on page 233. This implied that there was no free flow or accessibility about pain care in relation to the formation of pain management plans between the older persons and their nurses.

The information about the older person’s pain experiences in this study came by asking them to relate their story, beginning with their reason/s for presentation to hospital. It was quickly evident that the nurses caring for the older person were unable to relate detailed knowledge about that patient’s pain history. Moreover, this meant that for some older person patients an aspect of their pain story was permanently lost during periods when they themselves were unconscious and had travelled between one hospital or ward location and the next for a medical or surgical procedure.

The provision of pain care formulated by nurses was not devised with the needs of the older person at the forefront and instead often suited the nurses’ processes of task completion and clinical care routines. This meant that at times the provision of pain care resulted in some older persons such as Molly and Martha who commented on their experiences of losing their dignity as outlined previously within the section titled
Anticipating pain and avoiding embarrassment on page 208 and that there was no respect or consideration provided for their needs or preferences.

The older persons in this study spoke about being made to feel unpopular and having to interrupt the busy nurses in their clinical work routines. Increasingly the measures undertaken by the older person to gain the attention of the nurses become more desperate such as exposing areas of their bodies in public to provide evidence for validation of pain. Moreover, they also talked about being made to feel like a member of a lower class of society of being treated in a controlling manner and viewed like an animal that had no say in their care provision. This meant that when the older person did want to confront the nurses about adverse events they had experienced in relation to pain care provision a choice had to be made. It was as though they had learnt that they now faced a conundrum that they could complain and risk becoming unpopular, or not complain and put up with the treatment.

**Barriers and facilitators to nurses’ practices**

Barriers to the provision of culturally congruent pain care for the older person in this study related to a lack of uptake by the nurses in this study of EBP guidelines into their clinical pain care provision practices, despite the availability and proliferation of evidence available for them to use. Furthermore the nurses themselves had devised a set of social rules for the provision of pain care that was based on a combination of a lack of knowledge about pain and older person care in the presence of inconsistent clinical leadership which lacked clarity of roles. The implication was that the nurses in this study did not utilise the application and use of EBP within their experiences of being a mentor, leader or educator for the junior transitional nurses. Moreover on observation the clinical practices of the nurses in this study were lacking in the application of EBP
and the implication for the older person was that their experiences of pain care provision were less than optimal.

Evident was a lack of implementation and translation of EBP into their clinical practices. This was compounded by the nurses’ lack of critical reflection on how their own values and beliefs were causing issues and negatively influencing the quality of their ability to provide pain care for these older hospitalised persons. Assumptions about pain and older person care held by the nurses have directed their actions and behaviours within their own set of social rules. This has stemmed from a lack of clear organisational direction, structure, and available resources for input or support for the provision of leadership and mentorship as well as standardisation to direct nursing clinical practices. This was evident within the search of the grey literature that identified a lack of availability on the wards of EBP guidelines and policies or procedures in place to provide standardisation or guidance for the nurses, as well as a lack of meaningful feedback to the nurses that is inclusive of the older person’s viewpoint.

The provision for continuity of individualised and personalised pain care provision for the older person was completely absent or deficient by the nurses in this study. Evident was a lack of pain care continuity for the older person by the nurses from shift to shift, from ward transfer to another ward, and from one hospital to another. This was a direct result of an absence of any comprehensive documentation to transfer information about pain and no independent monitoring or follow up of the older person through their acute care admission journey.

A lack of comprehensive documentation about pain not only affected continuity, but also benchmarking for quality improvement projects that had a reliance on an audit of a document that had never been devised to provide individualised comprehensive pain
assessment or management provision. Also evident within the context was an environment of an all-prevailing cultural drift away from person-centred care and towards compliance with auditing that resulted in a perpetuation of a negative cycle. This meant that currently more culturally mediated barriers exist against the older person receiving culturally congruent pain care provision within acute care as compared to facilitating aspects being present.

The culturally mediated facilitators towards the provision of culturally congruent pain care for the older person by the nurses was that they had attempted to provide some level or form of leadership that was responsive to a perceived need. The nurses in this study undertook acts of subversion to provide comfort for the older person by accommodating their needs by devising hot packs and comfort measures by using the available linen resources on the ward. When a clear and mandated policy and procedure was in place for management of chest pain, the nurses in this study spoke about following that process clearly and promptly. Furthermore, a level of recognition was present and held by the nurses that they wished to improve their practices and outcomes of pain care provision.

**Location of findings within the current literature.**

The findings of this study confirmed that culturally mediated beliefs and values held by nurses about pain care provision for the older person served as a guide as well as determined or influenced their actions within their clinical practices. This was influenced by an absence of guidelines and policies or procedures in place to direct the nurses’ clinical practices. Evident was the observed lack of uptake and use of EBP by the nurses in this study for provision of pain care for the older person. The theoretical articles that have explored the barriers to implementation of EBP all work on an
assumption that presumes that there are guidelines already in place within the setting (Dogherty et al., 2013; Pun et al., 2013; Rolfe et al., 2008).

Previous research by Rycroft-Malone, Harvey, et al. (2004) and McCormack et al. (2002) have identified that research, the environmental context, and the culture in place as well as the leadership styles present will act either as a barrier or facilitator for the uptake of EBP. It is also worthy to note the comments by Rolfe et al. (2008) and Dogherty et al. (2013) that, unless research is incorporated into a standardised guideline within the clinical setting, the ability to influence clinical practices is limited. Pun et al. (2013) assert that re-evaluation is required of any pre-existing pain guideline or practice standards within the setting before any change is made. This study has provided new knowledge and contributed to the already existing literature by the identification of the need for guidelines to be in place within the context that encompasses EBP, inclusion of the older person and research. Otherwise, the culture and leadership styles that are present will merge to provide a set of social rules to determine how things such as pain care provision for the older person will be done.

This study has re-confirmed the belief held by nurses that they are able to determine the actual intensity and amount of pain that a person has based on their own subjective interpretations as previously reported and explored within the critical review of the literature undertaken in this thesis. This study extends this knowledge further by providing new information that nurses extend this belief towards those older persons whom are cognitively impaired, have communication impairments or developmental disabilities, and those who are dying. Not identified within the critical review of the literature and emergent from within the findings of this study are the nurses’ statements about the older person not telling them about their pain. A new finding of this study and previously unidentified within the literature is how these beliefs and values held by
nurses can contribute towards partial exclusion of the older person in participating in their pain care.

Similar to the findings of Söderhamn and Idvall (2003), this study has also identified that nurses will speak of placing a high value on relieving pain and undertaking a creative approach to problem solving pain. It is noted by both Carspecken (1996) and Schein (2010) that insight can be gained into the values held by a person by exploration of what they say that they do, as opposed to what is actually done in a situation when the espoused values of the organisation are required to be in operation. The findings of Dihle et al. (2006), who identified a gap between what nurses say they do and what is actually done by them in relation to pain assessment and management can be confirmed within the findings of this study for the older person. The new emerging knowledge from the findings in this study was that although nurses placed a high value when speaking about being a problem solver for pain, observation showed that they often excluded the older people from participating in this problem solving by holding these sessions in another geographic location away from the older person. It was also noted that when any problem solving did occur in close proximity that the nurses did not invite the older person to offer any input. Furthermore, the additional knowledge from this study is the extension of this knowledge further by the identification that not only did this gap exist in the nurses’ actions and clinical practices, but also what the nurses said that they heard as opposed to what the older person was actually saying to them about their pain.

In contrast to the studies by Dihle et al. (2006); Idvall et al. (2008); Manias et al. (2002) and Manias et al. (2005), the findings of this study did not identify nurses citing a lack of time as a barrier for the provision of pain care. Findings in this study are also consistent with the current literature by Anderson et al. (2011); Costello (2001);
Cowdell (2010); Spilsbury et al. (2007); Tutton and Seers (2004) that showed the high value placed by nurses on functional task completion of rounds. Importantly, and in contrast to Dihle et al. (2006); Idvall et al. (2008); Manias et al. (2002) and Manias et al (2005), this study did not find that the nurses were citing a lack of time as being a barrier to increasing inclusion of the older person and this was despite the nurses having a high value on functional task completion.

A finding of this study has identified the rigid imposition by nurses onto the older person about what they thought was appropriate for them when undertaking pain assessment and management processes. The only other resemblance found within other studies was when nurses conducted pain assessment as being based on a typology of the patient’s race (Klopper et al., 2006) and sex (Albarran et al., 2007), or when management of pain was influenced in relation to what country the nurses came from (Watt-Watson, Stevens, Garfinkel, Streiner, & Gallop, 2001). This study has shown new evidence of how a sub-culture of nurses will apply a typology of pain for the older person and impose it onto them within a clinical context of acute care, and this has not been previously identified within the literature.

The newly emergent knowledge from this study is how the values and beliefs held by the nurses have converged into an attitude that has been used by them to guide how they think, perceive and act when undertaking pain assessment and management for the older person in acute care. The novel findings of this study highlight the source of the behaviours displayed unconsciously by individual nurses when undertaking pain care provision for the older person as being a reflection of the social formation within the presence of a nursing sub-culture. Like the findings in the Willson (2000) study, this study has identified that nurses will develop a set of social rules that have been devised to function at their convenience. Unlike Willson (2000) whom identified only one set of
social rules in operation in relation to the timing and application of analgesia administration, this study has identified the existence of numerous social rules in place specific towards pain care provision for the older person.

This study has shown that when a reliance on a set of social rules by nurses for pain care provision was in place this will result in a lack of flexibility, negotiation and accommodation for the older person. Some similarities were present with the findings of Brown and McCormack (2006), Manias et al. (2005) and Joelsson et al. (2010), who noted a lack of an array of strategies used by the nurses to provide EBP interventions for those patients experiencing uncontrolled or problematic pain situations. Previously not identified within the literature is the numerous amount and array of social rules being used by nurses to govern their clinical strategies for pain that was intractable, breakthrough pain relief, advocacy, assessment and management of pain for those who are cognitively intact and those with a cognitive deficit or communication disability as well as those whom are dying. These aspects have not been previously identified with any detail within previous studies.

The findings of this study are consistent with the literature about the older persons’ experience of being an inpatient in acute care in relation to having to wait for nursing care (Anderson et al., 2011), not wanting to complain about their pain (Bédard et al., 2006; Cogan et al., 2014; Idvall, 2002), and not directly asking for specific opioid analgesia (Buchbinder et al., 2015). As previously reported by Stockwell (1972) the findings of this study have also identified that patients held to be unpopular by nurses were those older persons who complained a lot about having unrelieved pain. Similar to the studies by Brockopp, Ryan, and Warden (2003) and Neville and Roan (2014), the findings in this study has confirmed that nurses were conservative in their willingness to
expend extra energy or time to manage pain in those they termed as substance abusers and/or the older person with intractable or problematic pain.

Akin to those studies that have reported on the routines undertaken by nurses within acute care, the findings in this study have identified that nurses will not prioritise other interventions over the completion of a set task or a nursing round (Brown & McCormack, 2006; Davidson, 2011; Dihle et al., 2006; Ebright et al., 2003; Higgins et al., 2007; Manias et al., 2002; Manias et al., 2005; Rytterström, Unosson, & Arman, 2011; Storm-Versloot et al., 2014; Valizadeh et al., 2015). This study disputes the findings by Anderson et al. (2011) and Cowdell (2010), who identified that it was normal for an older person to wait to receive dispassionate and dispirited care from nurses in a routine manner. When undertaking a routine round of vital signs the nurses in this study did not undertake it in a dispirited manner, however, this study identified that the asking about pain was undertaken in a set, ritualised and almost formulaic manner.

This study has provided ground-breaking knowledge about how nurses within the clinical context will ask and receive a pain score from an older person. Moreover, newly emergent information and a contribution to a paucity of knowledge about the use of pain score for the older person was the understanding gained on how difficult it is for them to respond when they had multiple sites and types of pain. Similar to the findings by Eriksson et al. (2014) and Wikström et al. (2014) was the incongruence found to be held between nurses and patients about the meanings of pain scoring. This study extends and confirms the findings of Blondal and Halldorsdottir (2009), who identified that nurses would speak of the older person becoming frustrated and irritated when asked to rate their pain, and that this does in fact occur within the context of acute care. The previously unknown and emergent findings from this study identified how difficult
and complicated it was for the older person to provide a singular score for their pain when they were experiencing multiple sites and differing types of pain. Additionally, a new contribution from the findings of this study was the input from the older persons that they viewed the nurses as assessors of pain but not as managers of their pain. Moreover, this study has provided insight into the older persons’ experiences when their pain story was lost and the impact that this had on them during their journey through the acute care system.

The findings of this study demonstrated clearly an absence of EBP which mandates that for the older person there is a requirement for a comprehensive and individualised pain history to be undertaken (Abdulla et al., 2013; Closs et al., 2007; Hadjistavropoulos et al., 2007; Herr et al., 2006; Titler et al., 2009). As well, those aspects within EBP pain care provision, such as pre-procedural pain management (Czarnecki et al., 2011), breakthrough pain management for adults with cancer (SIGN 2008), rib fracture pain management for the older person (Winters, 2009), and blunt thoracic trauma pain management (Simon et al., 2005), were not adhered to or spoken about by the nurses. Furthermore, it was noted that there was a lack of uptake of EBP assessment processes and management plans that accommodated any current or pre-existing vision or hearing impairments (Grue et al., 2009), which are often experienced by the older persons. This study has identified that often the uptake and use of guidelines for the older person was not occurring within the nurses’ clinical practices, despite some nurses being aware of EBP pain assessment tools for those with a cognitive impairment.

This study provides previously unknown knowledge about the barriers of using a standardised format of the SAGO chart, which was never devised solely for documentation about pain, that contributed to the loss of the older person’s pain story. This adds to the findings by Rankin (2015), who identified that the use of a
computerised standardised form also lacked the ability for nurses to add any individualised information about their patients. Likewise, the findings of this study noted the equivalent inflexibility for pain documentation within the current SAGO charts being used by the nurses.

Comparable to the findings of the Micheals et al. (2007) study, the findings of this study identified nurses as having varied experiences in both the provision and receiving of education about pain. This study aligned with the descriptive correlation study by Watt-Watson et al. (2001) in that the nurses rated their level of education about pain as being high and excellent despite those nurses achieving a moderately low score when tested about their levels of knowledge. Furthermore, Watt-Watson et al. (2001) noted that the nurses themselves had not been involved in, or undertaken recent pain education sessions within that organisational context. Watt-Watson et al. (2001) were unable to determine the sources of the education being provided to those nurses in that study. This study provides new knowledge and enhances current knowledge to confirm that in the absence of official provision of pain education, those nurses who are in a leadership role and provide mentoring to their colleagues will be those who will undertake the provision and be a source of education for others.

This study has identified that when there is a predominant clinical environment in place that has no standardisation for quality improvement processes in relation to pain care provision nor a written policy or procedure that is in place that a drift will occur away from espoused organisational and professional values. Similar to the UK Francis Report (2013) and Australian Garling Report (2008), this study can confirm that when poor leadership is present in conjunction with the prioritisation of meeting performance criteria, that a deviation away from the implementation and translation of EBP into person-centred pain care provision can occur. This is comparable to the findings in the
studies by Carlstrom and Ekman (2012); Dogherty et al. (2013) and Mallidou et al. (2011) that, when an acute care nursing subculture lacks resources, their ability to engage or have ownership to undertake evaluation of their clinical practices will be hampered.

The use of Leininger’s culture care theory (1988) in combination with a focused ethnographic approach has not been undertaken previously for exploration of pain care provision to determine if the older person finds this as being culturally congruent and of benefit for them within the acute care setting. The approach used in this study has confirmed that within the organisational context of acute care, when a lack of EBP implementation and translation is present then nurses will devise a set of social rules as a means of a best fit within that situation. These social rules will lack evaluation, implementation of research and EBP, as well as excluding the older person’s experiences or perceptions. Furthermore, these social rules are more accommodating for the nurses within the acute care environment compared to being adapted by re-patterning or restructuring for the older persons’ benefit during pain care provision. This aspect simply has never been explored before in this manner within the literature and is an original contribution to nursing knowledge.

**Implications for clinical practice**

This study has made a significant and unique contribution to nursing knowledge by the use of Leininger’s culture care theory (1988) as a conceptual framework for a focused ethnographic approach into the exploration of the culturally mediated barriers and facilitators to nurses practices for pain care provision for the older person in acute care. Exploration has resulted in understanding of the implications when a deficiency of accessible policy and procedures occurs with a concurrent lack of EBP guidelines. This
was compounded further in the presence of nurses, who held a lack of knowledge about implementation or translation of EBP, pain, and care of the older person. The nurses in this study spoke of being the highly valued unofficial providers of education for their ward, whilst they themselves demonstrated a lack of knowledge in this area within their own clinical practices. This is a less than ideal combination that has not been previously reported elsewhere in the literature.

The implications for clinical practice are the uptake and use of social rules devised by nurses that are more adapted to accommodate the current climate of organisational drift that is in place. This is opposed to the implementation and active negotiation of person-centred care principles for pain care provision. New awareness and understanding has emerged from the findings in this study on the source point of when an individual nurse within the ward will pass on learnt behaviours to others, to perpetuate as well as replicate them within the context. The findings of this study have implications for any new implementations of practice change. For instance, the level of interest extended by the nurses in this study in undertaking the leading and direction of clinical reflection sessions for the ward will require careful consideration before consideration of their involvement at that level.

**Current clinical practices that need not change.**

Those aspects described by nurses as being positive aspects of nursing such as the connection that the ward staff had with the older person are to be commended and encouraged. Furthermore, the positive aspects in relation to the advancement of enablement of the older person, and celebrating milestones such as transfer home require broadcasting as well as dissemination for celebration within the acute care environment. The consistent ability of the nurses to provide support and reassurance to
the older person when in pain is to be applauded. This is despite the risk adverse organisational environment and climate, which did not, for example sanction the provision of heat packs because of a risk of a burn, nor promote the PRN IV route opioids for breakthrough pain relief.

**Clinical practices that require change.**

This study recommends that accessibility be increased within the setting of a guideline for pain care provision (Harmon et al., 2012), such as the Victorian Department of Health (2012) “Best care for older people everywhere” toolkit that provides an EBP individualised approach for the older person. This requires dissemination and mandated policy and procedures that are made available to the local area health services as well as at a state level. This can be achieved by extensive support from the area health service that extends into and across the wards for uptake as well as inclusion of nurse-led initiatives to translate and implement pain care EBP for the older person. Meaningful feedback and provision of benchmarking that can be shared across the acute care wards within the area health service and which are inclusive of the older persons’ input are required.

Policy and procedures are required to be in place that reflect the context in which pain care is provided. These need to be monitored by the use of quality improvement projects for benchmarking and standardisation for the implementation of individualised pain care. Quality improvement projects that rely on auditing alongside vital sign rounds are not indicative of the quality of pain care provision, and instead increased patient contribution derived from their input gained by qualitative means, such as follow up phone or semi-structured interviews, are required as opposed to patient surveys to assess satisfaction with pain care. The older person requires a meaningful process that they are
able to engage in and that allows inclusion of their perspectives about pain care provision and this also requires weaving into the provision of education for nurses.

An increase of knowledge is required for nurses in acute care in relation to pain care provision and caring for the older hospitalised person, which is also inclusive and standardised for both the organisation in which that care is delivered as well as those external providers of nursing education such as the university sector. The provision of standardised learning in relation to developing more effective styles of clinical nursing; leadership, mentoring, and delivering education that is reflective as well as inclusive of EBP is essential. The establishment of the ability of nurses within the clinical setting to implement and translate EBP, which is inclusive of research for policy and procedure development is also a prerequisite that needs to be normalised as part of their clinical practices and within their professional identity as a nurse.

There are current deficiencies of knowledge held by nurses about pain, care of the older person and care of those with a cognitive impairment such as delirium and dementia. Additionally deficient and evident within their clinical practices was an awareness about care of those older persons with developmental disabilities or communication impairments, as well as for those older persons who are dying. The provision of organisational support and establishment of education about pain, older person care, leadership, and implementation, as well as translation of EBP into clinical practices are required to be provided by those who are competent, clinically relevant and formally qualified to be able to provide that education. This education and training is required to focus on pain physiology, pharmacology, and mechanisms of pain, the assessment and management as well as the use of pain guidelines that is inclusive of the leadership roles required in order to deliver this within the context of the clinical settings. Support is required for the undertaking of research and provision of education is also required for
nurses to be able to undertake and embed current EBP guidelines within the formation and implementation of policy and procedures within their own clinical practices.

At a ward level, the timely transfer of pain-related information in the form of documentation of a comprehensive pain history, the type of assessment tool used and a clearly articulated management plan that is inclusive as well as individualised for the older person is required. This pain care provision information then can be transferred to follow the older person and provide continuity, not only from hospital to hospital, but ward-to-ward, and shift to shift as well as from one health care district to another. When the older person is unable to provide input into their pain history, assessment or management plans then family members, carers or a representative from the organisation that provides their care are required to provide information in relation to their pain care provision. The placement of those aspects required for pain care provision information needs to be available as a summary at the forefront of the patient’s bedside medical charts and updated daily in order to be accessed by nurses and accessible for benchmarking for quality improvement projects. Furthermore, this information requires independent input from an appropriately qualified and trained health care provider for its level of congruence with EBP pain care provision and individualisation for the older person.

**The consequences for the older person.**

The use of a single numerical score that focuses on a single location of pain has been shown to be of little benefit for pain care provision for the older people in this study. This was due to the older person having multiple sites and types of pain. That some older persons stated about their pain care provision that they did not feel it was safe and being left to feel like they belonged to a lower social class as well as feeling unpopular
is disturbing. For the older person in this study their experience of pain care provision from nurses meant that they relied heavily on the involvement of their family and friends for support. This was observed to be more evident for those older persons who had advanced cancer diagnoses, and they spoke of how they engaged in acts of subversion by accessing their own personal stocks of analgesics and adjuvants either they, or their family/friends or carers had brought in for them. For these patients being pro-active meant that they could manage their cancer breakthrough pain episodes. It also meant that they chose to exclude the nurses from participating in their pain care provision. To summarise, the experiences of those older persons who were cognitively intact was that at times they waited in pain and at other times they endured their pain.

For those older persons who were not cognitively intact, the evidence pointed towards their pain story as being lost completely, and this is more so for those who were in the terminal stages of dying. For those older persons with a cognitive impairment, their pain care provision occurred solely at the nurses’ discretion and did not involve the use of EBP tools to provide any continuity for assessment of their pain. Unable to articulate their complaints of pain, the nurses typified these older persons as expressing their pain in a physical manner that at times was directed towards them, resulting in these patients as being viewed as not only unpopular, but also dangerous, non-compliant, and not belonging on their ward. This occurred unless the carer for the older person with a cognitive impairment was able to be present and inform the nurses about pain mannerisms for pain cues. However, for this group of most vulnerable patients when information from a carer was observed to be gained, it was then lost by the lack of documentation of those facts by the nurses. Unable to be proactive for pain relief and engage in acts of subversion, at times this group of older persons not only waited in
pain, but also suffered needlessly in their pain and it is suggested that some died in uncontrolled pain.

**Trustworthiness and limitations**

Determination of trustworthiness, as Le Compte and Presissle (1993) note, does not have a singular approach that will be adequate for each research project. Guidance of the inquiry decisions and activities within this study (see chapter three conceptual framework and methodology) were in accordance with the criteria outlined by Lincoln and Guba (1985), and Lincoln, Lynham, and Guba (2011). These included aspects of credibility, transferability, dependability and conformability to monitor inquiry decisions and activities in this study (Lincoln & Guba, 1985; Lincoln et al., 2011).

Validity was constructed by what Cho and Trent (2006) assert is a transactional approach based on member checking, and peer review as well as a critique of previous ethnographic studies within the literature. Furthermore a theoretical form of validity was also undertaken by triangulation of the findings to provide a more consistent and objective representation of reality (Cho & Trent, 2006). This research is further strengthened by the provision of detail by this researcher, through self-disclosure provided by the documentation of previously held assumptions and reflexivity that detailed my position as a researcher in the field (Lincoln et al., 2011), as well as how I dealt with unforeseen consequences and my experiences in dealing with them (Altheide & Johnson, 2011; Reed-Danahay, 2001).

I undertook extensive processes to provide reflexivity to reduce the impact of myself as an instrument in the study by keeping two separate journals and one diary. Within the fieldwork journal, not only did I take notes, but I also drew sketches of the setting and the reflective journal was kept separate to document my thoughts as well as feelings
about the study. The diary provided valuable input in relation to documentation of
which participant I was meeting at what time and provided clarification for the timing of
the observation periods that was reflective of the nurses’ rostered shifts.

In addition, throughout this research peer review was provided with input from
supervisors and through oral presentations of the processes undertaken within this study
at national and international conferences. Member checking was also used throughout
by providing the nurse participants copies of the transcribed interviews by email,
however it was noted that often they spoke of not reading them. This meant that whilst
they were still provided, the nurses were encouraged to read them at their leisure and to
not hesitate if they wanted to contact the researcher about them at a later date. Member
checking then consisted mainly of asking the participants during the interviews to
provide verbal clarifications and to ask them for input. To enable the trustworthiness of
the study to be evaluated by others the theoretical and conceptual framework that
guided the processes of data collection, analysis and interpretation along with the
provision of an audit trail, has been described and related to the ethnographic approach
detailed in the previous chapters.

The focus of this study on nursing practice meant that there was no inclusion of family
members, other health care providers, or allied health care providers. Although those
older persons with cognitive and communication impairments were included in the
observational aspect of this study, their voices are silent as they were not interviewed.
Many older persons who were dying in acute care were not able to be invited to
participate in the study owing to an inability to approach because of their plight and as
family members were often absent.
The unintended study finding of acute care nurses’ acting as gatekeepers towards inclusion of the older person was not anticipated. I found that participating in research was a novelty for the nurses in this study and that, after a rapport was developed with them they spoke of initially viewing me as an auditor for compliance with organisational practices. I maintained a constant presence on the wards, in particular during the weekend and evenings as well as on night shifts and this served to break down that perception to a certain extent. This was noted by the change of how the nurses in this study introduced me to others by simply stating that I was ‘their research nurse’ who did research about them and their practices relating to how they assessed and managed pain for the older person.

The impact of changes in roles held by the nurses was not foreseen or anticipated, and this meant that the observation periods often could not go as planned. This was due to the participating nurse being informed often at the last minute or even during their shift that they no longer had a patient load for that shift. This contributed towards a gatekeeping effect as well as meaning that those older persons who wanted to be part of the study were denied the opportunity to do so.

The document review was limited by the fact that a lot of the medical documentation about the patients was hand written by nurses or medical staff and was at times indecipherable as well as not available in an electronic format. The patients’ medical charts were in constant demand by all members of the allied health team and at times, the review was undertaken in a piecemeal fashion. Missing, and/or incomplete medical notes and bedside charts, as well as those that were taken off the ward when patients were undergoing tests, meant that at times the document review was at risk of being incomplete. The researcher attempted to counter this by staying on the ward until, for
example, the older person had returned from their procedures, and this also increased
the length of time in the field.

The short stay period of many older persons combined with their constant transfer
between wards and hospitals meant that retrospective audit was not able to be
undertaken in a timely manner. When attempts were made to compare pharmacological
information such as medications received to the documented pain score provided it was
noted that there was often no correlation with what had occurred and with the
observation period. This, combined with only those patients who consented to the study
having their data accessed, meant that auditing of charts lacked numbers as well as
meaning.

**Reflections and challenges.**

In this study, it was difficult to engage junior nurses and the transitional nurses to
participate in this research. On reflection, the more experienced nurses were more
confident in their clinical practices and may have been more willing to be seen as a
leader by participating in research. In contrast, the junior nurses spoke of wanting to
concentrate on their shift and providing clinical care to get through the day.

Field work was difficult during the night shifts as it is dark and difficult to observe as
there are low light situations. Also, as a researcher, you are outside of your normal
sleep/wake hours and can lead to fatigue. The ability to negotiate access during these
times was also found to be problematic, as often the afterhours NUM managers of the
hospital/wards had not been informed of the study by the daytime managers. The
undertaking of semi-structured interviews on the nurses was also less than ideal, as they
would not be available except during their break times. Despite follow up interviews
being undertaken at times the depth of the interviews was comprised.
The experiences of immersion in the field over the period of eight months meant listening, looking, following and communicating with others as well as experiencing the sounds of acute care. It also involved a lot of time sitting around which facilitated the drawing of maps and sketches of the wards. Seasonal holidays affected the course of the fieldwork so participant recruitment could not occur until January (after Christmas break) and public holiday periods (e.g. Easter) delayed some of the fieldwork. Despite undertaking the research within a setting that provides continuous care, a researcher needs to be mindful of the time of year when recruiting and conducting fieldwork.

Future research.

Further research is required to be undertaken that explores how nurses will provide continuity of pain care provision that extends across wards and into other hospitals to improve collaboration and transfer of information that is inclusive of the older person. Further research is also required that provides input from those of the most vulnerable older persons in acute care, to include those whom have cognitive impairments, communication disabilities, developmental disabilities, and those who are dying. Additional input is also required of the family members, carers and significant others who are involved within the life ways of the older person and who provide pain care at home as to how they undertake this when their loved one is in hospital. Inclusion of other members of the health care provision within acute care for the older person is also required.

Proposed for future research is a mixed methods study using the action research implementation in health sciences framework (PARiHS) (Rycroft-Malone, 2004). This will incorporate the use of Leininger’s culture care theory (1988) to explore nurses’ care delivery in order to determine if the application of EBP evidence is more inclusive of
the older persons’ experiences and gained by semi-structured interviewing and observation. Benchmarking and feedback for quality improvement is needed in relation to the use of EBP assessment tools and use of management plans back to the nurses on the wards. Use of a PARiHS approach also facilitates more inclusion of the context of acute care settings taken into account by increased inclusion of NUM and nurses as a group collective, as well as inclusion of health care providers and family members for evaluation that includes benchmarking (Rycroft-Malone, 2004). Furthermore the use of a PARiHS approach will provide increased facilitation to prove ownership and normalisation of the implementation of evidence into practice by use of a facilitator who has been effectively trained and qualified to conduct a multi-site research project (Rycroft-Malone, 2004). However, the conduct of such an endeavour will require a person and a team who can facilitate a large project which will need to extend across an area health service and who is appropriately educated as well as qualified to do so in order to provide longevity.
Conclusion

Before undertaking this study, little was known about how nurses in acute care undertake the assessment and management of pain for the older person in acute care. The aspects of nursing culture that will impact on nursing practices when assessing and managing pain in the older person within acute care were noted to be the lack of uptake and implementation of EBP guidelines into clinical practices. The presence of culturally mediated barriers and facilitators to aspects of their clinical practices were identified as being contributors to not implementing EBP guidelines such as the use of social rules devised by the nurses in this study.

This focused ethnographic study has identified the culturally mediated array of social rules in place that are devised by nurses when an absence occurs of ready access to EBP guidelines, policies and procedures. Whilst these social rules are a best fit for the nurses within a clinical environment, they are typified by an organisational drift away from patient-centred care philosophies, and their presence acts as a major barrier for the provision, implementation and translation into clinical practice of EBP for pain care provision for the older person. The perceptions and experiences of those older persons receiving pain care provision when their pain story was lost and their pain care provision lacked continuity were explored.

In summary, this study has identified that the existence of numerous culturally mediated sets of social rules devised by nurses for pain care provision of the older person in the acute care system is a major barrier for delivery of culturally congruent pain care for this group of patients. The implication for those older persons who are the most vulnerable cannot be understated. This study has identified how a perfect storm can
occur when there is lack of knowledge about implementation, translation, and adaptation of EBP to provide support for nurses within their clinical practices, and how this will impact on their ability to provide continuity of pain care provision for the older hospitalised person. Furthermore, in the presence of an all pervading climate of overt ageism, a lack of education, no undertaking of research, and leadership which lacked clarity of roles as well as a climate of organisational drift in combination, this study has shown how this can exert an all-pervading barrier for the provision of pain care for the older person. The implication for the older person in acute care is waiting and enduring in pain. The study has shown that for those older persons who are the most vulnerable their experiences were of suffering in pain. To conclude, the main facilitating aspect present for the provision of culturally congruent pain care for the older person is that nursing is a profession and therefore able to conduct research into its own clinical practices in order to understand them and to potentially undertake change.
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Appendices
Appendix 1: Standard Adult Observation Chart (SAGO)

Figure 5 Standard Adult Observation Chart
## Appendix 2: Search terms

Table 13 List of search terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Search Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>&quot;pain&quot;[MeSH Terms] OR &quot;pain&quot;[All Fields]</td>
</tr>
<tr>
<td>Pain assessment OR pain management</td>
<td>(&quot;pain measurement&quot;[MeSH Terms] OR (&quot;pain&quot;[All Fields] AND &quot;measurement&quot;[All Fields]) OR &quot;pain measurement&quot;[All Fields] OR (&quot;pain&quot;[All Fields] AND &quot;assessment&quot;[All Fields]) OR &quot;pain assessment&quot;[All Fields]) OR (&quot;pain management&quot;[MeSH Terms] OR (&quot;pain&quot;[All Fields] AND &quot;management&quot;[All Fields]) OR &quot;pain management&quot;[All Fields])</td>
</tr>
<tr>
<td>Person OR People</td>
<td>&quot;persons&quot;[MeSH Terms] OR &quot;persons&quot;[All Fields] OR &quot;people&quot;[All Fields]</td>
</tr>
<tr>
<td>Elderly</td>
<td>&quot;aged&quot;[MeSH Terms] OR &quot;aged&quot;[All Fields] OR &quot;elderly&quot;[All Fields]</td>
</tr>
<tr>
<td>Aged</td>
<td>&quot;aged&quot;[MeSH Terms] OR &quot;aged&quot;[All Fields]</td>
</tr>
<tr>
<td>Older person OR Geriatric</td>
<td>(older[All Fields] AND (&quot;persons&quot;[MeSH Terms] OR &quot;persons&quot;[All Fields] OR &quot;person&quot;[All Fields])) OR geriatric[All Fields]</td>
</tr>
<tr>
<td>Hospitals</td>
<td>&quot;hospitals&quot;[MeSH Terms] OR &quot;hospitals&quot;[All Fields]</td>
</tr>
<tr>
<td>Acute care</td>
<td>(&quot;acute&quot;[All Fields] AND &quot;care&quot;[All Fields]) OR &quot;acute care&quot;[All Fields]</td>
</tr>
<tr>
<td>Surgical patient OR surgical ward</td>
<td>(&quot;surgical procedures, operative&quot;[MeSH Terms] OR (&quot;surgical&quot;[All Fields] AND &quot;procedures&quot;[All Fields] AND &quot;operative&quot;[All Fields]) OR &quot;surgical&quot;[All Fields] AND &quot;operative surgical procedures&quot;[All Fields]) OR (&quot;patients&quot;[MeSH Terms] OR (&quot;patients&quot;[All Fields] OR &quot;patient&quot;[All Fields])) OR ((&quot;surgical procedures, operative&quot;[MeSH Terms] OR (&quot;surgical&quot;[All Fields] AND &quot;procedures&quot;[All Fields] AND &quot;operative&quot;[All Fields]) OR &quot;operative surgical procedures&quot;[All Fields] OR &quot;surgical&quot;[All Fields]) AND ward[All Fields])</td>
</tr>
<tr>
<td>medical wards OR medical patient</td>
<td>(medical[All Fields] AND wards[All Fields]) OR (medical[All Fields] AND (&quot;patients&quot;[MeSH Terms] OR &quot;patients&quot;[All Fields]))</td>
</tr>
<tr>
<td>Inpatients</td>
<td>&quot;inpatients&quot;[MeSH Terms] OR &quot;inpatients&quot;[All Fields]</td>
</tr>
<tr>
<td>Nursing</td>
<td>&quot;nursing&quot;[Subheading] OR &quot;nursing&quot;[All Fields] OR (&quot;nursing&quot;[MeSH Terms] OR &quot;nursing&quot;[All Fields])</td>
</tr>
<tr>
<td>Nurses</td>
<td>&quot;nurses&quot;[MeSH Terms] OR &quot;nurses&quot;[All Fields]</td>
</tr>
<tr>
<td>Nursing profession</td>
<td>&quot;nursing&quot;[MeSH Terms] OR &quot;nursing&quot;[All Fields] OR (&quot;nursing&quot;[All Fields] AND &quot;profession&quot;[All Fields]) OR &quot;nursing profession&quot;[All Fields]</td>
</tr>
</tbody>
</table>
Appendix 3: Current EBP guidelines for pain assessment and/or management

Table 14 Current EBP guidelines for pain assessment and/or management

<table>
<thead>
<tr>
<th>Reference</th>
<th>Title</th>
<th>Findings</th>
<th>Critical commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Czarnecki et al., 2011)</td>
<td>Procedural Pain Management: A Position Statement with Clinical Practice Recommendations.</td>
<td>Patients of all ages are entitled to optimal pain relief and comfort management before, during and after procedures. All health care providers have a responsibility to advocate and intervene to support the best interests of the patient. This is inclusive of stopping the procedure to provide additional comfort measures if it becomes apparent that the current plan is ineffective.</td>
<td>A lot of the recommendations have a paediatric focus, but are easily transferable to the adult population. Has clinical practice guidelines outlining recommendations for before, during, and after procedures.</td>
</tr>
<tr>
<td>(Closs et al., 2007)</td>
<td>Guidance on the assessment of pain in older people</td>
<td>Incorporates evidence based statements and has recommendations for clinical practice. Is a critical review of the literature.</td>
<td>Has an algorithm for assessment of pain in older people. Does not include recommendations for translation into clinical practice.</td>
</tr>
<tr>
<td>(Hadjistavropoulos et al., 2007)</td>
<td>An interdisciplinary expert consensus statement on assessment of pain in older persons</td>
<td>Recommendations are made for the physical and emotional assessments of pain for the older person. Recommendations are provided for those with a cognitive impairment. Evaluates the pain assessment tools for the older person. Improving pain assessment requires involvement in quality improvement projects. Difficulty of assessment is the selection of the most appropriate approach with a failure being the lack of assessment.</td>
<td>Is multi-disciplinary. Recognises that pain assessment is situational and context dependent. Has a three phase comprehensive model for the domains of assessment. Some recommendations for tools to use for translation into practice.</td>
</tr>
<tr>
<td>Authors</td>
<td>Title</td>
<td>Summary</td>
<td>Additional Notes</td>
</tr>
<tr>
<td>-------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Herr et al., 2011</td>
<td>Pain assessment in the patient unable to report: position statement with clinical practice recommendations</td>
<td>Presents a hierarchy of pain assessment techniques for those who are unable to report their pain. Begins with the patients self-report, search for potential causes of pain, then observation of behaviours then a proxy report of family members/carers of pain and behaviour changes. Then attempt an analgesic trial. Does this with recommendations for specific subpopulations including infants/preverbal toddlers, the critically ill and unconscious, those with dementia, the intellectually disabled and for those at the end of life.</td>
<td>Includes a recommendation to establish a procedure for pain assessment within each institution in each healthcare facility. Reassessment of the patient is required with documentation that is specific and appropriate for the individual patient. Noted that the tools proposed for those with an intellectual disability had not been tested for acute care and only one tool for adults. With the end of life pain assessment tool being only tested in hospice and long term care.</td>
</tr>
<tr>
<td>S.I.G.N., 2008</td>
<td>Control of pain in adults with cancer: a national clinical guideline</td>
<td>Guideline that provides recommendations for pain secondary to cancer Multi-disciplinary and also of interest to those patients with cancer pain and their carers. Has a section that is inclusive of patients and carers with a focus on the importance of communication. Also included spirituality, the subjective experience of pain and meaning making.</td>
<td>Not intended or construed or to serve as a standard of care as these are to be determined on the basis of all clinical data available. Takes into account psychosocial issues. Due to frailty, cognitive impairment or communication deficits not all patients able to relate the pain story completion of pain scoring tools may not be possible, and families or health professionals may act as a surrogate.</td>
</tr>
<tr>
<td>Titler et al., 2009</td>
<td>Summative index: acute pain management in older adults</td>
<td>Aims to determine the number of indicators that require meeting to define adherence to EBP guidelines. This is to provide a benchmarking for quality of acute pain care. Came up with 18 item summative index made up of 6 factors.</td>
<td>Has use for quality improvement projects.</td>
</tr>
<tr>
<td>Winters, 2009</td>
<td>Older adults with traumatic rib fractures: an evidence based approach to their care</td>
<td>Rib fractures are extremely painful and require an accurate pain assessment. Recommends the use of an epidural and PCA or paravertebral and PCA.</td>
<td>Has an algorithm for management of pain in rib fractures that takes into account the number of rib fractures. Recommends also a bowel regime.</td>
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<tr>
<td>Simon et al., 2005</td>
<td>Pain management guidelines for blunt thoracic trauma</td>
<td>Epidural analgesia is the optimal modality of pain relief for blunt chest wall injury and is the preferred technique after severe blunt thoracic trauma. This has been shown to increase pulmonary function and improves pain perception.</td>
<td>When an older person has cardiopulmonary disease or diabetes they should be considered as a candidate for epidural analgesia due to increased mortality.</td>
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<tr>
<td>Reference</td>
<td>Study Description</td>
<td>Findings</td>
<td>Research Questions</td>
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<tr>
<td>(Williams et al., 2012)</td>
<td>Evaluating the feasibility and effect of using a hospital-wide coordinated approach to introduce evidence based changes for pain management</td>
<td>No significant changes or decreases of patient pain scores noted and patients were not included. Bi-monthly audits of selected indicators for pain management was undertaken for Quality improvement Undertook random spot checks if numeric pain scoring correlated with document review over a period of a year. Identified that the percentage of patients with a documented pain score increased on each nursing shift between phase 1 and 2.</td>
<td>Australasian study that involved an action research process Involved the introduction of 30 pain resource nurses to act as clinical champions for pain at a local level Hospital wide document review</td>
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<tr>
<td>(Cairncross, Magee, &amp; Askham, 2007)</td>
<td>A hidden problem: pain in older people. A qualitative study</td>
<td>The residents spoke of being reliant on pharmacological interventions, that they rarely saw their GP for a review and limited options for alternatives. A lot of equipment actively caused pain- particularly hoists and non-pharm interventions such as hot showers was dependant on staff time A lot of the residents were noted to be stoic and suffering in silence, yet the care staff were failing to ask them about their pain.</td>
<td>Undertaken by the Pickers institute as a mixed methods study, but largely qualitative. Research questions focused on the residents own assessment of their pain, how their pain was usually managed or treated, what their own role was in its management and whether they thought if anything could be done to improve its management.</td>
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<tr>
<td>(Grue et al., 2009)</td>
<td>Vision and hearing impairments and their association with falling and loss of instrumental activities in daily living in acute hospitalised older persons in five Nordic hospitals</td>
<td>Half of the patients in the study had a hearing impairment and one third had impaired vision One fifth had a combination of both hearing and vision impairments The prevalence was less than studies in nursing homes, but higher than the general community These sensory problems are often overlooked in medical wards.</td>
<td>Hearing and vision impairments were found to be frequent among older patients in the medical wards, with this sensory loss being also associated with a fear of falling.</td>
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<tr>
<td>(Drew et al., 2014)</td>
<td>The use of “as needed” range orders for opioid analgesics in the management of pain: A consensus statement of the American Society of Pain Management Nurses and the American Pain Society</td>
<td>The treatment of pain requires individual titration of analgesics by a practitioner competent in pain assessment, analgesic administration and evaluation of response to treatment PRN range orders for analgesics must be written in accordance with EB clinical practice guidelines Institutions should allow PRN range orders for opioid analgesia to meet the mandate for safe and effective pain management. Processes are required to ensure staff competency in the writing, implementation and interpretation of these orders. Ongoing safety and quality of pain management practices require monitoring</td>
<td>Nurses are required to base their decisions of the implementation of a PRN range on a thorough pain assessment and knowledge of the drug to be administered Pain assessment tools individualised to the patient that are valid and reliable are to be used The pharmacokinetics of the opioid require consideration The pharmacokinetics of the opioids for the older person require consideration</td>
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<tr>
<td>(Fishman et al., 2013)</td>
<td>Core competencies for pain management: results of an inter-professional consensus summit</td>
<td>Consensus derived competencies within four domains Multidimensional nature of pain Pain assessment and measurement Management of pain and the Context of pain management.</td>
<td>Aim was to develop core competencies in pain assessment and management for health professional education Found that veterinary medicine had five times more pain content than did medicine Worldwide a deficiency in all health areas with nominal and fragmented hours allocated for pain education content</td>
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<tr>
<td>(Victorian Department of Health, 2012)</td>
<td>Best care for older people everywhere: the toolkit 2012</td>
<td>Focuses on interventions that improve the functional status of hospitalised older persons Has a comprehensive section on pain, cognition, delirium and dementia</td>
<td>Starts with five facts about pain and provides some background information. Has ten different assessment tools for those cognitively intact and provides four for those with severe cognitive impairments and/or with communication difficulties. Also has extensive links to EBP references for further reading. Has input for discharge planning for ongoing pain management Easily the most practical guideline developed in an Australian context</td>
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Appendix 4: Articles included in the critical review of the literature

Table 15 Articles critiqued in literature review

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<tr>
<th>Author</th>
<th>Title</th>
<th>Focus of study</th>
<th>Main themes</th>
<th>Study design</th>
<th>Methods</th>
<th>Limitations</th>
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<tr>
<td>(Albarran et al., 2007)</td>
<td>It was not chest pain really, I can't explain it!</td>
<td>Exploration of the nature of cardiac symptoms experienced by women during their myocardial infarction</td>
<td>Gradual awareness: Symptom presentation and distribution of chest pain in women may not follow the typical MI pattern</td>
<td>Qualitative descriptive</td>
<td>Semi-structured interviewing</td>
<td>Excluded those with cognitive and communication impairments Included those under the age of 65</td>
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<td></td>
<td>An exploratory study on the nature of symptoms experienced by women</td>
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<td>Not having pain in the chest: Women with a MI may present with non-specific chest symptoms, difficult to interpret or recognise by pts and health professionals</td>
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<td></td>
<td>during their myocardial infarction</td>
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<td>Reactions to symptom: Rather than focusing on presence or absence of traditional cardiac symptoms, need to invite women to describe their symptom history which will generate more information</td>
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<td>(Brown, 2006)</td>
<td>Sleep satisfaction, perceived pain and acute confusion in elderly</td>
<td>Purpose to describe sleep satisfaction, pain perceptions and psychological concerns of subjects undergoing similar procedures</td>
<td>Pain increased in those who developed delirium and is greater in unplanned surgical admission</td>
<td>Mixed methods</td>
<td>Interview, pain scoring and retrospective auditing</td>
<td>Excluded those with cognitive impairments</td>
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<td></td>
<td>clients undergoing orthopaedic procedures</td>
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<td>Sleep: Reduced in those who experienced delirium</td>
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<td>(Browne &amp; McCormack, 2006)</td>
<td>Determining factors that have an impact upon effective evidence based pain management with older people, following colorectal surgery: an ethnographic study</td>
<td>Examination of pain mgte practices with older people in an acute care hospital admitted for colorectal surgery</td>
<td>Comprehensive pain assessment, improved documentation and proficient communication that includes older pts is necessary to improve pain management practices</td>
<td>Ethnographic</td>
<td>Non-participant observation of nurses Patients pre and post operation semi-structured interview</td>
<td>Excluded those with cognitive impairments The older person patients were not interviewed</td>
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<tr>
<td>(Closs &amp; Briggs, 2002)</td>
<td>Patient’s verbal descriptions of pain and discomfort following</td>
<td>Post-operative orthopaedic patients’ use of language to describe pain and discomfort. Three pain descriptors were assessed for congruence with the widely used McGill pain questionnaire</td>
<td>4 themes to describe pain: i) use of words to describe sensations, common vocabulary of sensory, affective and evaluative words. 2. Intensity/severity: pain intensity is a dimension of pain experience which pts can report without scales. 3. Use of analogy: use of an external reference point by describing what was experienced by a common known cause eg toothache in my hip.</td>
<td>Qualitative descriptive</td>
<td>Interviews and verbal descriptor comparison with MPQ</td>
<td>Not stated if included those with cognitive impairments Included those under the age of 65</td>
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<td></td>
<td>orthopaedic surgery</td>
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<td>Discomfort was the largest theme, most common and detailed</td>
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<td>(Dihle et al., 2006)</td>
<td>The gap between saying and doing in postoperative pain management</td>
<td>To increase understanding about how nurses contribute to post-op pain in a clinical setting, aim to identify barriers to achieving optimal post-op pain relief</td>
<td>Overall finding is a gap between what nurses say they do and what they actually do in post-op pain mgte</td>
<td>Qualitative descriptive</td>
<td>Observation semi-structured interviews of the nurses</td>
<td>Not stated if included those with cognitive impairments The older person patients were not interviewed Included those under the age of 65</td>
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<td></td>
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<td>1. Had theoretical knowledge about central issues in post-op pain mgte, but do not always use this information in the clinical setting 2. No education for patients pre or post-op about pain mgte. 3. Nurses observed to use unsystematic and insufficient methods for assessment of pain 4. No written material available on the ward 5. Nurses who not the patients advocate if pain was experienced during mobilisation</td>
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<tr>
<td>(Idvall et al., 2008)</td>
<td>Perspectives of Swedish patients on postoperative pain management</td>
<td>To describe the perspectives of surgical patients from different surgical wards</td>
<td>1. Thoughts of pain were constantly present and in focus for the pts 2. Notes routine of post op pain management focuses on pts assessment of pain intensity and treatment of pain pharmacologically 3. pts pain knowledge is based on previous experiences and presumptions about pain 4. The pts individual strategies or strategy knowledge must be highlighted to best plan an individualised pain management strategy 5. Must in a format that can be added to the routine or standard plan 6. Health care workers need to be more aware of how their authority and attitudes influence the patient</td>
<td>Qualitative descriptive</td>
<td>Interview of the patients at discharge</td>
<td>Excluded those with cognitive impairments Included those under the age of 65</td>
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<td>Reference</td>
<td>Title</td>
<td>Methods</td>
<td>Findings</td>
<td>Design</td>
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<td>(Pederson et al., 2010)</td>
<td>Patients experience of pain and pain relief following hip replacement surgery</td>
<td>To describe pts' experience of pain and pain relief following hip replacement surgery</td>
<td>Main finding is that immediate post-op pain needs improvement in management, as pts described it as 'intense'. This combination of inefficient pain management during first post-op days contributed to a combination of pain and fear of mobilisation during post op days. Gap between pts saying how wonderful the staffs were and drugs for relieving pain, yet described their pain in the most horrific manner. Patients engaged in their own self-care abilities, highlighting the need for individualised care.</td>
<td>Qualitative descriptive</td>
<td>Semi-structured interviews</td>
<td>Excluded those with cognitive impairments and those in understanding Swedish</td>
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<tr>
<td>(Kim et al., 2005)</td>
<td>Strategies of pain assessment used by nurses on surgical units</td>
<td>To identify the criteria nurses actually used to assess post-op pain and the kind of knowledge they drew on from past experience</td>
<td>The most frequent strategy was a reliance on criteria that related to the pts' appearance and drew on their past experience. Specific analgesic and non-pharmacological interventions were used by the nurses.</td>
<td>Phenomenography</td>
<td>Two phases, beginning with a structured interview, before observation and follow up interviews on nurses directly after they had conducted pain assessments.</td>
<td>Did not interview the patients to gain their perspectives. Included those under the age of 65.</td>
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<tr>
<td>(Klopper et al., 2006)</td>
<td>Strategies in assessing post-operative pain- A South African study</td>
<td>Used System's system of pain categories for assessment of acute post-operative pain</td>
<td>Nurses used four categories for assessment criteria. The most frequent strategy was a reliance on criteria that related to the pts appearance and drew on their past experience.</td>
<td>Phenomenography</td>
<td>Two phases, beginning with a structured interview, before observation and follow up interviews on nurses directly after they had conducted pain assessments.</td>
<td>Excluded those who did not speak English, those with cognitive impairments and also those who had metastatic cancer. Included those under the age of 65.</td>
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<tr>
<td>(Manias &amp; Williams, 2007)</td>
<td>Communication between patients with chronic kidney disease and nurses about managing pain in the acute hospital setting</td>
<td>Examined communication between patients with chronic kidney disease and nurses about managing pain in the acute hospital setting.</td>
<td>Specific analgesic and non-pharmacological guidelines for patients with chronic kidney disease should be developed and made available in practice to facilitate effective pain management. Change champions of renal units are needed to support nurses in dedicating specified time for communicating with patients about managing pain.</td>
<td>Single group non-comparative</td>
<td>Observations and interviews of both nurses and patients</td>
<td>Excluded those who did not speak English. Included those with cognitive impairments by use of a proxy consent process for next-of-kin only. Included those under the age of 65.</td>
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<tr>
<td>(Manias et al., 2002)</td>
<td>Observation of pain assessment and management - the complexities of clinical practice</td>
<td>Investigation of nurse patient interactions with post surgical patients</td>
<td>Themes of barriers to pain management: 1. Nurses actively interrupted during pain assessment. 2. Levels of attentiveness to patient pain cues varied. 3. Nurses interpreted patient's pain differently to that of the patients. 4. How nurses dealt with competing demands of other health care providers within acute care.</td>
<td>Observational design</td>
<td>Set timed periods of observation that was audio recorded. Semi-structured questioning of nurses proceeding observed interactions undertaken and audio recorded.</td>
<td>Not stated. Included those under the age of 65.</td>
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<tr>
<td>(Manias et al., 2005)</td>
<td>Nurses' strategies for managing pain in the postoperative setting</td>
<td>To determine the strategies that nurses used to manage patients pain in the postoperative setting</td>
<td>Six main themes: 1. Managing pain effectively - nurses used strategies by identification of pain cues and responded quickly to minimise pain by medication or non-pharmacological interventions and were proactive in getting orders charted. 2. Prioritising pain experiences for pain management - nurses prioritised activities that at times trivialised the patients pain experience such as the completion of medication, vital sign observations and wound care rounds. 3. Missing pain cues for pain management - nurses missed patient cues of pain being present both when articulated clearly and ambiguously. 4. Regulators and enforcers of pain management - nurses policed when routine medication was given but also made sure that the medications were not given before the nurses being left waiting in pain until their medications were due. 5. Preventing pain - nurses statements to patients that they were preventing pain related more to medication adherence as opposed to strategies of comfort provision, positioning or exercise. 6. Reactive management of pain - the nurses avoided PRN medications for management of pain after the patient had experienced the pain and did not provide them as a pre-emptive measure to avoid pain.</td>
<td>Single group non-comparative design</td>
<td>Set timed periods of observation that was audio recorded. Semi-structured questioning of nurses proceeding observed interactions undertaken and audio recorded.</td>
<td>Excluded those whom lacked an appropriate interpreter to explain the study. Included those under the age of 65.</td>
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<td>Study</td>
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<td>(Manias, 2012)</td>
<td>Complexities of pain assessment and management in hospitalised older people: A qualitative observation and interview study</td>
<td>Assessed and managed for older persons admitted to a geriatric evaluation and management unit. Based on an assumption that experiences are socially organised.</td>
<td>Four main themes: 1. Communication: nurses used simplistic questioning to assess all types of pain and did not use tools despite some patients having communication impairments. 2. Strategies: patient charts were reviewed for inappropriate medications meant that nurses were influenced about whether patients could tolerate pain or not. 3. Organisation for care: changes in time of day affected the availability of analgesia provision and a lack of staff availability over night and during busy periods of the day meant that some older persons had to wait for pain relief. 4. Complexities of healthcare needs of the patients meant judgements were made by nurses about toleration of pain, and the intensity of the pain experienced by the older persons.</td>
<td>Naturalistic observational design. Set timed periods of observation. Interviewing of nurses not the older person participants. Included those who did not speak English. Included those with cognitive impairments.</td>
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<tr>
<td>(Manias et al., 2006)</td>
<td>Patients’ decision-making strategies for managing postoperative pain.</td>
<td>Strategies used by postoperative patients to facilitate pain management decisions.</td>
<td>Strategies observed were: 1. Passive recipient for pain relief. 2. Problem solving and active negotiation were less commonly used.</td>
<td>Single group non-comparative design. Set timed periods of observation that was audio recorded. Semi-structured questioning of nurses proceeding observed interactions undertaken and audio recorded. Excluded those who lacked an appropriate interpreter to explain the study.</td>
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<tr>
<td>(Idvall &amp; Söderhamn, 2003)</td>
<td>Nurses’ influence on quality of care in postoperative pain management: A phenomenological study</td>
<td>Description and meaning of nurses influence on the quality of care in postoperative pain management gained by vignettes written by experienced clinical nurses describing complex postoperative pain situations.</td>
<td>General meaning of nurses influence consisted of: 1. The nurses perception of an unsatisfactory situation concerning the pain of the surgical patients. 2. The nurses personally intervened to facilitate management of pain. 3. The nurses aimed to change the outcome of the situation in a positive direction. The meaning of a nurse influence was interpreted as an aspiration to relieve the patients from their suffering by using professional skills and knowledge in a creative, problem-solving process.</td>
<td>Phenomenological approach and Karlsson empirical phenomenological psychological method. Does not include the clinical setting or the older person.</td>
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<td>(Willson, 2008)</td>
<td>Factors affecting the administration of analgesia to patients following repair of a fractured hip</td>
<td>Factors that influenced decision making were: 1. Time. 2. Organisation of care. 3. Influence of the time of the shift (ie night or day). 4. Impact of the multidisciplinary team. 5. Concerns over opioid use, information giving and collection of information.</td>
<td>Behaviours were dependant on: 1. Location and time of shift. 2. Senior nurses directing junior nurses on analgesic administration. 3. Adherence to a ward dogma about pain assessment and management that did not reflect the policy or procedures of the hospital.</td>
<td>Ethnographic. Observation and semi-structured interview. Did not interview the older person. Excluded those with cognitive impairments.</td>
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<td>(Clabo, 2005)</td>
<td>Examining the role of social context in nurses’ pain assessment practice with postoperative clients</td>
<td>The impact of sociocultural context of the practice on the nurse assessment of post-operative patients pain, based on Bourdieu’s theory of practice.</td>
<td>Nurses used assessment criteria from three spheres: 1. The clients narrative of pain. 2. Evident criteria demonstrated by the client. 3. Use of a reference typology of expected pain assessment findings.</td>
<td>Ethnography. Observation and semi-structured interview. Did not interview the patients. Excluded those with cognitive impairments. Included those under the age of 65.</td>
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<td>(Reep et al., 2010)</td>
<td>Perspectives and experiences of elective surgery patients regarding pain management</td>
<td>Examination of the perspectives of elective surgical patients regarding pain management postoperatively.</td>
<td>Three main themes: 1. Perceptions of pain management goal was to feel no pain, not to have to experience pain. 2. Patients views of nurses role in pain management was to know what pain they are in and pre-empt it. 3. Interaction in pain management involved taking into account the cultural aspects of the patients themselves.</td>
<td>Qualitative descriptive. Interview. Did not interview the nurses. Included those under the age of 65.</td>
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(Baatsen et al., 2009) Nursing pain management— a qualitative interview study of patients with pain hospitalized for cancer treatment

- Exploration of cancer patients experience of pain whilst hospitalised in acute care for treatment

- Patients found it difficult to express expectations of nursing pain management and competencies; however noted that they wanted:
  1. Nurses to be present and supportive
  2. To gain information and share knowledge with nurses
  3. Nurses to take care of their medication
  4. Although they believed that nurses were caring people, there was a perception of differences in the individual strategies used by nurses for related interventions
  5. Noted that the nurses lacked a clear role in pain management as being the first step in improving pain for patients

Qualitative descriptive Semi-structured interviewing Did not interview the nurses Included those under the age of 65

(Spillivary et al., 2007) Pressure ulcers and their treatment and effects on quality of life: hospital inpatient perspectives

- To explore patients perceptions and experiences of having a pressure ulcer whilst in hospital

- Patients reported that pressure ulcers and their treatment affected their lives emotionally, mentally, physically and socially

- Described the quality of care they received varied, discomfort and pain during dressing changes

- Patients stated they are dependent on other to manage, treat and care for their ulcers.

- Noted that nurses would not acknowledge pain, discomfort and distress of having an ulcer

Qualitative descriptive Semi-structured interviewing Did not interview the nurses Included those under the age of 65

(Pomer & Wellard, 2007) Hearing what older consumers say about participation in their care

- Exploration of older peoples perception of participation in their care in acute care

- Used thematic analysis

1. Older people equated participation with being independent
2. Highlighted the complexity of the notion of participating when unable to engage in self care activities
3. Difficulties of communication and inability to administer own medications as an inpatient (in regards to pain relief, instead of asking for pain medication and waiting- patients would take their own)

Critical ethnography Participant observation and interviewing of both nurses and the older person Excluded those with cognitive impairments and non-English speaking

(Anderson et al., 2011) Experiences of care time during hospitalisation in a medical ward: older patients perspective.

- To describe older patients experience of receiving care during hospitalisation in an acute care medical ward

- Main themes of:
  1. hospitalisation requires a lot of waiting and patients manage this in different ways
  2. the importance patients placed with developing relationships with professionals as this promoted feelings of security and reduced anxiety and fear
  3. importance of being more involved in their own care
  4. importance of having detailed information about their stay as this helped facilitate participation

Qualitative descriptive Semi-structured interviewing Excluded those with cognitive impairments and the illiterate


- Construct of a discourse based on patient notes, family members of patients and patients who had experienced delirium

- Agist discourse
  1. older people who had been delirious were offered subject positions of
    a. being old doesn’t matter
    b. a second childhood
  2. older people who had experienced delirium resisted this agist discourse

Discourse analysis In depth interviewing Excluded those with current cognitive impairment

(Coker et al., 2008) Pain Management Practices: Older Adults on Acute Medical Units

- The purpose was to determine the current state of pain management in older adults on general units within a medical ward

- Found that 50% of older patients were in pain, nurses had limited awareness of their patient’s pain. Documentation of assessment and management were lacking and pain was undertreated

- Fewer than 60% of patients stated that they told their nurse about their pain. A lack of standardisation for clinical measurement of pain

Cross sectional survey design Simultaneous Interview of nurses, patients undertook a patient survey form and had pain measurement conducted on them on the same day as well as a chart audit Those with a recent surgical diagnosis of cancer or had a recent surgical procedure were excluded. Included those who had cognitive impairment by a substitute decision maker for those patients

(Todd et al., 2011) Right place – wrong person: dignity in the acute care of older people

- To explore the dignity of older persons in the acute care settings in four different UK national health care trust hospitals

- The notion that acute care wards are not the right place for the older person patient was repeatedly expressed by ward staff and management

- Whose interests matter- the effect of being cared for in a risk adverse environment

1. right place, wrong patient- the environment of the wards did not cater to the older person by disorientating, dismay from having to share
2. seeing the person- task based care, staff disconnected and dissatisfied
3. influences on dignified care- unable to provide as an integral and essential aspect dignity for the older person

Ethnographic Non-participant observation, semi-structured interviews of patients, carers, staff and managers, focus groups No statement that ethical approval had been gained, article is of overall poor quality

(Eriksson et al., 2014) Numeric rating scale: patients’ perceptions of its use in postoperative pain assessments.

- To describe how patients perceive the use of its post-operative pain assessments

- Three main themes:
  1. use of a NRS facilitated communication of pain-patients perceived rating of pain intensity guided the health care professionals choice of treatment
  2. it put demands on the health care professionals and care routines- patients did not want to be seen as an individual who complains but they did not get the right information about how to respond to the pain and whether to ask for pain relief
  3. contained interpretation difficulties – the NRS was insufficient to describe pain, pain is difficult to rate and it created uncertainty about how it was used by health care professionals

Qualitative descriptive Phenomenographic approach being two semi-structured interviews on day one and five post-operatively Had to be able to understand Swedish, excluded were those with a cognitive impairment or in need of ICU care Included those under the age of 65
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<td>Main theme was that of staff reacting to relief of discomfort instead of being proactive to create an environment that facilitated comfort</td>
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<td>1. The nature of discomfort/confort for the patients was enduring discomfort, actively seeking relief from discomfort by physical activity</td>
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<td>2. The staff spoke of attempting to provide comfort by letting the patients know the processes that occurred in hospital and providing information for them to fill in. They suggested that comfort was part of holistic care provision</td>
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<td>3. Approach of the nurses towards the patients was either engaged or disengaged</td>
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<td>4. Knowing the patient personally as a pre-requisite to achieving comfort</td>
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<td>5. The focus of comfort provision was focused on the essential basics of daily care, viewed as extras such as brushing teeth which was difficult for the patients to access regularly</td>
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<td>6. The context was that of a work environment as opposed to a place of living, little privacy or public places for the long term patients.</td>
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<td>7. Powerlessness of the patients in getting their basic needs met and not allowed to self-medicate as well as their knowledge about their own bodies was not valued by the nurses.</td>
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<td>8. Care organisation was influenced by an individualistic approach to care with ad hoc staff allocation which created insecurity in patients who did not know whom was going to care for them day by day</td>
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<td>Ethnography</td>
<td>Participant observation, in depth interviewing of both staff and the older person field noted written after period of observations</td>
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<td>Did not include those with dementia, delirium, or disabilities</td>
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<tr>
<th>Tutton, (2005)</th>
<th>Patient participation on a ward for frail older people</th>
<th>To explore the meaning of participation for older people in hospital and how staff can enhance patient participation in care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Four main themes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Facilitation - previously participation was a taken for granted concept, only by engaging in self-reflection did the nurses realise how controlling their care provision was and that it did not affect the older person the opportunity to participate. The staff became more aware of their care provision and stepped back to optimise patient participation within the environment of care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Partnership sub-themes of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Making connections, picking up cues, attempting to interpret these and identifying appropriate actions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not respecting the wishes of the patients, losing their trust by not involving them in the negotiation of the care provision. By engaging in reflection about how care was provided for the patients and asking them for what they wanted and facilitating an optimal outcome.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Understanding the patient sub themes of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Accepting the others - the importance of gaining and retaining an emotional connection between individuals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For patients this meant acceptance, that they require assistance with living, being grateful for that help, being patient in waiting for their needs to be met and being aware that they are one of many that require care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Use of emotion in a positive way to engage with others in order to provide care and stay emotionally connected</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Controlling their own emotional response by controlling their feelings and acting in a way that focused on the patients and their needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refers to nurses strong negative emotions about life and death on the ward which meant that if not managed effectively that opportunities for participation were curtailed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses can become increasingly aware of the potential for facilitation and creation of opportunities for participation. It is crucial that those working with older people develop a deeper understanding of what participation means and are empowered in order to act in ways that will fit in with the older person’s needs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommends research processes that integrate both patient and staff views of participation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action research</td>
<td>Patient and nurse interviews, Focus groups of nurses</td>
<td></td>
</tr>
<tr>
<td>Phase one - Focus group with 4 nurses and 9 patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phase two - two findings of phase one provided back to staff in written and oral formats</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phase three - throughout the study 3 staff members were interviewed at the beginning, middle and end of the study</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff and qualitative interviews with 9 patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phases - healthcare professionals kept reflective journals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi-structured interviewing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Wikstrom et al., 2014</th>
<th>Healthcare Professionals’ Perceptions of the Use of Pain Scales in Postoperative Pain Assessments</th>
<th>To describe how health care professionals perceive the use of pain scales in postoperative care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Four descriptive categories emerged</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Use of pain scales facilitated the understanding of post-operative pain - recall for the detection of the presence of pain, helped understanding of the patients experience of their pain by undertaking screening with the pain scale several times a day with fluctuations in the patients pain intensity over one or several days as being more easy to follow, they facilitated hand over between health care professionals when presented together with what medication had been given</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Facilitated treatment of pain, allowed the health care professional to stay one step ahead when controlling pain, provided an opportunity for choice of which drug to use or pain relieving care actions, they facilitated the evaluation of pain relieving actions before and after treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Demanded a multi-dimensional approach – not appropriate for all patients, patients had to understand how to rate their pain, the patients answers require interpretation as a low value may be given, but the patient still asks for medication- questioning the patient at rest and on movement was perceived as helpful, the interpretation of a pain score required a ‘clinical eye’ being a fear of reliance on the score and when the patients account conflicted with what was being observed - a reliance on facial expressions, eyes and movement, breathing, heart rate and blood pressure was deemed essential</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Was affected by work situations- the health care professionals expressed their insecurity in using a pain scale- being that they added their own values, patients compared their pain with others. Explaining the scales required time and patients required motivation to use them.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A social cultural aspect was noted that health care professionals had devised their own way of determining pain that was not using the pain scale, management and local guidelines encouraged the use and documentation of pain scales and this was seen as an encouraging aspect by the health care professionals, to find time to gain a pain score meant that a need was expressed for combining the gaining of it within other care routines or tasks and that pain scoring should cease when the patient found that pain had become manageable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health care professionals should respect patients choice to express their pain with their own words when referring to difficulties in interpreting pain into a rating and this needs to be emphasised into local guidelines as patients safety is at risk if a reliance only on rating when treating pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phenomenography</td>
<td>Semi-structured interviewing</td>
<td></td>
</tr>
<tr>
<td>Sweden</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

383
<table>
<thead>
<tr>
<th>Reference</th>
<th>Study Title</th>
<th>Summary</th>
<th>Methodology</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Costello, 2001)</td>
<td>Nursing older dying patients: findings from an ethnographic study of death and dying in elderly care wards</td>
<td>To explore the experiences of dying patients and the care provided by nurses for them. Care of older dying patients was defined by a lack of emotional engagement. 1. Non-disclosure within the institution about death and dying was a major barrier for engagement with patients who were dying. 2. A lack of effective communication about terminal diagnosis's and how this was conveyed to the old person. 3. Nurses provided mainly physical care to dying patients and little evidence was present of spiritual or emotional care being provided although the nurses stated that they provided this. 4. Terminal care for dying patients was hampered by the prevailing hospital culture being based on a biomedical model as opposed to a patient centred model. 5. How the nurses undertook palliative care was based on an acute care curative ideological model. 6. Provision of physical care for palliated patients was provided at the end of the nursing shift.</td>
<td>Ethnographic</td>
<td>Full participant observation. Semi-structured interviewing of nurses, physicians, auxiliaries and patients.</td>
</tr>
<tr>
<td>(De Silva &amp; Rolls, 2010)</td>
<td>Health-care system and nursing in Sri Lanka: An ethnography study.</td>
<td>Exploration of nurses cancer pain management in Sri Lanka and reports on two aspects found the health care system and nursing. States the Sri Lankan health care system is an considerable strain. 1. Poor hospital management allows doctors to admit too many patients leading to overcrowding and chaotic work environments with unsustainable resource allocation. 2. Nurses work in adverse conditions, are powerless. 3. Nurses professional situation is changing and directions for policy makers and international nursing organisations to improve nursing education and governance in Sri Lanka are called for. 4. Sri Lankan nurses are in a situation of medical dominance with minimal acknowledgment of their nursing input.</td>
<td>Ethnographic</td>
<td>Non-participant observation and semi-structured interviewing of nurses.</td>
</tr>
<tr>
<td>(De Silva &amp; Rolls, 2011)</td>
<td>Attitudes, beliefs and practices of Sri Lankan nurses toward cancer pain management: An ethnographic study.</td>
<td>To explore the experiences and cancer pain management practices of nurses. Suggested that the Sri Lankan nurses perform poor cancer pain management practices due to a lack of resources, a shortage of nurses and poor workload allocation within the hospital. 1. Sri Lankan nurses lack autonomy, work in a task orientated system that rarely acknowledged the cancer patient needs. 2. Calls for improvement in Sri Lankan nursing cancer pain management and changes in the curriculum of nursing courses in Sri Lanka.</td>
<td>Ethnographic</td>
<td>Non-participant observation and semi-structured interviewing of nurses.</td>
</tr>
<tr>
<td>(Rankin, 2015)</td>
<td>The rhetoric of patient and family centred care: an institutional ethnography into what actually happens.</td>
<td>To examine technological advances that are designed to improve nurses work and investigated how it impacts on the co-ordination of nurses work to provide patient and family centred care. 1. Bed use technologies that streamline patient discharge processes has serious consequences for nurses capacity to notice and attend to patient and family needs. 2. The contemporary managerial focus on patient and family centred care is organised to recruit family as workers on behalf of the hospitals efficiencies. 3. The nurses capacity to contribute their professional knowledge is being undermined by an imperative to facilitate discharge of the patients. The ideological construction of patient centred care obscures what is actually happening when represented within an organisation of their work that is removed and centred within a computer program.</td>
<td>Institutional Ethnography</td>
<td>Observation and interviewing of family members, and nurses. Presents a case study but does not interview the older person whom is the topic of the article.</td>
</tr>
<tr>
<td>(Crowell, 2010)</td>
<td>Care of older people with dementia in an acute hospital setting.</td>
<td>To investigate the experiences of nurses and patients in relation to the care delivered to and received by those older persons with dementia in an acute care setting. Four main themes 1. Staff appeared to work in switched off mode; they worked within a set of social rules that represented a cultural norm. 2. There was little empathy for patients with dementia. 3. Habitus was firmly embedded with the new staff being swiftly socialised into the that culture. 4. With current practice being accepted by the staff as the way things are and therefore was rarely changed. Patient experiences was that they found their hospital stay was difficult and sometimes disturbing experience. The staff worked hard and attempted to provide good care but was constrained by the organisational and environmental factors. There was also a lack of a person centred approach.</td>
<td>Ethnography</td>
<td>Observation and semi-structured interviewing of nurses and the older person.</td>
</tr>
</tbody>
</table>
Grey literature search strategies and results.

The search of the NSW state policy directives and guidelines database as noted in Table 16 Search terms for the National health policy directives and guidelines database, retrieved in total 368 documents that mentioned pain management, or pain assessment, and breakthrough pain management as well as the older person (NSW Deptment of Health., 2015). However, only one individual NSW state guideline, policy, or procedure was found to be specific for pain management in acute care and that was for the management of chest pain.

Table 16 Search terms for the National health policy directives and guidelines database

<table>
<thead>
<tr>
<th>Search terms used</th>
<th>Number of documents retrieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Best care for older people everywhere</td>
<td>653</td>
</tr>
<tr>
<td>Pain management OR assessment</td>
<td>103</td>
</tr>
<tr>
<td>Older person</td>
<td>150</td>
</tr>
<tr>
<td>Breakthrough pain management</td>
<td>115</td>
</tr>
<tr>
<td>Initially perceived as relevant and</td>
<td>1021</td>
</tr>
<tr>
<td>Not relevant</td>
<td>1009</td>
</tr>
<tr>
<td>Total fully evaluated</td>
<td>12</td>
</tr>
<tr>
<td>Not specific for older people or pain assessment or pain management</td>
<td>9</td>
</tr>
<tr>
<td>Specific for the older person</td>
<td>1</td>
</tr>
<tr>
<td>Specific for pain assessment or pain management for adults</td>
<td>1</td>
</tr>
<tr>
<td>Specific for pain assessment or pain management for the older person</td>
<td>0</td>
</tr>
</tbody>
</table>

The 12 documents reviewed in detail are as noted below in Table 17 NSW policies and procedures reviewed for guidance for pain care provision. In these documents, it although it was often outlined that pain assessment and management was a requirement for compliance and noted to be best practice, there was no specific guideline, policy, or procedure in place. Only a ‘Chest pain evaluation’ policy directive was specific for the assessment of chest pain which included reassessment as well as specific management of chest pain which was inclusive of an algorithm to provide minimum standards in accordance with EBP.
Table 17 NSW policies and procedures reviewed for guidance for pain care provision

<table>
<thead>
<tr>
<th>Name of state wide policy/procedure/guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition and management of patients who are clinically deteriorating</td>
</tr>
<tr>
<td>Code of conduct</td>
</tr>
<tr>
<td>Palliative care role delineation Framework</td>
</tr>
<tr>
<td>Palliative care: flexible breakthrough (rescue opioid doses for severe episodic pain in the community)</td>
</tr>
<tr>
<td>Chest pain evaluation (NSW chest pain pathway)</td>
</tr>
<tr>
<td>Inter-facility transfer process for adults requiring specialist care</td>
</tr>
<tr>
<td>Peripheral intravenous cannula (PIVC) insertion and post insertion care in adult patients</td>
</tr>
<tr>
<td>Open disclosure policy</td>
</tr>
<tr>
<td>Responding to abuse of older people</td>
</tr>
<tr>
<td>Clinical handover-shift handover</td>
</tr>
<tr>
<td>Assessment and management of people with behavioural and psychological symptoms of Dementia (BPSD).</td>
</tr>
<tr>
<td>High-risk medicines management</td>
</tr>
</tbody>
</table>

The local area health search of policies and procedures using the same search terms outlined in Table 16 Search terms for the National health policy directives and guidelines database returned a total of 678 articles, of which four were determined to be relevant and were reviewed. As noted below in Table 18 Local Area Health policies, procedures and or guidelines for pain, there are none that are specific for the assessment and management of pain in the older person or adult in acute care.

Table 18 Local Area Health policies, procedures and or guidelines for pain

<table>
<thead>
<tr>
<th>Name of Local Area Health policy/procedure/guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatric pain assessment and management</td>
</tr>
<tr>
<td>Prescribing guideline for midazolam</td>
</tr>
<tr>
<td>Nurse and midwife initiated medicines</td>
</tr>
<tr>
<td>Care co-ordination and referral processes for older people in acute care settings</td>
</tr>
</tbody>
</table>

A separate search of the APS website that is located within this area health service was undertaken. The APS manages post-operative and post-trauma pain as part of an integrated multidisciplinary pain service that delivers EB multidimensional care for those persons who have acute, chronic, and cancer pain both in the community as well as in hospital settings. The results of a search of the APS website is as shown in Table 19 Acute pain service policies, procedures and or guidelines noted that 16 documents were located and reviewed.
In total, one document was found that is specific for the older person. However, this article is a summary of a much larger article by Goucke et al. (2005) which is guideline for management of pain in residential aged cared facilities for the older person and while not including those pain assessment tools recommended by Goucke et al. (2005), the summary provided does recommend their use.

Table 19 Acute pain service policies, procedures and or guidelines

<table>
<thead>
<tr>
<th>Name of APS guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain matters: Pain in the elderly – a summary of residential aged care pain management</td>
</tr>
<tr>
<td>Opioid quick steps</td>
</tr>
<tr>
<td>Reconsidering opioid therapy</td>
</tr>
<tr>
<td>Opioid treatment agreement</td>
</tr>
<tr>
<td>Opioid authorisation and prescription</td>
</tr>
<tr>
<td>Group health patient handout- Chronic opioid risks</td>
</tr>
<tr>
<td>Opioid selection</td>
</tr>
<tr>
<td>Dose equivalence and opioid rotation</td>
</tr>
<tr>
<td>Opioid adverse effects</td>
</tr>
<tr>
<td>Opioid misuse</td>
</tr>
<tr>
<td>Reconsidering drug therapy for neuropathic pain, CRPS and fibromyalgia</td>
</tr>
<tr>
<td>Red and yellow flags</td>
</tr>
<tr>
<td>Procedural intervention guidelines</td>
</tr>
<tr>
<td>Managing conflict in clinical innervations</td>
</tr>
<tr>
<td>Analgesic medication in pregnancy</td>
</tr>
<tr>
<td>Mind body quick steps</td>
</tr>
</tbody>
</table>

The manual search of each of the eight wards within both hospital sites as shown in Table 20 Ward based policies, procedures, and/or guidelines for pain, identified one policy for the referral to APS, and two procedures for the use of S8 drugs for the management of pain in adults within ED. Furthermore, three paper based procedures and care plans were located. One guideline and nursing pathway for the management of patients admitted with fractured ribs was found in the paper filling system within four wards of hospital Y. Each hospital had separate paper forms for documentation about pain with hospital Y having a three-page form and hospital X having a section in a six page form.
Table 20 Ward based policies, procedures, and/or guidelines for pain

<table>
<thead>
<tr>
<th>Name of ward based policy/procedure/guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical care management. Section three Direct care:</td>
</tr>
<tr>
<td>Use of S8 medications in the emergency department to manage acute pain</td>
</tr>
<tr>
<td>Administration of morphine sulphate for the management of severe pain in patients over 16 years</td>
</tr>
<tr>
<td>Management of patients admitted with fractured ribs (dated 2011)</td>
</tr>
<tr>
<td>Pain management guideline for hospital Y (dated 2005)</td>
</tr>
<tr>
<td>Inpatient assessment tool for hospital X</td>
</tr>
</tbody>
</table>

A search for education provision within the hospitals was largely unsuccessful, as noted by Table 21 Education available within each hospital site. A search of the NSW state wide standardised education provider, an online system known as the Health Education and Training Institute (HETI) identified that three 20 minute online sessions existed, and at the time of writing two were available, with the remainder under development. The manual search of the wards revealed a paper based self-directed learning package on one of the surgical wards in hospital X that had been created in 2009 was still currently available for the nurses to use.

Table 21 Education available within each hospital site

<table>
<thead>
<tr>
<th>Location and date</th>
<th>Format</th>
<th>Title</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health education and training institute</td>
<td>Online</td>
<td>Acute pain management for adults</td>
<td>Not yet available</td>
</tr>
<tr>
<td>Health education and training institute</td>
<td>Online</td>
<td>Pain assessment</td>
<td>Available</td>
</tr>
<tr>
<td>Health education and training institute</td>
<td>Online</td>
<td>Patient controlled analgesia</td>
<td>Available</td>
</tr>
</tbody>
</table>
Appendix 5: Ethical approval form

11 October 2012

Professor I Higgins
School of Nursing & Midwifery
Faculty of Health
University of Newcastle

Dear Professor Higgins,

Re: An ethnographic study of the clinical practice of nurses when assessing & managing pain in older people in the acute care setting (12/09/19/4.03)

Reference No: 12/09/19/4.03
Reference No: HREC/12/HNE/313

Thank you for submitting the above ethical review for a multi-centre study. This project was first considered by the Hunter New England Human Research Ethics Committee at its meeting held on 19 September 2012. This Human Research Ethics Committee is constituted and operates in accordance with the National Health and Medical Research Council’s National Statement on Ethical Conduct in Human Research (2007) (National Statement) and the CPMP/ICH Note for Guidance on Good Clinical Practice. Further, this Committee has been accredited by the NSW Department of Health as a lead HREC under the model for single ethical and scientific review. The Committee’s Terms of Reference are available from the Hunter New England Local Health District website: http://www.hnehealth.nsw.gov.au/Human_Research_Ethics.

I am pleased to advise that following acceptance under delegated authority of the requested clarifications and revised Information Statement schedule by Dr Nicole Gerrand Manager, Research Ethics & Governance, the Hunter New England Human Research Ethics Committee has granted ethical approval of the above project.

The following documentation has been reviewed and approved by the Hunter New England Human Research Ethics Committee:

- For the Information Sheet for Research Project (Nurses) (Version 2 dated 22 September 2012);
- For the Consent Form for Research Project (Nurses) (Version 2 dated 3 October 2012);
- For the Information Sheet for Research Project (Patients) (Version 2 dated 23 September 2012);
- For the Consent Form for Research Project (Patients) (Version 2 dated 3 October 2012);
- For the Information Sheet for Research Project (Carer) (Version 1 dated 27 September 2012);
- For the Consent Form for Research Project (Carer) (Version 1 dated 27 September 2012);
- For the Semi Structured Interview Guide for Older Cognitively Intact Inpatients (Version 2 dated 23 September 2012); and
- For the Semi Structured Interview Guide of Nurse Participants (Version 2 dated 22 September 2012)

For the protocol: An ethnographic study of the clinical practice of nurses when assessing & managing pain in older people in the acute care setting

Approval has been granted for this study to take place at the following sites:

- Local Health District

Approval from the Human Research Ethics Committee for the above protocol is given for a maximum of 3 years from the date of this letter, after which a renewal application will be required if the protocol has not been completed.

The National Statement on Ethical Conduct in Human Research (2007), which the Committee is obliged to adhere to, include the requirement that the committee monitors the research protocols it has approved. In order for the Committee to fulfill this function, it requires:

- A report of the progress of the above protocol be submitted at 12 monthly intervals. Your review date is October 2013. A proforma for the annual report will be sent two weeks prior to the due date.

- A final report must be submitted at the completion of the above protocol, that is, after data analysis has been completed and a final report compiled. A proforma for the final report will be sent two weeks prior to the due date.

- All variations or amendments to this protocol, including amendments to the Information Sheet and Consent Form, must be forwarded to and approved by the Human Research Ethics Committee prior to their implementation.

- The Principal Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:
  - any serious or unexpected adverse events
    - Adverse events, however minor, must be recorded as observed by the investigator or as volunteered by a participant in this protocol. Full details will be documented, whether or not the investigator or his deputies considers the event to be related to the trial substance or procedure. These do not need to be reported to the Human Research Ethics Committee.
    - Serious adverse events that occur during the study or within six months of completion of the trial at your site should be reported to the Manager, Research Ethics & Governance, of the Human Research Ethics Committee as soon as possible and at the latest within 72 hours.

• Serious adverse events are defined as:
  - Causing death, life threatening or serious disability.
  - Cause or prolong hospitalisation.
  - Overdoses, cancers, congenital abnormalities whether judged to be caused by the investigational agent or new procedure or not.
  - Unforeseen events that might affect continued ethical acceptability of the project.

• If for some reason the above protocol does not commence (for example it does not receive funding); is suspended or discontinued, please inform Dr Nicole Gerrand, as soon as possible.

A copy of this letter must be forwarded to all site investigators for submission to the relevant Research Governance Officer.

Should you have any concerns or questions about your research, please contact Dr Gerrand as per the details at the bottom of the page. The Human Research Ethics Committee wishes you every success in your research.

Please quote 12/09/19/4.03 in all correspondence.

Human Research Ethics Committee wishes you every success in your research.

Yours faithfully

For: Associate Professor M Parsons
Chair
Human Research Ethics Committee
Appendix 6: Documentation for ethics

Poster inviting participants to the study.

Are you interested in participating in research designed to explore the factors that impact on how nurses assess and manage pain?

Please contact the Research Student
Joanne Harmon RN (BN Hons) PhD candidate
School of Nursing and Midwifery, Faculty of Health
University of Newcastle

Figure 6 Poster inviting participants to the study
An exploratory study of the pain management practices by nurses

Nurse Version 2 22/09/2012

If you are a registered nurse with more than 6 months practice in a medical or surgical ward you are invited to participate in this study which will be conducted by the PhD research student Joanne Harmon, under the supervision of Professors Isabel Higgins and Sian Maslin-Prothero from the School of Nursing and Midwifery and Dr Peter Summons from the School of Design, Communication and Information Technology at The University of Newcastle

Why is the research being done?

The focus of the study is based on the nursing care of older persons in acute care about aspects such as pain management. This involves the exploration of the practices of nurses for example when they assess and manage pain in older people in an acute care setting. In particular this study is designed to explore these factors that impact on the practices of nurses such as the barriers and facilitating aspects for assessing and managing pain.

Who can participate?

Registered Nurses who have worked on a medical or surgical ward for more than 6 months are invited to participate in this study. Older patients who have given their permission for the student researcher (Joanne Harmon) to observe them are also invited to participate.
What choice do you have?

Participation in this research is entirely your choice, only those people who give their informed consent will be included in the project. Whether or not you decide to participate, your decision will not disadvantage you in any way and will not affect your employment or future employment prospects. If you do decide to participate you may withdraw from the project at any time and withdraw all information about yourself from the project without giving a reason. You can withdraw aspects or all of the information from the interview.

What would you be asked to do?

If you agree to participate, you will be asked to;

- Allow the researcher, Joanne Harmon (JH) to observe you, when attending to patient care to an older person for example when you are undertaking pain assessment and pain management.
  - The observation periods will occur within your normal rostered shift, for two hours, over a period of seven days, at a mutually agreeable time.

- You will be asked to participate in a maximum of five individual one-to-one follow-up interviews:
  - The interviews will be conducted by JH who will use open ended questions
    - Discussion will be about the processes observed,
    - You will be asked to confirm and/or clarify your actions, and
    - The reasons underpinning the strategies employed during the pain assessment process and management.
  - The interview will be audio recorded and later transcribed verbatim for ease of analysis.
  - You will also be asked to comment on the researcher’s interpretation of the interaction between you and the older person.
  - On request you can ask for the recording to be stopped at any time and you can edit the tape.

- If you are interested in the findings of this study, you may request a project report by contacting the researcher Joanne Harmon at the address provided at the end of this sheet.

- Prior to the observation periods and interviews you will be asked to sign and return the attached consent form.

- A member of the team (JH) will then contact you to arrange a date and time for the observation periods and interviews.

- The researcher will also take notes about any documentation in relation to pain that has been written by you

How much time will it take?

The observation period will take approximately two hours and will be conducted during your rostered shift, on the ward where you are regularly employed. In addition there may be up to
five interviews, and these interviews will take approximately 5 to 20 minutes, to be conducted at a time that suits you, that may or may not be in business hours. The location for the interview will be in a private area located near the ward or if you prefer at another preferred location.

**Are there any risks or benefits of participating?**

In the unlikely event any negligent, unethical or illegal actions are observed this will be brought to your attention by the researcher nurse, who is obliged to report this to the nursing unit manager (NUM) of the ward. In addition, the appropriate policy and procedure for reporting adverse events within your facility will be followed and the event will be reported to the Hunter New England local health district ethics committee as required.

Whilst it is not anticipated that the interview will cause distress, discussion about subconscious actions or routines that you may have not been aware of, may be uncomfortable and disturbing. Should you become distressed, you will be invited to consider talking to the employer assistance program (EAP) on 02 4921 2822 or the EAP co-ordinator 02 4985 3289.

**How will your privacy be protected?**

You are assured that the information given to us will not be identifiable to ensure your anonymity. All information received from you will be in strict confidence. Information will be coded; numbers & pseudonyms will replace the names of people, health service, hospitals and wards participating in the project. Completed consent forms and identifying data will be stored in a separate locked filing cabinet or on a password protected computer accessible only to the Researcher (JH) and Project Manager- Professor Isabel Higgins. No identifying information will be placed on any of the study materials. Pseudonyms (another name) will be used for any publications deriving from this study. On completion of the project, the recorded audio recording will be destroyed and all textual data will be kept in a secure password protected directory for seven years, after which all information will be destroyed.

**How will the information collected be used?**

The results of the research will be presented in a thesis and disseminated by publication in peer reviewed journals and conference presentations. A formal project report will be written which will include recommendations for practice and indications for further research. This information will be disseminated to health services, policy makers, and higher education institutions responsible for providing registered nurse education.

**What do you need to do to participate?**

Please read this information letter and be sure you understand its contents before you consent to participate. If there is anything you do not understand, or if you have questions, please contact Joanne Harmon.
Further information

If you would like to participate, please complete and return the attached consent form in the reply paid addressed envelope provided. The researcher, Joanne Harmon - will then contact you to arrange an informal briefing session, where you can ask any further questions.

Joanne Harmon is a registered nurse who is present only in a researcher’s role and as such will not perform any nursing duties.

Thank you for considering this invitation.

Yours sincerely

Joanne Harmon
Principle researcher

Professor Isabel Higgins
Project Supervisor

Contact details

Principle researcher

Joanne Harmon (RN)
School of Nursing and Midwifery
Faculty of Health,
The University of Newcastle

Chief Investigator

Professor Isabel Higgins (RN)
School of Nursing and Midwifery
Faculty of Health,
The University of Newcastle

Dr Peter Summons
School of Information Technology and Design, Faculty of Science
The University of Newcastle

Professor Sian Maslin Prothero (RN)
School of Nursing and Midwifery
Edith Cowan University
Complaints about this research

This research project has been approved by the Hunter New England Area Human Research Ethics Committee, Reference No 12/09/19/4.02 Should you have any concerns regarding your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to;

Dr Nicole Gerrand
Manager, Research Ethics and Governance
Consent form for registered nurses.

Project supervisors
Professor Isabel Higgins
Dr Peter Summons
Conjoint Professor Sian Maslin-Prothero
The University of Newcastle
University Drive, Callaghan, 2308

Research Student
Joanne Harmon RN (BN Hons) PhD candidate
School of Nursing and Midwifery, Faculty of Health
The University of Newcastle
University Drive, Callaghan, 2308

An exploratory study of the pain management practices by nurses

Nurse Version 2  03/10/2012

1. I agree to participate in the above research project and give my consent freely (Yes/No).
2. I understand that the project will be conducted as described in the Information Letter, a copy of which I have retained (Yes/No).
3. I understand that I can withdraw from the project at any time and do not have to give any reason for withdrawing (Yes/No).
4. I consent to:
   i. A member of the team contacting me to organise suitable times and location for observation and interview as described in the information sheet (Yes/No).
   ii. The researcher observing me during clinical practice whilst caring for older people for periods of one to two hours, five times over a period of seven days within my normal roster (Yes/No).
   iii. Five follow-up interviews associated with the observation periods at a time that is mutually agreed (Yes/No).
   iv. The interviews being audio recorded and transcribed as described in the information letter (Yes/No).
   v. The researcher taking notes about any documentation undertaken in regards to pain assessment and/or management (Yes/No).

5. I understand that my personal information will remain confidential (Yes/No).
6. I have had the opportunity to have questions answered to my satisfaction (Yes/No).

Print name:

Designation:

Signature:

Date:
Yours sincerely

Joanne Harmon  
Principle researcher

Professor Isabel Higgins  
Project Supervisor

Contact details

Principle researcher

**Joanne Harmon (RN)**
School of Nursing and Midwifery  
Faculty of Health,  
The University of Newcastle

Chief Investigator

**Professor Isabel Higgins (RN)**
School of Nursing and Midwifery  
Faculty of Health,

Isabel.Higgins@newcastle.edu.au

**Dr Peter Summons**
School of Information Technology and Design,  
Faculty of Science  
The University of Newcastle

**Professor Sian Maslin Prothero (RN)**
School of Nursing and Midwifery  
Edith Cowan University

Complaints about this research

rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to;

Manager, Research Ethics and Governance Hunter New England Local Health District
Semi-structured interview guide for registered nurses.

Interview settling period

The purpose of using semi-structured questions as an approach for interviewing is to facilitate conversation.

Introductions

- Explanation of the study in lay terms
- Confirmation of
  - Voluntary consent for interview and to have it audio recorded

Goal is to provide a comfortable environment for the participants.

‘Discussion and reflection about clinical practice can be at times distressing and if you begin to feel distressed or uncomfortable let me know... I will cease the interview and, if you wish I can give you the number of the employer assistance program.’

Opening – background information

- Can you describe your experiences as a registered nurse?
  - Using your own words, How would you describe yourself as a nurse?
  - Where did you work before here, have you done any more study or likely to...

Focus & examples of questions to be asked

- Can you tell me about your experiences when assessing and managing pain in older patients?
  - What prompts do you look for?
  - Are there any things that make it challenging for you?
  - What makes it easy or what helps? And is this the same for all patients?
  - What hinders your ability to assess pain?
  - What hinders your ability to monitor pain?
  - What aspects of pain are the most important for you?
  - What helps when you are assessing pain?
  - Can you tell me what expectations you have for pain in this patient?
  - What is your experience of using pain assessment tools?
- Can you tell me what you did to manage patient X, Y, or Z’s pain?
  - Was this your usual practice?
  - What things hinder your ability to manage pain well?
  - How do you know if and when your intervention is effective or not?
- What is your role regarding pain assessment and management?
  - Could you describe expectations that others might have of you re pain assessment and management?
  - What makes it difficult for you to meet these?
  - What makes it easier?
Can you describe what is required for pain documentation?
  o  What resources are available here for you?
  o  Which aspects do you refer to the most or least?
  o  What aspects would you change?

Concluding questions
  •  If you wanted to give advice to other nurses about assessing and managing pain what would you tell them...? Really why...can you tell me more

Closing the interview
  •  Thank you for sharing your experiences with me, they are valuable and important
  •  Possibility of follow up interview if interested, if you want to tell me more
  •  Indicate recording has finished
  •  Spend a period of time de-briefing with the participant about their experience and acknowledge further their contribution.
Dear Sir/Madam,

You are invited to participate in this study which will be conducted by the research student under the supervision of Professors Isabel Higgins and Sian Maslin-Prothero from the School of Nursing and Midwifery and Dr Peter Summons from the School of Design, Communication and Information Technology at The University of Newcastle.

Why is the research being done?

The aim of the study is to explore the factors that impact on the practices of nurses when they are assessing and managing pain in older patients.

Who can participate?

People over the age of 65 years who are hospitalised and who experience pain. Nurses who care for older inpatients are also being invited to participate.
What are you being asked to agree to?

You are being asked to agree to the presence of a researcher (Joanne Harmon) who will observe the practice of nurses, who have consented to the study. The observations will occur for up to two hours a day, over a period of two to three days whilst they are attending to your care. Whilst the researcher is observing the nurse giving your care she will also take notes of what she observes that relate to the purpose of the research. No notes will be recorded that can identify you in any way.

In addition, you are also being asked to be interviewed at a location within the hospital that is convenient to you and in a private area. The presence of the researcher and the conduct of the interview are not intended to impact your care. Your care needs will be given priority at all times. The interview is designed to explore your experience of care with a focus on having pain assessed and managed by nurses. You may be asked to agree to a follow up interview. The interview will be conducted face to face and be audio recorded for transcription and analysis. The interview will occur in the hospital while you are still an inpatient in a private area either in or near the ward. You will also be asked to agree to the researcher (Joanne Harmon) accessing your medical and bedside charts for notes in relation to your pain, pain assessment and management, the reason(s) for your admission to hospital and your medical diagnosis.

How much time will it take?

The observation periods will take up to two hours over two or three days. The interview will take from twenty minutes to forty minutes, and you may be asked to agree to a follow up interview as noted above.

Are there any risks or benefits in participating?

The researcher (Joanne Harmon) will not participate in the care given to you. If illegal or negligent action is observed this will be reported as per the hospital and
It is not anticipated that during the observation or interview that you will experience discomfort or harm. However, discussion about pain may be a source of distress for you. Should this occur, you will be invited to talk to a staff member who may refer you to a hospital counsellor.

**How will your privacy be protected?**

In respect to your privacy, the researcher will not observe any aspect of showering, toileting, bed baths or invasive procedures.

All information received from you will be strictly confidential. A pseudonym (another name) will be used to replace your name, the health service, hospital and wards participating in this study. Pseudonyms will be used for any publications deriving from this study. On completion of the study, the audio recording gained from the interview/s will be destroyed and all data will be kept in a secure password protected location at the University of Newcastle for seven years, after which all information will be destroyed.

**How will the information collected be used?**

The results of this study will be used by Joanne Harmon to write a Doctoral thesis and feature in seminar presentations, conferences and journal publications. If you are interested in the findings of this study, you may request a project report by contacting the researcher (Joanne Harmon) at the address provided at the end of this sheet.

**What do you need to do to participate?**

Please read this information letter and be sure you understand its contents before you give your verbal permission. If there is anything you do not understand, or if you or your family members have questions, please feel free to contact the researcher, Joanne Harmon, whose details are given at the end of this letter.

If you wish to be interviewed please inform the Nursing Unit Manager, or his/her representative or the senior nurse who initially contacted you, as you will be required to sign a consent form for this.
What are your rights?

If you give verbal permission for the researcher to be present during the delivery of your care for this study and/or your consent to being interviewed, your rights are protected as follows:

1. You have the right to ask questions of the nursing unit manager, the nurse, or the researcher.
2. You have the right to refuse permission for this study and your refusal will not change how you are treated by any member of Hunter New England Local Health District, now or in the future.
3. You can ask the nurse to request the researcher to leave for no reason during the observation period and/or interview.
4. Your care and treatment will not be affected in any way, now or in the future.

Further information

Thank you for considering this invitation,

Yours Sincerely,

Student researcher  
Joanne Harmon (RN)  
School of Nursing and Midwifery  
Faculty of Health, The University of Newcastle

Chief Investigator  
Professor Isabel Higgins (RN)  
School of Nursing and Midwifery  
Faculty of Health, The University of Newcastle

Dr Peter Summons  
School of Information Technology and Design, Faculty of Science  
University of Newcastle

Professor Sian Maslin Prothero (RN)  
School of Nursing and Midwifery  
Edith Cowan University  
Western Australia
Complaints about this research
This research project has been approved by the Reference No: 12/09/19/4.02

Should you have any concerns regarding your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or if an independent person is preferred to:

Dr Nicole Gerrand
Manager, Research Ethics and Governance.
Older person consent form.

Project supervisor
Project Team Members
Professor Isabel Higgins
Dr Peter Summons
Conjoint Professor Sian Maslin-Prothero
The University of Newcastle
University Drive, Callaghan, 2308

Research Student
Joanne Harmon RN (BN Hons) PhD candidate
School of Nursing and Midwifery, Faculty of Health
The University of Newcastle

Consent form for research project (Patients):
An exploratory study of pain management in older people in acute care settings
Patient Version  2 03/10/2012

1. I agree to participate in the above research project and give my consent freely. yes/no
2. I understand that the project will be conducted as described in the Information Letter, a copy of which I have retained. yes/no
3. I understand that I can withdraw from the project at any time and do not have to give any reason for withdrawing. yes/no
4. I understand that participating in the research will not affect my treatment in any way. yes/no
5. I consent to:
   vi. A face to face interview as described in the information letter. yes/no
   vii. The interview being audio recorded and transcribed for analysis. yes/no
   viii. The researcher being present for designated observation periods whilst the nurse is providing care for me. yes/no
ix. The researcher accessing my medical records as described in the information letter. yes/no

6. I understand that my personal information will remain confidential. yes/no
7. I have had the opportunity to have questions answered to my satisfaction. yes/no

Print name: ___________________________ Date
Signature: ___________________________ : __________
Contact details ___________________________

Yours Sincerely,

Principle researcher
Joanne Harmon (RN)
School of Nursing and Midwifery
Faculty of Health, The University of Newcastle

Chief Investigator
Professor Isabel Higgins (RN)
School of Nursing and Midwifery
Faculty of Health, The University of Newcastle

This research project has been approved by the Hunter New England Area Research Ethics Committee, HNEHREC Reference No 12/09/19/4.02 Should you have any concerns regarding your rights as a participant in this research, or you have a complaint about the manner in
which the research is conducted, it may be given to the researcher, or if an independent person is preferred to;

Dr Nicole Gerrand

Manager, Research Ethics and Governance
Information sheet for research project (family member/carer):
An exploratory study of the pain management practices by nurses

Dear Sir/ Madam,

Your family member/ or the person who you are the carer for are invited to participate in this study which will be conducted by the research student under the supervision of Professors Isabel Higgins and Sian Maslin-Prothero from the School of Nursing and Midwifery and Dr Peter Summons from the School of Design, Communication and Information Technology at The University of Newcastle

Why is the research being done?

The aim of the study is to explore the factors that impact on the practices of nurses when they are assessing and managing pain in older patients.

Who can participate?
People over the age of 65 years who are hospitalised and who experience pain. Nurses who care for older inpatients are also being invited to participate.

What are you being asked to agree to?
You are being asked to agree on behalf of your family member (or the person you care for) to the presence of a researcher (Joanne Harmon) who will observe the practice of nurses, who have consented to the study. The observations will occur for up to two hours a day, over a period of two to three days whilst they are attending to care of your family member (or the person you care for). When the researcher is observing the nurse giving care, she will also take notes of what she observes that relate to the purpose of the research. No notes will be recorded that can identify your family member or (or the person you care for) in any way.

You are also being asked to agree to the researcher (Joanne Harmon) accessing your family member (or the person you care for) medical and bedside charts for notes in relation to pain, pain assessment and management, the reason(s) for their admission to hospital and their medical diagnosis.

You may, if you prefer, designate a member of staff (being the nurse unit manager or anyone else you wish) to decide on a daily basis if your family member (or the person you care for) is to be included in the observation period/s. This consent will not apply to any other situation or circumstance for your family member (or the person you care for) in any way now and in the future.

**How much time will it take?**

The observation periods will take up to two hours over two or three days.

**Are there any risks or benefits in participating?**

The researcher (Joanne Harmon) will not participate in the care given to your family member (or the person you care for). If illegal or negligent action is observed this will be reported as per the hospital and Hunter New England Local Health District’s policy. It is not anticipated that during the observation periods that your family member (or the person you care for) will experience discomfort or harm.

**How will your privacy be protected?**
In respect to your family member (or the person you care for) privacy, the researcher will not observe any aspect of showering, toileting, bed baths or invasive procedures.

All information received from your family member (or the person you care for) will be strictly confidential. A pseudonym (another name) will be used to replace their name, the health service, hospital and wards participating in this study. Pseudonyms will be used for any publications deriving from this study. On completion of the study all data will be kept in a secure password protected location at the University of Newcastle for seven years, after which all information will be destroyed.

**How will the information collected be used?**

The results of this study will be used by Joanne Harmon to write a Doctoral thesis and feature in seminar presentations, conferences and journal publications. If you are interested in the findings of this study, you may request a project report by contacting the researcher (Joanne Harmon) at the address provided at the end of this sheet.

**What do you need to do to participate?**

Please read this information letter and be sure you understand its contents before you provide consent on behalf of your family member (or the person you care for). If there is anything you do not understand, or if you or your family members have questions, please feel free to contact the researcher, Joanne Harmon, whose details are given at the end of this letter.

**What are your rights?**

When you give consent for the researcher to be present during the delivery of your family member family member (or the person you care for) care for this study. You, your family member family member (or the person you care for) rights are protected as follows:

1. You and your family member family member (or the person you care for) have the right to ask questions of the nursing unit manager, the nurse, or the researcher.
2. You and your family member (or the person you care for) have the right to refuse permission for this study and your refusal will not change how you are treated by any member of Hunter New England Local Health District, now or in the future.
3. You and your family member (or the person you care for) can ask or indicate for the nurse to request the researcher to leave for no reason during the observation period.
4. You and your family member (or the person you care for) care and treatment will not be affected in any way, now or in the future.
5. If you wish for a designated staff member to provide daily consent for your family member (or the person you care for) on your behalf, this will be applicable for this study only.

Thank you for considering this invitation,

Yours Sincerely,

Student researcher
Joanne Harmon (RN)
School of Nursing and Midwifery
Faculty of Health, The University of Newcastle

Chief Investigator
Professor Isabel Higgins (RN)
School of Nursing and Midwifery
Faculty of Health, The University of Newcastle

Complaints about this research
This research project has been approved by the
Hunter New England Area Research Ethics Committee, Reference No: 12/09/19/4.02
Should you have any concerns regarding your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or if an independent person is preferred to;

Dr Nicole Gerrand  
Manager, Research Ethics and Governance
Semi-structured interview guide for older cognitively intact inpatients.

Interview settling period
The purpose of using semi-structured questions as an approach for interviewing is to facilitate conversation
Introductions
- Explanation of the study in lay terms
- Confirmation of
  - Voluntary consent for interview and to have it audio recorded

Goal is to provide a comfortable environment for the participants
- ‘Discussion about pain can be at times distressing and if you begin to feel distressed or uncomfortable let me know... I will cease the interview and, if you wish... we can ask a nurse or a councillor to talk to you.’

Opening – background information
Can you tell me why you are here in hospital...?
Focus
- Can you tell me about your experience of pain...?
What has this been like for you...?
Has it been what you expected...?

Can you describe how this has been different/same from what you expected?

- What was it like (just then) explaining to a nurse what your pain is like for you...?
  - Can you describe to me how you got their attention for your pain... either just then or in times before...?
- Can you tell me more about that...?
  - What was it like for you when the nurse did X or Y...?
  - How were you feeling then...? Or can you give me an example...?
  - Can you describe to me about what helped you with what was happening...did you do anything different to cope...?
- You have had a number of nurses looking after your pain while you have been in hospital...can you describe the other kinds of things have they done for your pain...what did that feel like for you?

Concluding questions
- If you wanted to give advice to other people about having the same pain experience as you, what would you tell them...? Really why...

Closing the interview
- Thank you for sharing your experiences with me, they are valuable and important
- Possibility of follow up interview if interested, if you want to tell me more
- Indicate recording has finished
- Spend a period of time de-briefing with the participant about their experience and acknowledge further their contribution.
Document review schedule.

Document review schedule for older inpatients

**Document review per patient**

- Reason for admission
- Diagnosis
- What types of documentation for pain assessment and management are in use?
  - at the bedside,
  - in the medical charts and
  - available on the ward
- What is being documented for assessment of pain, where and in what format?
- What is being documented for management of pain where and in what format?
  - Are pharmacological/non-pharmacological responses recorded and in what format?
- Is there replication of pain records?
  - What was documented (or not)?
  - Where and in what format?

**General review of documents per ward**

- Is there a policy or procedure in place in use?
  - at the bedside,
  - in the medical charts and
  - available on the ward/online
- What types of guidelines/ algorithms are in use?
  - at the bedside,
  - in the medical charts and
  - available on the ward/online
Appendix 7: The older person participants in this study

The following Table 22 The older person participants in this study presents information in relation to the 42 older person participants in this study. The reasons for presentation often began before presentation to ED, but for this study a focus is placed on while in acute care. This information was gained by speaking to the older person patients in this study and with the reasons for presentation to ED provided within the medical notes.

Table 22 The older person participants in this study

<table>
<thead>
<tr>
<th>Patients name</th>
<th>Age</th>
<th>Sex</th>
<th>Reason for presentation to ED</th>
<th>Social aspects gained mainly from speaking to the older person, and from medical notes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Justin</td>
<td>73</td>
<td>M</td>
<td>BIBA c/o feeling unwell, N&amp;V, fall, pain in foot- ulcerated foot</td>
<td>Developmentally delayed, lives independently in the community in a group home.</td>
</tr>
<tr>
<td>Belinda</td>
<td>76</td>
<td>F</td>
<td>BIBA, Decreased mobility- unable to walk, hip pain 4/10 in ambulance acute pain, numbness bi lat fingers, 2/52 pain in joints, states pain 8-9/10.</td>
<td>CALD Pt had presented earlier to another hospitals ED, given medications unsure on how to use. Lives 3 hours drive away in country.</td>
</tr>
<tr>
<td>Jessica</td>
<td>73</td>
<td>F</td>
<td>BIBA Immobility, unable to move generalised weakness, Hx 4/12 of fluctuating oedema/ unwell for past 4/7 days BNO D4</td>
<td>Lives with husband, has chronic pain from previous car accident and C3#</td>
</tr>
<tr>
<td>Simon</td>
<td>65</td>
<td>M</td>
<td>Cramping, bi-lat hip pain, clinically jaundiced</td>
<td>CALD Develops hepatic encephalopathy grade V when in hospital and is admitted to ICU on day five and returns to ward on day nine.</td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Gender</td>
<td>Admission Note</td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>-----</td>
<td>--------</td>
<td>--------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Peter</td>
<td>73</td>
<td>M</td>
<td>BIBA collapse at home? Confusion poor historian. Previously IADLs, still works. Recent (?) thoracotomy and R/O ribs (not documented what side or which ribs)- later find out it is L side 6 weeks ago.</td>
<td></td>
</tr>
<tr>
<td>Marcus</td>
<td>89</td>
<td>M</td>
<td>Triage exacerbation of APO on a background of CCF. Numerous chronic and complex issues which leads to the patient becoming palliated and later passed away while an inpatient.</td>
<td></td>
</tr>
<tr>
<td>Brianna</td>
<td>69</td>
<td>F</td>
<td>BIBA, 3 days inc SOB, tight chest able to speak in short sentences- self meds no ventolin, atrovent and predinsolone. 3 nebs on route remains SOB SaO2 98% 24 RR 2 lt o2, ED sago pain 3/10 on arrival. During her 2nd day of stay Brianna experiences a serious charting error of her Jurnista. Entry reads- Noted charting error. Pt receives Jurnista 16mg SR at home- was charted Hydromorphone IR and had received 4 x 4mg tablets (error picked up by pharmacy) registrar contacted and issue discussed with NUM. Brianna is informed about the medication error and it is officially reported as per policy and procedure.</td>
<td></td>
</tr>
<tr>
<td>Janet</td>
<td>68</td>
<td>F</td>
<td>Elective procedure surgical intervention. Notes that the chairs are uncomfortable to sit on.</td>
<td></td>
</tr>
<tr>
<td>Alexis</td>
<td>83</td>
<td>F</td>
<td>BIBA as family not coping, w/ inc SOB and fluid retention on B/G of D/C on xx/x for similar [8days prior]. Alexis reports on admission increased SOB- felt as though she was going to choke SOBOE, receives extensive S/W input.</td>
<td></td>
</tr>
<tr>
<td>Brett</td>
<td>84</td>
<td>M</td>
<td>BIBA, presents with pain, abdo. on going complications post op infections, has PICC line insitu w/IVAB pump. Presented to ED and was informed to represent. Lives with wife, has daughter close by. Later passes away at home 2 weeks after discharge.</td>
<td></td>
</tr>
<tr>
<td>Richard</td>
<td>88</td>
<td>M</td>
<td>BIBA post fall T/F from X, INR 15.8 and UTI. For sub-acute input before transfer home. Disabilities- with one leg shorter than the other but no reason is provided within his admission notes.</td>
<td></td>
</tr>
<tr>
<td>Barry</td>
<td>86</td>
<td>M</td>
<td>BIBA, fall, unspecified- mechanical. Lives alone, No regular GP (states hasn’t seen a GP for ‘years’) Smoker Drinker ETOH 1-5 beers a day. Develops incontinence, not known if it is new or not due to minimal knowledge about daily habits.</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Gender</td>
<td>History</td>
<td>Presenting Problem</td>
</tr>
<tr>
<td>--------</td>
<td>-----</td>
<td>--------</td>
<td>-------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Beryl</td>
<td>82</td>
<td>F</td>
<td>Transferred from the X, with prednisolone induced psychosis from steroids and complicated by a UTI, hyponatremia, MMSE 27/30. GSC 15</td>
<td>Lives with daughter.</td>
</tr>
<tr>
<td>Rhonda</td>
<td>92</td>
<td>F</td>
<td>BIBA sudden onset of pain in R knee at rest. Nil observable injury. Knee swollen and inflames. Pt given 2.5 mg morphine IV on route</td>
<td>Had spontaneous rupture of a bakers cyst. CALD Lives at home with son, widow/ Failed ASET mobility review in ED which notes ‘...pt attempted to mobilise severe pain standing, difficulty weight bearing. R knee swollen +++ unable to mobilise only able to take a small number of steps secondary to pain and discomfort. Ortho review notes tense haemorrhesis (bleeding into joint space), advanced OA no # seen. X3 aspiration attempts in ED- unsuccessful’</td>
</tr>
<tr>
<td>Donna</td>
<td>84</td>
<td>F</td>
<td>BIBA- fall. Found on floor naked by neighbour.</td>
<td>BSL 3mmol/L wound behind knee bleeding diarrhoea on scene + blood ? prolapsed bowel. Pain on arrival 0/10. Donna states she ‘ fell gently onto buttocks, waited ½ hour until neighbour heard’ CALD lives alone, recent widow, Donna deteriorates while admitted and passes away. Has no advanced care plan.</td>
</tr>
<tr>
<td>Harriett</td>
<td>94</td>
<td>F</td>
<td>BIBA (called by friend) inc pain in lower back for 3 days, blood in urine, nil N&amp;V.. C/O inc pain when walking, thoracic lumbar region</td>
<td>CALD, Lives alone Catholic care visits, but has a good friend who called ambulance. Deaf in left ear. Has a documentation of ‘compliance issues w/meds- doesn’t like taking meds’ however this was not the case and Harriett was noted to be compliant.</td>
</tr>
<tr>
<td>Lilly</td>
<td>91</td>
<td>F</td>
<td>BIBA fall sore right wrist</td>
<td>Husband is carer and Lilly lives at home. Services are being organised</td>
</tr>
<tr>
<td>Mark</td>
<td>85</td>
<td>M</td>
<td>Presents post seizure. Wife reports pt turned his head to L, became ridged and L arm began to shake nil acute distress</td>
<td>GCS 14= normal for pt. Lives with wife who is carer. Requires prompting and reminding for ADL’s</td>
</tr>
<tr>
<td>Walter</td>
<td>87</td>
<td>M</td>
<td>BIBA-urinary retention and constipation. Has past urine this mane. Distended abdo- nausea and dry retching</td>
<td>Lives alone, IADLs, Using stick as mobility aid, has Cleaner once a wk, Quit smoking many years ago, ETOH one a night. Went to golf club played a round then developed shakes and lower abdominal pain on Tuesday with difficulty passing urine. Discharged from ICU onto surgical ward. Geriatrician R/V = Enablement plan, encourage independence for transfer into rehabilitation</td>
</tr>
<tr>
<td>Bill</td>
<td>64</td>
<td>M</td>
<td>Presents with pain abdo-haemorrhage. Ambulant into tirage c/o PR bleeding, pain 5/10 and cramping. On examination appears thin and lethargic. Weak radial pulse 100 bpm afeb Hx of ischemic colitis, IHD</td>
<td>Married lives with wife. Was transferred into coronary care ward</td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Gender</td>
<td>History</td>
<td>Current Condition</td>
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<tr>
<td>Ronald</td>
<td>82</td>
<td>M</td>
<td>Present with pain acute 11.00</td>
<td>Presented with Abdo pain upper and lower back after mowing the lawn. Becomes rapidly unwell in ED requiring emergency laparotomy for a duodenal perforation D/C to ward on day 4. Has PCA</td>
</tr>
<tr>
<td>Suzanne</td>
<td>65</td>
<td>F</td>
<td>Complications of chemotherapy / haematology / oncology. BIBA w/ lethargy, T 39.1 HR 110 nil pain, nil SOB, seizure yesterday. GCS 15</td>
<td>Mobilises with a 4ww. Carer for her husband who has had recent extensive cardiac surgery. Suzanne has had her diagnosis of a brain tumour only 3 months ago, she has had two craniotomies and at the rehabilitation centre broke her ankle. She has increasing weakness on her left side.</td>
</tr>
<tr>
<td>Mildred</td>
<td>81</td>
<td>F</td>
<td>Fall unspecified, BIBA passer-by found outside unit GCS 14/15 bilat pain in knees</td>
<td>Mildred states she went to check on her mailbox yesterday at 1900, slipped and fell down-states she slept outside all night, c/o bilat hip pain and couldn’t get up. Then stated that she crawled inside to take her meds, unable to explain how she got back outside.</td>
</tr>
<tr>
<td>Allison</td>
<td>85</td>
<td>F</td>
<td>Fall unspecified, BIBA carer concern = vital call, ambulant to ambulance</td>
<td>Lives alone. Social issues extensive family involvement regarding Allison staying at home or going into a hostel. Allison states she does not want to live in a hostel</td>
</tr>
<tr>
<td>Fleur</td>
<td>92</td>
<td>F</td>
<td>referred GP to ED, Discharged from XX hospital yesterday post fall 2/52- fell on tailbone and hit head on floor. Since discharge minimal mobilisation due to pain across lumbar region, R Knee &amp; N/V. And decreased in ADL's BIBA from home as per community RN.</td>
<td>Fleur had fallen and on presentation to another hospitals ED was discharged that day. The next day the community nurse called an ambulance for her as she had not moved. On the second presentation to the same previous ED it was noted that she had acute on chronic sacral fractures. This event was documented and policy and procedure was noted to of been followed. Fleur was then transferred into the study site.</td>
</tr>
<tr>
<td>Julia</td>
<td>74</td>
<td>F</td>
<td>BIBA dizziness, lethargy, palpitations and general malaise. Decreased appetite 5 days. Pt had PPM 3 weeks ago (CRT-P no defib). Pt looks tired HR irregular on monitor 34-80 Bpm. Pt states feels irregular. Nil N &amp; V bp 162/83 T 36, pt warm and well perfused. good radial pulse</td>
<td>Lives alone, has a friend who visits a couple of times a week. No services- independent with ADLs and mobility. Had a pace maker inserted, became very unwell in the community and represented. Noted issues with pacemaker. Noted full policy and procedure had been followed regarding the reporting of this event. Not for resite of pace marker unless non-capture or diaphragm stimulation. Nil further events since sotalol ceased and PPM reprogrammed and is working appropriately. Julia has become de-conditioned requiring OT, SW and physio input.</td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Gender</td>
<td>Presenting Complaints</td>
<td>Medical History</td>
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<tr>
<td>Martha</td>
<td>90</td>
<td>F</td>
<td>Presents with fall unspecified BIBA after fall. Skin tear to bilat legs and R hand. Nil LOC. Able to wgt bear, some pain in back from deep breathing</td>
<td>Non-smoker, lives with daughter, good social support, very independent. Does not receive a PCA. Has a history of polio myalgia with cardiac complications. Martha states she lost her balance in front garden after returning from visiting family who live 5 hours’ drive away. She informs me that she is anxious for discharge as a granddaughter has had a new baby who lives 6 hours away and Martha wants to go and see the baby as well as help out as much as she can.</td>
</tr>
<tr>
<td>Brigid</td>
<td>84</td>
<td>F</td>
<td>Pain generalised with deterioration in general health, decreased appetite due for a Hartman’s next month. Walked into ED department</td>
<td>Not able to cope at home, lives alone, daughter concerned that surgery will be refused if Brigid loses more weight. New diagnosis of bowel cancer. Has a RRT call during admission for hypotension. Brigid states in her interview that she had extensive PR bleeding but did not want to go to her doctor because he is male. She has a colostomy bag which she thought was going to bigger because the nurses described it as the size of a handbag and her handbag is a large one. Also she developed a pressure ulcer on her heel.</td>
</tr>
<tr>
<td>Hilda</td>
<td>78</td>
<td>F</td>
<td>BIBA after onset of pain at 5 am. Presents with diarrhoea, pain, abdo, N&amp;V States SOB ass w/ pain O/A alert and well perfused. OBS 190/90, 37 OC, 97 bpm given morphine 10 mg and odansetron on route with good relief BSL 11.4mmol/l States much better now due to pain relief</td>
<td>Lives alone, has extensive social issues and a new diagnosis of somatoform disorder and dementia. In her notes a summary was presented by the psych review that outlined the numerous surgical and medical consults that Hilda had received, notably although her initial complaint is about abdominal pain there is no case management noted nor input sort from the acute pain service</td>
</tr>
<tr>
<td>Ian</td>
<td>77</td>
<td>M</td>
<td>BIBA SOB, presents with respiratory, pt alert not talking RR 60, SaO2 100% on 6Lt O2 with salbutamol neb, normotensive low grade temp.</td>
<td>Discussion in ED re: NFR Ian states this has never been discussed with him before, not ready to make decisions about this but asked to think about it. Not for home O2 due to current smoking. lives with daughter, home care x3 week</td>
</tr>
<tr>
<td>Molly</td>
<td>73</td>
<td>F</td>
<td>Transfer from x following admission for N&amp;V, for rehab. Presents with pain, R hip difficulty moving due to pain, awaiting a hip replacement</td>
<td>Has just placed a 2 year apprehended violence order out against son (10 weeks ago) previously son was live in carer, now neighbour is the carer and pt lives alone. Volunteer. House bound. widower 3 years Molly was to have her hip replacement done after waiting 18months earlier this year. At her pre-op clinic it was identified that she required a pace maker and her upcoming hip and later knee surgery was cancelled.</td>
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<td>Name</td>
<td>Age</td>
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<td>Details</td>
<td>Notes</td>
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<tr>
<td>Hazel</td>
<td>85</td>
<td>F</td>
<td>BIBA presents with pain, pain 6/10 radiating to back, epigastric sternal pain. Given GTN, aspirin</td>
<td>In the medical notes it is documented that Hazel states she felt unwell and took some bi-carb</td>
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<td>and ondansetron by paramedics became hypotensive, now pale, wants to use bowels. Pain 1/10.</td>
<td>and vomited. Son present- states Hazel has a tendency to ‘self-medicate’ Hazel denies: Hazel</td>
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<td></td>
<td>Husband passed away at 0300 this am.</td>
<td>is quite upset her husband passed way 0300 on day of admission to ED (1400). Lives alone.</td>
</tr>
<tr>
<td>Iris</td>
<td>66</td>
<td>F</td>
<td>Elective admission for surgery, L mastectomy</td>
<td>Has an adverse event post op- develops a bleed and requires readmission into theatre. Iris</td>
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<td>was aware and informed about this. For this second readmission into the operating theatre it</td>
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<td>is noted in the medical notes that she was a difficult intubation due to ‘minimal neck flexion’.</td>
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<td>Iris lives at home, husband is carer for her and for her adult developmentally delayed grandson</td>
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<td>who lives with them. States struggles with ADL’s, requires help from husband. Can walk 100m</td>
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<td>limited by pain and shortness of breath. Significant polyarticular arthritis likely cause-</td>
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<td>including C-spine. History of recurrent falls.</td>
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<tr>
<td>Ninnette</td>
<td>66</td>
<td>F</td>
<td>P/G presented to haematology C/O SOB, rash, puffy eyes due to present tomorrow for treatment</td>
<td>Ninnette is from the country about 7-8 hours’ drive away and is receiving treatment as an output</td>
</tr>
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<td>by staying locally in hospital accommodation. Ninnette presented to haematology ward when she</td>
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<td></td>
<td></td>
<td>becomes sick, instead of ED. Ninnette experiences shingles for the first time while in hospital</td>
</tr>
<tr>
<td>Carol</td>
<td>84</td>
<td>F</td>
<td>Elective surgery, excision of skin lesion</td>
<td>Lives in retirement village alone, daughter near by.</td>
</tr>
<tr>
<td>Kirsty</td>
<td>75</td>
<td>F</td>
<td>Elective admission for surgery, R/O melanoma R foot +/- skin graft</td>
<td>Lives alone</td>
</tr>
<tr>
<td>Astrid</td>
<td>79</td>
<td>F</td>
<td>BIBA with L chest pain since early mane C/O SOB, O/A eyes shut, easily rousable, dry mucous</td>
<td>CALD Lives in granny flat next to daughters house.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>membranes, normotensive, RR16, poorly perfused looks Jaundiced, Nil further C/O pain given 2x GTN</td>
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<td></td>
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<td></td>
<td>and 120mg fentanyl, CALD Lives in granny flat next to daughters house.</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Sex</td>
<td>Medical History</td>
<td>Current Status</td>
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<tr>
<td>-------</td>
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</tr>
<tr>
<td>Sally</td>
<td>86</td>
<td>f</td>
<td>Presents with injury- BIBA. Was washing leg large skin tear to same. Nil distress NSW AS states V SOB on exertion. 3x dressings in situ- blood stained.</td>
<td>Experiences a lot of pain during wound dressing. Got skin tear from fall originally. Has Geriatrician review for rehabilitation. Sally has so much pain from her injury.[see appendix] that she refuses to mobilise to the bathroom and becomes functionally incontinent. She receives input from the wound CNC nurse who documents that her wound care has been inappropriate and this is formally reported.</td>
</tr>
<tr>
<td>Edith</td>
<td>83</td>
<td></td>
<td>Admitted for non semi and APO. BIBA APO bi-lat crackles. 85% NRB.</td>
<td>Lives alone, independent with ADLS, meals on wheels, cleaner 1x fortnight. Supportive daughter walks 50m</td>
</tr>
</tbody>
</table>
Appendix 8: A reflective statement by the researcher

I am a clinically current ICU RN who works in a very large tertiary referral trauma ICU that I am told has a catchment area the size of Scandinavia. In my clinical work, I routinely consult with the current policy and procedure that is available on the computer. I also will direct transitional nurses to also look at the policy and procedures as well as clinical practice guidelines on the web site. This is because the ICU I work in is a mixed general ICU and from shift to shift an RN will be required to look after surgical, medical, cardiac, neurological and trauma patients at a moment’s notice. Therefore, to standardise and reduce ambiguity I will consult the computer and ask the more senior nurses as well as the doctors about patients. I like working like this and I feel comfortable knowing that I am doing my utmost to provide EBP care for the ICU patients that I care for.

I also have undertaken a qualitative descriptive previous pilot study using an ethnographic approach to explore how close to nurses clinical practices was a pain assessment and management algorithm. I compared the algorithmic approach to the nurses in order to determine if it was reflective or congruent with the clinical setting. Presented as an honours in nursing thesis, primarily I identified that nurses were undertaking a lot of pain assessment and management activities that were incongruent with the EBP algorithm. This lead to this PhD as the previous pilot study was small and did not include the older person. Furthermore the pilot study was located within one hospital setting and I was unable to determine if what I had identified merely required a quality improvement within that setting or not. Therefore I extended the study out into two different hospitals from the initial pilot study and I went into as many acute care wards as possible. I am convinced that nurses are the experts in assessing and managing
pain but no one knows what it is that they are doing due to the lack of research in this area and as well, I am concerned that the older person’s perspectives of receiving this pain care provision are not known. This is more so for those who have a cognitive impairment. I know that ethnography is time consuming but I am also aware of how powerful it can be after my minimal experiences within the pilot study.

**Walking onto the wards.**

The following is a reflective statement written by the researcher at the beginning of the study. It is written in the first person perspective. The aim is to give the reader an idea of what it is like to walk onto numerous acute care wards and immerse yourself for 6 months.

As I enter the wards I am always struck at first by how empty they initially appear. I say ‘hello’ to the ward clerk who is at the front desk and typically located at the entrance of the ward, but I keep walking. I know what I am doing. I walk forward and I have my props at my side, being a small bag and a pen. I do not stop and I always project a smile and confidence. I know to say ‘hello’ to the ward clerk and call them by name. I know that the ward corridor can be followed in whichever way it twists or turns, if I come to a dead end, I just turn around. I look at the nurses I smile and say ‘hello- how you going’ to those who will make eye contact. Nurses, who don’t make eye contact, do not want to disturbed and they will move with purpose, because they are busy in a task.

I know how to walk onto a ward because I am a registered nurse who has a lot of experience with walking onto different wards. When I worked in acute care previously before ICU, I undertook a series of rotations between vastly different acute care wards in a total of four hospitals within two different area health services over a period of two years. In total I worked in seven different types of acute care wards. I do not, (nor ever
have) worked in any senior role being NUM, Acting NUM, Nurse Educator, and nor am I a clinical nurse consultant or even a clinical nurse specialist.

I am a ward nurse, admittedly the location of where I work has now changed and I work part time in ICU, but I am still a ward nurse. I am not employed by any of the participating hospitals; however I am employed within the same area health service local district.

I walk down the corridors and sometimes I see nurses flit across from room to room in the distance if it is a long ward. If the design of the ward leaves the corridors crooked and bent, I am aware that a nurse will ‘pop’ around a corner at any time. I see ‘packs’ of people moving in groups. I pass the nurse stations and see people sitting down at the bench writing or on the phone. The nurses wear uniforms. Sometimes they will have a name badge on. It can be tricky to determine who they are, what type of nurse they are and what their name is, as the name badge can be at hip or chest height which is often obscured. All around is a hive of activity with a muted hum of conversation. People talking, laughing, groaning and making noise.

I see glimpses of patients in rooms as I pass. In bed, sitting on chairs, being wheeled on commode chairs. I see them being walked by the physiotherapist, I see them talking to their family members or nurses. Occasionally I pass one in the corridor and say ‘hello’. Easy to see who is who, the patients all have gowns on or PJ’s, and the visitors have street clothes on. The patients will have wound dressings, IV poles with pumps that are beeping. Sometimes they are lying on their bed, staring at the TV or seemingly into space, into nothing.

I am an ICU nurse and I ‘see’ patients differently. I see them as being stable, uncomplicated and not at risk of deteriorating. I look at the interventions and view them
from an ICU point of view - simple, uncomplicated and routine. I look at the nurses and do not see a busy ward. I miss the sound of constant beeping machinery that indicates in ICU a fluctuation from standard. I know the sounds of ventilators, dialysis machines, IV pumps, feed pumps, and the alarms on the monitors, plus many more. A multitude of sound, a cacophony of beeping things that puts the families who visit on edge and baffles the RMO’s. I can still hear my fellow ICU colleagues calling for others to watch their patients while they leave them to get a drug, to speak to the RMO and get a trolley ready for an emergency intubation or the crash trolley for CPR. I hear the tone and pitch of the nurses’ voices increase when things are going wrong and the shouts for assistance when things are going ‘pear shaped’.

Now the acute care wards I see it as quiet and calm. I can hear the quietly modulated tones of nurses and doctors in discussion. Occasional bursts of laughter and comments about the weather. I can only hear a beep from a patient requesting assistance, which goes up in a leisurely tone when not answered in time. Occasionally I hear a PCA machine that ‘squeals’ when the infusion is about to run out. I also hear constantly the IV machines beeping and I know this means that the infusion has ended. I hear the staff asking for keys in an unhurried tone. I see people having muffled conversations. I look at people moving unhurriedly. The atmosphere to me is relaxed, restful and pleasant to the point of being dull at times.

I make sure that I keep this to myself. I know better than to say how ‘quiet’ it appears to me. I nod my head with sympathy when the nurses talk about the RRT that happened that morning, how busy it was then, and how busy it is now. I know from my past experience of working on acute care wards that the perceptions of what nurses term ‘busy’ will be different from ward to ward. I am acutely aware because I do know; I remember what it is like to have a busy day on an acute care ward.
I know that each ward has different interpretations of what busy means. Some wards this means a lot of admissions and discharges, a patient who has died, or a busy surgical day list. Having a heavy patient load makes a shift busy. Or a patient who requires a lot of interventions, such as complicated dressings, medication regimes, meetings with family and input from others. Being in charge also makes a day busier as well as having a student nurse to mentor. These wards I know are busy; they are just a different type of busy.

I make sure that I am dressed in smart casual clothes with shoes that cover my foot and have a flat heel. My shoes have grip and do not make a sound. I do not want shoes that make a ‘click clack’ noise. The ‘click clack’ is the sound of a woman wearing a pair of heels, not nursing shoes. The nurses all know the sound of ‘click clack’ shoes- they are the shoes worn by those who do not work regularly on a ward and typically are senior managers.

I have a badge at chest height that reads ‘Joanne Harmon’. It is in very large print. I also have my student identification badge at hip height. At one hospital site I sign in every time and wear a visitor’s badge. I like my badges, they identify that I am a nurse and not a doctor, that I have a purpose for being there.

I have a small canvas bag that I got at a nursing conference; it has a nursing logo on it about residential care. Within this bag is my diary for making dates for field work, posters to put up on the ward and information sheets about the study along with consent forms. I usually put it somewhere at the nurses’ station. It is a bag that says ‘nurse’ all over.

When I do my observation periods I have a small flip pad that I write in, and a small handbag where it can fit in a side pocket. In my bag I only have some pens, some
antacids and a small amount of cash. I use the cash to buy a coffee. All sites have coffee carts or a small shop where you can buy a coffee of varying degrees of palatability—hence the antacid. I learn to be cautious of the coffee, but I sit and have one any way.

Why do I sit and drink bad coffee? This is because everyone comes to the coffee shops. At some stage or another NUM, the DON, a nurse or an older person participant will walk past or stop for a coffee and a chat. It is another chance to talk and socialise. I answer questions and I share my enthusiasm for the study. I do not sit there and write up a reflection or do any written work. As I noted that I would concentrate on my work and miss opportunities to speak to people.

Speak to people! I am talking all the time. I talk to everyone, physiotherapists, doctors, anyone who I can engage. I know that the more I talk about my study, the more normalisation that will result and also I have an alternative motive. It keeps me on the spot and makes the time that I spend on the ward go for longer. I am being seen at the scene as it were. It is very easy to walk through a ward and not engage with any of the nurses. So depending on how busy the ward is I try to talk to everyone. First up I will speak to the in-charge nurse, clinical care co-ordinator and the NUM. I do this to because it is polite to let them know that I am there; this becomes increasingly less formal as time progresses.

I do this in order to immerse myself in the scene. This is because of all the formal in services I initially undertook to introduce myself, the response of the ward nurses on hearing about the study was that I was there to ‘audit them’. I noted in my reflective diary that;

*The nurses on these wards equate any person doing research about the field of nursing is a quality improvement person who is auditing them for compliance with policy and procedure; such*
as if they have their personal protective equipment on them. I found out very quickly that none of them had ever actually met or spoken to a nurse who did any sort of sociological research about what nurses did, for nurses and by nurse. I had not counted on their lack of knowledge nor preconceptions.

(Reflective journal entry 9)

The nurses on the ward simply did not have a category for me, so I invented one that involved being present at all shifts, polite and asking them about their day as well as also speaking openly and candidly about research. I knew that I was making in-roads when midway through the fieldwork the nurses on the ward starting informing other nurses and health care providers that I was ‘their research nurse’ who was ‘doing research’ about ‘them and what they did’.